

Do you have a history of or conviction for a violent crime? Yes No

If yes, explain: _____

How did you learn about UBCSS? _____

Who referred you? _____

Why are you interested in working for UBCSS? _____

After reviewing the functions of the position you are applying for, do you have the ability to perform the essential functions of the position in a reasonable manner? Yes No

Note to applicant: Do not answer this question unless you have been informed about the requirements of the position.

Educational Data

<i>Name & Address of Sr. High, College, University, Graduate School & Post Graduate School</i>	<i>No. of years attended</i>	<i>Major</i>	<i>Degree</i>	<i>Date Conferred</i>
High School				

Subject Matter of Thesis and/or Dissertation: _____

Fellowships (if teaching fellowships, name course taught; if research, name area of study)

<i>Field of Study</i>	<i>University</i>	<i>From Month/Year</i>	<i>To Month/Year.</i>	<i>Supervisor</i>

Internship/Residency/Practicum

<i>Agency: Public-Private, Clinic, Hospital, School</i>	<i>From Month/Year</i>	<i>To Month/Year.</i>	<i>Responsibilities</i>	<i>Supervisor</i>



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EMPLOYMENT APPLICATION ADDENDUM

Please complete as fully as possible.

Have you ever been convicted of a crime?

_____ Yes

_____ No

Have you ever had a finding of abuse or neglect?

_____ Yes

_____ No

Do you have any civil conviction?

_____ Yes

_____ No

Have you been adjudged civilly or criminally liable for abuse of a mentally challenged individual?

If YES, Please provide details such as nature of the conviction/finding of circumstances surrounding the conviction/finding. Date of age when committed or finding issued. Was the conviction/finding an isolated incident, and evidence of rehabilitation?

Signature

Date



PRACTITIONER CHECKLIST

Clinicians Name: _____ Degree: _____
 License Type, State & #: _____
 Date issued: _____
 NPI#: _____
 Taxonomy Code: _____

DIRECTIONS: Check yes or no for each item as it applies to your professional clinical background. For each item checked yes, attach a detailed description of the event, including copies of relevant documentation. Failure to provide sufficient information required determining a clear understating of the nature and outcome of the event can result in rejection of your application.

1. Has your professional liability insurance ever been denied, canceled or not renewed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever had your medical or professional license or registration revoked, suspended or limited?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever voluntarily relinquished your professional license or registration when there was a challenge or pending challenge to the professional license?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is there a pending challenge to your professional license or registration?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has your professional or clinical staff membership ever been voluntarily or involuntarily suspended or terminated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever surrendered your clinical privileges upon threat of censure, restriction, suspension, or revocation of such privileges?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has Medicare, Medicaid, or any other federal, state or local authority brought charges against you for alleged inappropriate rates, billing or quality of care issues?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you ever been named as a defendant in any criminal proceeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you ever been convicted in any crime involving the abuse of minors?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have you ever been subject of disciplinary actions by any professional association or organization, e.g., licensing board?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Has your facility membership in any medical or other professional school ever not been renewed or subject to disciplinary action?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Are there any current health problems that make you unable to carry out any essential professional duties as defined by the requested appointment and privileges, and your job description in the agency under the contact being sought?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Are you aware of any pending malpractice claims?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Have you ever had any malpractice claims settled?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Have you ever been debarred from contracting with the State of Delaware, any other State or the government of the united States?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychiatrists Only	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Have you ever had your permit to prescribe drugs revoked or suspended?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Has your specialty board status ever been suspended, diminished, revoked or not renewed?	<input type="checkbox"/> Yes <input type="checkbox"/> No



AUTHORIZATION TO RELEASE INFORMATION

I, _____,
(NAME-PRINTED)

hereby authorize you, as a former, (herein the “Company”) to release and disclose to Upper Bay Counseling and Support Services, Inc. (“Upper Bay”), and its agents, information pertaining to my employment. I release the Company and Upper Bay and their employees or agents from any damages, liabilities, and /or claims that may result from the release and indemnify Upper Bay (and its agents and employees) against any liability that my result from making inquires about me to that Company.

I hereby further authorize that a photocopy of the authorization may be considered as valid as an original.

Date: _____

Signature: _____

Other names used at the Company, if applicable:

Witness: _____

(Name-Printed)



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EDUCATION VERIFICATION

Name of Applicant

Social Security #

Name & Address of School:

Phone & title of person supplying the information:

Information Verified:

Degree: _____

Major: _____

Date Graduated: _____

Other: _____

I authorize you to respond to this request and consent to the release of information verifying my education to UBCS MD/DE Statewide Operations.

Signature of Applicant

Date

Signature of HR Representative or Designee

Date



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DRIVER'S SUPPLEMENT TO PRE-EMPLOYMENT APPLICATION

Name: _____ Job Title: _____

Driver's License No: _____ State _____

Expiration Date: _____

Home Telephone# _____

Is your License under suspension? Yes ____ No ____

Has your License been revoked? Yes ____ No ____

Are you 21 years old or older? Yes ____ No ____

Is your driver's license restricted? Yes ____ No ____

If so, please explain _____

Do you have points against your license? Yes ____ No ____

If so, please advise number of points _____

I hereby authorize UBCSS and it's affiliates or agents to investigate my driver's record.

I certify that the above information is complete and correct to the best of my knowledge.

I, the undersigned, understand that before UBCSS takes an adverse action against me based on the information acquired in the Driver's License check UBCSS will provide me with a copy of the report.

Signature: _____

Date: _____