APPLICATION FOR EMPLOYMENT

CLATSOP BEHAVIORAL HEALTHCARE

65 N Hwy 101, Suite 204
Warrenton, Oregon 97146

Equal access to programs, services, and employment is available to all persons. Those applicants requiring reasonable accommodation to the application and/or interview process should notify Clatsop Behavioral Healthcare Human Resources at (503) 325-5722.

PLEASE PRINT

Position(s) applied for:_________________________ Date of application _______________

Date available to begin work: _____________

NAME:____
(LAST) (FIRST) (MIDDLE)

ADDRESS:____
(STREET) (CITY) (STATE) (ZIP)

MAILING ADDRESS:____
(if different than above) (PO BOX) (CITY) (STATE) (ZIP)

TELEPHONE ______________________ CELL:____

APPLICANT'S CERTIFICATION

Please read carefully before signing. If you have any questions regarding the following statements, please ask for assistance.

I certify that, to the best of my knowledge and belief, the answers given by me to the foregoing questions and the statements made by me in this application are correct and complete. I understand that any false information contained in this application may result in my discharge.

I authorize you to communicate with all my former employers, school officials and persons named as references. I hereby release all employers, school and individuals from any liability for any damage whatsoever resulting from giving such information.

I understand that as this organization deems necessary, I may be required to work overtime hours or hours outside a normally defined work day or work week. If employed, I understand and agree that such employment may be terminated at any time and without any liability to me for any continuation of salary, wages, or employment related benefits.

_______________________________________ ________________
APPLICANT'S SIGNATURE DATE

EDUCATION AND TRAINING

HIGH SCHOOL________________________________(Years) 9 10 11 12 GRADUATED [ ] YES [ ] NO
GED [ ] YES [ ] NO

COLLEGE/UNIVERSITY____

COMPLETE ADDRESS:____

MAJOR__________________________DEGREE________________________YEAR RECEIVED:________________

PROFESSIONAL/SPECIALITY LICENSE TYPE ____

COLLEGE/UNIVERSITY____

COMPLETE ADDRESS:____

MAJOR__________________________DEGREE________________________YEAR RECEIVED:________________

PROFESSIONAL/SPECIALITY LICENSE TYPE ____

TRADE SCHOOL________________________SUBJECT:________________________YEAR COMPLETED:________

COMPLETE ADDRESS:____

APPRENTICE SCHOOL:________________________SUBJECT:__________________YEAR COMPLETED:________

COMPLETE ADDRESS:____

MAY WE REQUEST A DEGREE VERIFICATION? [ ] YES [ ] NO

SIGNATURE____**DATE**____________________

Were you previously employed by Clatsop Behavioral Healthcare? [ ] YES [ ] NO

Are you legally eligible for employment in this country and can show verification? [ ] YES [ ] NO

Have you ever had a substantiated allegation of abuse? [ ] YES [ ] NO

LANGUAGE PROFICIENCY

LIST LANGUAGE SKILLS, OTHER THAN ENGLISH, YOU HAVE AND YOUR LEVEL OF PROFICIENCY
(SPEAK, READ, WRITE, ETC.) ____

____

WORK EXPERIENCE

(LIST THE LAST TEN (10) YEARS' WORK EXPERIENCE BEGINNING WITH THE MOST RECENT)
(IF NEEDED, PLEASE ADD ADDITIONAL PAGE)

NAME OF EMPLOYER: ____________________

TYPE OF BUSINESS: ____________________ PHONE NUMBER ____________________

ADDRESS: ____________________
(STREET) (CITY) (STATE) (ZIP)

DATES EMPLOYED: FROM __________ TO __________ WAS EMPLOYMENT [ ] FULL-TIME [ ] PART-TIME

REASON FOR LEAVING: ____________________ MAY WE CONTACT EMPLOYER? [ ] YES [ ] NO

BRIEF DESCRIPTION OF DUTIES: ____________________

NAME OF EMPLOYER: ____________________

TYPE OF BUSINESS: ____________________ PHONE NUMBER ____________________

ADDRESS: ____________________
(STREET) (CITY) (STATE) (ZIP)

DATES EMPLOYED: FROM __________ TO __________ WAS EMPLOYMENT [ ] FULL-TIME [ ] PART-TIME

REASON FOR LEAVING: ____________________ MAY WE CONTACT EMPLOYER [ ] YES [ ] NO

BRIEF DESCRIPTION OF DUTIES: ____________________

NAME OF EMPLOYER: ____________________

TYPE OF BUSINESS: ____________________ PHONE NUMBER ____________________

ADDRESS: ____________________
(STREET) (CITY) (STATE) (ZIP)

DATES EMPLOYED: FROM __________ TO __________ WAS EMPLOYMENT [ ] FULL-TIME [ ] PART-TIME

REASON FOR LEAVING: ____________________ MAY WE CONTACT EMPLOYER? [ ] YES [ ] NO

BRIEF DESCRIPTION OF DUTIES: ____________________

REFERENCES

LIST SUPERVISORS AND CO-WORKERS KNOWN, BUT NOT RELATED TO YOU, FOR AT LEAST 3 YEARS

1. NAME:________________________________TITLE:____________________YEARS KNOWN:___________

   BUSINESS:____________________________________PHONE NUMBER:____________________

   EMAIL_______________________________________

2. NAME:________________________________TITLE:____________________YEARS KNOWN:___________

   BUSINESS:____________________________________PHONE NUMBER:____________________

   EMAIL ______________________________________

3. NAME:________________________________TITLE:____________________YEARS KNOWN:___________

   BUSINESS:____________________________________PHONE NUMBER:____________________

   EMAIL:______________________________________

Pre-Employment Driving Record Screening

Request for Department of Motor Vehicle Record

Clatsop Behavioral Healthcare is requesting the completion of the following so a motor vehicle record report can be obtained prior to hiring and will be reviewed annually for all employees. By completing, signing and dating this form you acknowledge consent to obtain your motor vehicle record and consent to the information contained therein to be used by CBH and its insurance company to determine your employment eligibility for this driving position. Infractions involving alcohol, excessive speed or unsafe driving practices could be grounds for not being hired or termination of employment as the employer sees fit. It is your responsibility to contact the Department of Motor Vehicles to dispute any discrepancies you feel exist on your Motor Vehicle Record. Neither the employer nor the insurance agency takes any responsibility for the information contained therein.

Name:____

Date of Birth:____

Driver's License Number:_________________________________

State Licensed:____

Signature:____

Date:____

A Motor Vehicle Records check will be completed by HR for Oregon licensees only. Any out of state licensed candidates will need to submit their Motor Vehicle Record report prior to hire and annually thereafter.

Please submit application along with your cover letter and resume to jobs@clatsopbh.org. Please also include the position title in the subject line.