



**Upper Bay Counseling & Support Services,
Inc.**
200 Booth Street, Elkton, MD 21921
Phone: 410-996-5104
Fax: 410-996-5197

Position:	_____
Date Employed:	_____
Unit or Dpt.:	_____
Salary:	_____
Status:	<input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> T <input type="checkbox"/> FFS
Work Schedule:	_____
Replacement:	_____
Addition:	_____

Date: _____

The employment policies of UBCSS are to recruit and hire qualified employees without discrimination because of race, religion, creed, color, age, sex, marital status, national origin, citizenship status, ancestry, disability, veteran status, communication ability or sexual orientation and to treat them equally with respect to compensation and opportunities for advancement – including upgrading, promotion and transfer –consistent with individual skills and the needs of UBCSS.

Please print:

Name: _____
Last First Middle

Address: _____
Street & Number City State Zip

Telephone: _____ Cell Number: _____

Email: _____

SECTION I

Employment Desired

Position Applying For: _____ Full-time Part-time

Hours Preferred: _____ Date available to start work: _____

Have been previously employed by UBCSS? Yes No

If so, Position? _____ When? _____ Supervisor? _____

Salary Expectation: _____

Personal

Are you currently charged, excluded, suspended, debarred, or otherwise ineligible to participate in the federal health care programs, including Medicare and Medicaid? Yes No

Have you ever been discharged from employment? Yes No

Have you ever been discharged from employment due to abuse of residents or clients?

Yes No If yes, explain: _____

How did you learn about UBCSS? _____

Have you or anyone you know ever been in treatment here (if so, who and when) _____

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># of Credits</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>

List all professional Licenses and/or Certificates

<i>License/Certificate</i>	<i>State-issuing Organization</i>	<i>Number</i>	<i>Date Issued</i>

Previous Employment Record

(List previous 5 years, if applicable)

List most recent employment first

<i>From</i>	<i>To</i>	<i>Employer Name Address & Phone</i>	<i>Position</i>	<i>Salary</i>	<i>Reason for Leaving</i>

May we contact your present employer for references? Yes No

Employment/Professional References

<i>Name</i>	<i>Relationship to Candidate</i>	<i>Title</i>	<i>Organization</i>	<i>Address & Telephone</i>

Personal References

<i>Name</i>	<i>Address</i>	<i>Occupation</i>	<i>Telephone</i>

Friends or Relatives Employed by UBCSS (including relatives by marriage)

<i>Name</i>	<i>Location</i>	<i>Relationship</i>

Do you have any plans for continuing your education or training? If so, what are your plans?

Describe any education, training, or specialized equipment knowledge you have received which would be applicable for work with UBCSS.

SECTION II

Criminal Background

Please complete as fully as possible.

Have you been convicted of a criminal offense related to the provision of health care items or services and have not been reinstated in the federal health care programs? Yes No

Have you ever had any convictions? (This will include state and out-of-state convictions) Yes No

If yes, explain and give date of conviction? _____
(Conviction will not be an absolute bar to employment except as requested by law.)

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

If yes, explain: _____

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? Yes No

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

* **Note:** Please understand that **any falsification** in response to these questions may result in termination of employment or rescission of offer.

SECTION III

Please complete this section if you are a licensed clinician. If not, please check here: Not Applicable

Practitioner Checklist

Degree: _____ License Type: _____ State: _____

Number: _____ 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 understanding 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 the 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 contract 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	
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

Please provide an explanation for any "Yes" answers on the following page

SECTION III

Explanation for “Yes” answers on previous page:

SECTION IV

Psychotherapy Clinical Competency Survey

Purpose of the Survey:

The Clinical Competency Survey was developed to allow psychotherapists to self-identify basic areas of clinical competency. This will assist the Admissions Department to accurately assign new clients to appropriately trained therapists.

If any of the below categories apply to you please put a value in the spreadsheet as detailed below

1 = I have the basic skills to do this

Blank = I cannot do this, I am not sure, I have no real knowledge or experience

Area of Clinical Competence	Rating	Area of Clinical Competence	Rating
1. Early Childhood		17. Anti-Social Personality	
2. Child		18. Dissociation	
3. Adolescent		19. Family Violence	
4. Adult		20. Co-Occurring	
5. Geriatric		21. Eating Disorders	
6. Trauma		22. Gay / Lesbian / Gender Identity	
7. CBT		23. Impulse Control Disorders	
8. Addiction		24. Mood Disorders	
9. Anger Management		25. OCD	
10. Couples / Marital		26. PTSD	
11. Family		27. Sex Offender	
12. EMDR		28. Sex Abuse Victim	
13. ADHD		29. Creative Arts Therapies	
14. Attachment Disorders		30. Other	
15. Serious and Persistent Mental Illness		17. Anti-Social Personality	
16. Borderline		18. Dissociation	

SECTION V

Authorization to Release Information

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

SECTION VI

Education Verification

Name of Applicant: _____ Social Security Number: _____

Name & Address of School: _____

<i>For HR Use Only</i>	
Name, title & phone of person supplying information: _____	

Degree: _____	Major: _____
Date Graduated: _____	Other: _____

SECTION VII

Driver's Supplement to Pre-Employment Application

Name: _____ Job Title: _____

Driver's License No: _____ State: _____

Expiration Date: _____

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 yes, explain: _____

Do you have points against your license:
(within 3 years) Yes No If yes, number of points: _____

Have you received a ticket for speeding,
probation before judgement (PBJ), or any
other vehicle code violation within the
past 5 years? (If "Yes," give date and description of violation(s).
If speeding, include your actual speed and the speed limit.) Yes No If yes, explain: _____

Had any auto insurance refused, cancelled
or expired in the past 3 years? Yes No If yes, explain: _____
Or been excluded or restricted on a
policy in the past 3 years?

Been required to file evidence of financial
responsibility in the past 3 years? Yes No If yes, explain: _____

Had any comprehensive losses (deer, fire,
glass breakage, theft, etc.) in the past 3 years? Yes No If yes, explain: _____

While driving any motor vehicle, commercial
or personal, been involved in an accident during the past
3 years? Yes No If yes, explain: _____

Refused to submit to a chemical test or been
given probation before judgment for an
alcohol violation in the past 3 years? Yes No If yes, explain: _____

I hereby authorize Upper Bay Counseling and its 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 understand that before Upper Bay Counseling takes an adverse action against me based on the information acquired in the driver's license check, Upper Bay Counseling will provide me with a copy of the report.

SECTION VIII

Computer Skill Survey

Please answer the following questions:

Hardware

1. Can you identify the following:

- | | | | |
|----------|------------------------------|-----------------------------|--------------------------------|
| Mouse | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Maybe |
| Keyboard | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Maybe |
| Monitor | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Maybe |
| Power | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Maybe |
| Network | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Maybe |
| Printer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Maybe |
| Modem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Maybe |

Looking at the network port on the PC (assuming the network cable is plugged in) can you tell if you have a network connection? Yes No Maybe

General Computing

2. Do you know how to add the following devices to your PC?

- | | | | |
|-----------------|------------------------------|-----------------------------|--------------------------------|
| Local printer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Maybe |
| Network Printer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Maybe |

3. Do you know how to do the following:

- | | | | |
|--|------------------------------|-----------------------------|--------------------------------|
| Create a desktop shortcut | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Maybe |
| Log off the PC without shutting down | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Maybe |
| Lock/Unlock the PC | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Maybe |
| Change password without being prompted | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Maybe |
| Map a network drive | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Maybe |
| Open an application from the start menu | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Maybe |
| Access Remote Desktop | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Maybe |
| Open/Save a file from a network location | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Maybe |

4. Rate yourself on what you feel your level of knowledge is in each of the following applications using a scale from 1 to 10.

- 1** Having never used the application
- 5** Having used the application and familiar with basic functions, such as formatting, summation, and having used some higher level functions
- 10** Having designed databases, macros, mail merge, effect driven presentations, and used all higher functions

<u>Application</u>	<u>Rating</u>									
Microsoft Word	1	2	3	4	5	6	7	8	9	10
Microsoft Excel	1	2	3	4	5	6	7	8	9	10
Microsoft PowerPoint	1	2	3	4	5	6	7	8	9	10
Microsoft Publisher	1	2	3	4	5	6	7	8	9	10

Additional Comments: _____

APPLICANTS CERTIFICATION AND AGREEMENT

It is unlawful in Maryland to require or administer a lie detector test as a condition of employment or continued employment. An employer who violates this law is subjected to criminal penalties and civil liabilities. I hereby certify that the facts set forth in the above employment application are true and complete to the best of my knowledge. I understand that if employed, falsified statements shall be considered cause for dismissal. I further understand that during my orientation period, my employment and compensation can be terminated, with or without cause and without notice at anytime, and that following my orientation period my employment and compensation can be terminated at anytime, with or without notice, for any reason deemed sufficient by Upper Bay Counseling & Support Services, Inc. (UBCSS). In addition, I agree during my employment with UBCSS I will report to the Corporate Compliance Office if I am charged, excluded, suspended, debarred, or otherwise ineligible to participate in the federal health care programs, including Medicare and Medicaid. I understand that if charged with violation or otherwise found ineligible to participate in federal health program that I will be removed from employment with UBCSS and may not reapply until the resolution of such charges, criminal action, suspension, or proposed exclusion. By accepting employment I agree to these conditions.

I realize that I may undergo an investigation before or at any time of employment as per state law, conducted by the appropriate state and federal agencies. If I am involved in direct care, this investigation must be completed before I begin employment.

I understand that a drug test may be required at UBCSS after being offered employment, but before being employed and employment is contingent upon the satisfactory results of said test. I hereby authorize UBCSS to investigate all information pertinent to my application for employment. I understand that any offer of employment may be rescinded if my references are inadequate or unacceptable to UBCSS in its absolute and sole discretion. I understand that if hired, my employment at UBCSS is temporary and contingent upon the receipt of acceptable results from my criminal background checks so that I am eligible to participate in the federal health care programs, including Medicare and Medicaid. Again, I am aware that employment is contingent upon the satisfactory results of reference checks and other background checks.

Signature **Date**

(If accepted for employment, you must furnish documentation of proof of identity, authorization to work in the United States, and have a drug test performed within 72 hours of hire.)