COLUMBIANA COUNTY MENTAL HEALTH CLINIC d.b.a.
THE COUNSELING CENTER APPLICATION FOR EMPLOYMENT
(PRE-EMPLOYMENT QUESTIONNAIRE) (AN EQUAL OPPORTUNITY EMPLOYER)

Please complete the employment application in its entirety, answering each question, and providing complete dates, address, phone information, etc. Please do not mark "see attached resume" or similar phrase in any section of the employment application.

DATE_____

NAME **SOC.SEC.#**

LAST FIRST MIDDLE

PRESENT ADDRESS

STREET CITY STATE ZIP

PERMANENT ADDRESS

STREET CITY STATE ZIP

PHONE NO._____ **ARE YOU 18 YEARS OR OLDER?** ☐ YES ☐ NO

ARE YOU PREVENTED FROM LAWFULLY BECOMING EMPLOYED IN THIS COUNTRY BECAUSE OF VISA OR IMMIGRATION STATUS? ☐ YES ☐ NO

HAVE YOU EVER BEEN CONVICTED OF A FELONY, SEX RELATED, AND/OR CHILD ABUSE RELATED OFFENSE? ☐ YES ☐ NO

EMPLOYMENT DESIRED

POSITION | DATE YOU CAN START | SALARY DESIRED

ARE YOU EMPLOYED NOW? ☐ YES ☐ NO IF SO, MAY WE INQUIRE OF YOUR PRESENT EMPLOYER? ☐ YES ☐ NO

EVER APPLIED TO THIS AGENCY BEFORE? ☐ YES ☐ NO WHERE?_____ WHEN?_____

REFERRED BY

EDUCATION	**NAME AND LOCATION OF SCHOOL**	**NO. OF YEARS ATTENDED**	**DID YOU GRADUATE?**	**SUBJECTS STUDIED**
HIGH SCHOOL				
COLLEGE/UNIVERSITY				
TRADE, BUSINESS OR CORRESPONDENCE SCHOOL				

LICENSES AND CERTIFICATIONS OBTAINED_____

_____

GENERAL

SUBJECTS OF SPECIAL STUDY OR RESEARCH WORK_____

_____

SPECIAL SKILLS_____

ACTIVITIES: (CIVIC, ATHLETIC, ETC)_____

EXCLUDE ORGANIZATIONS, THE NAME OF WHICH INDICATES THE RACE, CREED, SEX, AGE, MARITAL STATUS, COLOR OR NATION OF ORIGIN, ETC. OF MEMBERS.

U.S. MILITARY OR NAVAL SERVICE_________________________ RANK____________________ PRESENT MEMBERSHIP IN NATIONAL GUARD RESERVES___________

THIS FORM HAS BEEN REVISED TO COMPLY WITH THE PROVISIONS OF THE AMERICANS WITH DISABILITIES ACT AND THE FINAL REGULATIONS AND INTERPRETIVE GUIDANCE PROMULGATED BY THE EEOC ON JULY 26, 1991

EMPLOYERS – LIST BELOW LAST FOUR EMPLOYERS, STARTING WITH CURRENT AND LAST 3

DATE MONTH AND YEAR	NAME AND ADDRESS OF EMPLOYER	SALARY	POSITION	REASON FOR LEAVING (eg, Resigned, Terminated, Laid-off, Quit, or Other)
FROM:				
TO:				
☐ PART-TIME ☐ FULL-TIME	# HOURS PER WEEK			

DATE MONTH AND YEAR	NAME AND ADDRESS OF EMPLOYER	SALARY	POSITION	REASON FOR LEAVING
FROM:				
TO:				
☐ PART-TIME ☐ FULL-TIME	# HOURS PER WEEK			

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TO:				
☐ PART-TIME ☐ FULL-TIME	# HOURS PER WEEK			

IN CASE OF EMERGENCY NOTIFY

NAME ADDRESS PHONE NO.

Date Signature

The Columbiana County Mental Health Clinic dba The Counseling Center follows the rules and regulations governing fair employment practices, all applicant's rights to privacy shall be respected, and the results of inquiries shall be treated as confidential.

COLUMBIANA COUNTY MENTAL HEALTH CLINIC
dba The Counseling Center
LISBON, OHIO

APPLICANT STATEMENT/RELEASE

I certify to the Columbiana County Mental Health Clinic, dba The Counseling Center, hereinafter referred to as the Center, that all the information submitted by me on this application is true and complete and I understand that if any false information is given, if I am employed, my employment may be terminated at any time.

I understand that the position for which I am applying does not involve contractual obligations by myself, nor my employer. That is, employment with the Center is not for any fixed period of time. Employees have the right to resign for any reason and leave the Center at any time for any reason. Likewise, the Center may terminate an employee's employment at time, for any legitimate reason.

It is my understanding that the Center will make a thorough background investigation of my entire work history and may verify all data given in my application for employment, resume, related papers, or oral interviews. I authorize such investigation and I understand that falsification of information given by me shall be grounds for termination.

In consideration of my employment, I agree to conform to the Center's rules and regulations. I agree, at all times, including after successful completion of the introductory period, my employment with the Center is considered to be "at-will" and the employment relationship and compensation may be terminated with or without notice at any time for any legitimate reasons by either party. I also understand and agree that the terms and conditions of my employment may be changed, with or without cause, and with or without notice, at any time by the Center. I understand that no Center representative, other than its Executive Director, and then only when in writing and signed by the Executive Director, has any authority to enter into any agreement for employment for any specific period of time, or to make any agreement contrary to the foregoing.

Having made application with the Center, I hereby authorize any related investigation of my background, whether or not it is of record. I release all persons assisting in the investigation from any liability related to the giving, receiving, and disclosure of such information.

(A copy of this signed release will serve the same as the original.)

SIGNATURE DATE

COLUMBIANA COUNTY MENTAL HEALTH CLINIC dba The Counseling Center

REFERENCES

The Columbiana County Mental Health Clinic dba The Counseling Center follows the rules and regulations governing fair employment practices. Each applicant's right to privacy is respected and the results of all inquiries are treated in confidence by The Center.

APPLICANT NAME: DATE:

INSTRUCTIONS: Please list two different business references (which should include supervisors who have supervised your work in present or recent past employment) and one personal reference (who should not be a relative) in the following section, complete all name, phone, and address information in their entirety. (Please also do not put "See Resume" in lieu of completing each section). Thank you for your attention to this request.

Business Reference 1: (Present or past employment)

Company Name: _____

Individual to Contact: _____

Title of Contact: _____

Telephone Number: _____

Mailing Address: _____

Email Address: _____

Business Reference 2:

Company Name: _____

Individual to Contact: _____

Title of Contact: _____

Telephone Number: _____

Mailing Address: _____

Email Address: _____

Personal Reference:

Name: _____

Relationship (i.e., neighbor, friend): _____

Telephone Number: _____

Mailing Address: _____

Email Address: _____

COLUMBIANA COUNTY MENTAL HEALTH CLINIC
dba The Counseling Center
40722 State Route 154, P.O. Box 429
Lisbon, Ohio 44432

AUTHORIZATION FORM—CONSUMER REPORT

DISCLOSURE

By this document, Columbiana County Mental Health Clinic, dba The Counseling Center, hereinafter referred to as the Center, discloses to you that a consumer report may be obtained as part of a pre-employment investigation and/or at any time during your employment. The consumer report would be used for employment purposes only. If the Center takes any adverse employment action which is based in whole or in part on information contained in the consumer report, you will be notified of the adverse action and provided with a summary of your rights under the federal Fair Credit Reporting Act.

Your signature below authorizes the Center to obtain a consumer report at the present time and/or at any time during your term of employment.

AUTHORIZATION

I have read the disclosure notice above and hereby authorize Columbiana County Mental Health Clinic, dba The Counseling Center to obtain a consumer report at the present time and/or any time during my term of employment.

Print Name:_____

Signature:_____

Date:_____

Save As Print Clear Form