



**Authorization to Contact References**

I, \_\_\_\_\_ hereby give South Bay Mental Health Center, Inc. permission to contact the references listed below for the purpose of verifying job position and performance. I authorize South Bay Mental Health Center to contact my former employers and authorize my former employers to release information pertaining to my record, my work habits, and my work performance while in their employ.

Signature: \_\_\_\_\_

Please provide the names of three **professional references** that are relevant to previous employment experiences and you have known for at least one year.

1.) Reference Name: \_\_\_\_\_

Relationship/ Affiliated By: \_\_\_\_\_

Company/ Agency: \_\_\_\_\_

Phone Number : \_\_\_\_\_

E-mail Address: \_\_\_\_\_

2.) Reference Name: \_\_\_\_\_

Relationship/ Affiliated By: \_\_\_\_\_

Company/ Agency: \_\_\_\_\_

Phone Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

3.) Reference Name: \_\_\_\_\_

Relationship/ Affiliated By: \_\_\_\_\_

Company/ Agency: \_\_\_\_\_

Phone Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

## Employment History

Please complete this section in addition to submitting a resume. Start from the most recent or current position. You may include volunteer positions. Please ensure you document a minimum of a 10-year employment history.

From	To	Company	Position	Salary
Supervisor		Phone Number	Reason for Leaving	May we Contact?

From	To	Company	Position	Salary
Supervisor		Phone Number	Reason for Leaving	May we Contact?

From	To	Company	Position	Salary
Supervisor		Phone Number	Reason for Leaving	May we Contact?

From	To	Company	Position	Salary
Supervisor		Phone Number	Reason for Leaving	May we Contact?

It is unlawful in Massachusetts to require or administer a lie detector test as a condition of employment.  
An employer who violates this law shall be subject to criminal penalties and civil liability.

I hereby state that the information given by me in this application and attached resume is true in all respects. I understand that if any information in this application or attached resume is found to be false in any respect, South Bay Mental Health Center may withdraw any offer of employment or terminate my employment. I understand that this employment application and any other South Bay Mental Health Center document are not employment contracts and that I may leave or be terminated from South Bay Mental Health Center at any time with or without any reason or notice. Any statements made to the contrary are disavowed and should not be relied upon by any prospective or existing employee. I understand that completing this application creates no rights, express or implied, to employment with South Bay Mental Health Center. I further understand that all offers of employment are conditional upon the receipt of references and a Criminal Offender Record Information check deemed acceptable by South Bay Mental Health Center, as well as the successful completion of an introductory period which may be extended at South Bay Mental Health Center's discretion.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\*South Bay Mental Health Center, Inc. complies with laws which prohibit discrimination based on race, age, color, religion, sex, national origin, ancestry, marital status, sexual orientation, disability, generic information, uniformed military service or any other status protected by applicable law.

**CORI Authorization**

(EOHHS XSBMHC)

SOUTH BAY MENTAL HEALTH CENTER, INC. has been certified by the Criminal History Systems Board for access to CORI conviction data and pending criminal case data. As an applicant/employee for a position, I understand that a criminal record check will be conducted for conviction and pending criminal case information only and that it will not necessarily disqualify me. The information below is correct to the best of my knowledge.

\_\_\_\_\_  
Applicant/Employee Signature

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**APPLICANT/EMPLOYEE INFORMATION (PLEASE PRINT)**

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Middle Name

\_\_\_\_\_  
Maiden Name or Alias (If Applicable)

\_\_\_\_\_  
Mother's Maiden Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Place of Birth

Former Addresses: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Sex

\_\_\_\_\_  
Height

\_\_\_\_\_  
Weight

\_\_\_\_\_  
Eye Color

\_\_\_\_\_  
State Driver's License Number

\*\*The above information was verified by reviewing the following form of government issued photographic identification:

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**EMPLOYER INFORMATION**

Requested By:

\_\_\_\_\_  
Signature of CORI-Authorized Employee at South Bay Mental Health Center

## Interviewing at South Bay Mental Health Center: Privacy Practices

At South Bay Mental Health Center, client confidentiality has always been central to our interviewing, training and practice. Additionally, South Bay is compliant with recent federal legislation, referred to as the HIPAA Privacy Rule, designed to protect patient privacy. It is important that you are aware of the Privacy Rule as you begin the interviewing process at South Bay.

HIPAA is the acronym for the Health Insurance Portability and Accountability Act of 1996, which includes provisions requiring national standards re: privacy and security, to protect personal health information. The HIPAA Privacy Rule contains standards for the use and disclosure of an individual's protected health information (PHI) by healthcare providers. The standards set out a range of administrative requirements that assure that healthcare providers maintain an environment that will promote the privacy and security of PHI. Improper uses or disclosures of PHI are subject to criminal and civil sanctions.

The Privacy Rule:

- Limits the use and release of individually identifiable health information;
- Gives patients the right to access their medical records;
- Restricts most disclosure of health information to the minimum needed for the intended purpose;
- Establishes safeguards and restrictions regarding disclosure or records for certain public responsibilities, i.e., public health, research and law enforcement;
- And requires healthcare providers to provide patients with notice of patient's privacy rights and the healthcare provider's privacy practices.

By signing this form, I acknowledge my understanding that individually identifiable health information is protected by the HIPAA Privacy Rule, which limits the use and restricts disclosure of protected health information.

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Signature of Applicant

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Date of Applicant Signature

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Printed Name of Applicant

# Affirmative Action Voluntary Information

To be completed by applicant. Not for interview purposes. To be filed separately from application. This information is used to satisfy the Affirmative Action requirements of Section 503 of the Rehabilitation Act or is necessitated by another federal law or regulation.

As required, we comply with government regulations including Affirmative Action obligations where they apply.

In an effort to comply with requirements regarding government record keeping, reporting and other legal obligations, we ask that you complete this applicant data survey. Your cooperation is appreciated.

Please be advised that this survey is not a part of your official application for employment. It is considered confidential information that will not be used in any hiring decision.

We consider applicants for all positions without regard to race, color, religion, sex, national origin, age, veteran status or any other legally protected status.

Position(s) applied for \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Referral Source

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Walk-In                    | <input type="checkbox"/> Government Employment Agency | <input type="checkbox"/> Private Employment Agency |
| <input type="checkbox"/> Employee                   | <input type="checkbox"/> Relative                     | <input type="checkbox"/> School                    |
| <input type="checkbox"/> Advertisement-Source _____ |   | <input type="checkbox"/> Other _____               |

Name of person who referred you (if applicable) \_\_\_\_\_

### Applicant Information

Name \_\_\_\_\_  
Last First Middle

Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

- Male  Female

### Please check one of the following Equal Employment Opportunity Identification Groups:

- |   |   |                                   |
|---|---|-----------------------------------|
| <input type="checkbox"/> White (Not of Hispanic Origin) | <input type="checkbox"/> Black (not of Hispanic origin) | <input type="checkbox"/> Hispanic |
| <input type="checkbox"/> American Indian/Alaskan Native | <input type="checkbox"/> Asian/Pacific Islander         |                                   |

### Special Notice

#### To Vietnam Era Veterans, Disabled Veterans, and Individuals with physical or mental disabilities:

Government contractors subject to the Vietnam Era Veterans Readjustment Act of 1974 and the Rehabilitation Act of 1973 required to take affirmative action to employ and advance in employment qualified disabled veterans of the Vietnam era and qualified handicapped individuals.

You are invited to volunteer this information, if you qualify, to assist in proper placement and determining reasonable accommodation. This information will be considered confidential. Refusal to provide this information will not adversely affect your consideration for employment.

If you so wish to be identified, please check if any of the following are applicable:

- Vietnam era Veteran (served between 1964-1975)  Disabled Veteran  Individual with a Disability

Name: \_\_\_\_\_

Center: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

TB History

If the answer is "yes" to any of the following questions then do a symptom screen

- 1) Have you ever had a positive skin test for TB? Yes  No
- Do you have the results written down?  
Date \_\_\_\_/\_\_\_\_/\_\_\_\_ result (in MM) \_\_\_\_\_
- 2) Have you ever had a positive blood test for TB?  
Date \_\_\_\_/\_\_\_\_/\_\_\_\_ result: \_\_\_\_\_
- If the answer is "no" to all of the above STOP
- 3) Do you have a chest x-ray result written down  
Date \_\_\_\_/\_\_\_\_/\_\_\_\_ result: normal  abnormal
- 4) Did you take medication for your positive skin test?
- 5) Have you ever been sick with TB disease?  
If yes, did you take medication for your illness?

TB Risk Assessment

- Client Risk Factors: Yes  No
- 1) Have you ever illicit drugs \_\_\_\_\_
  - 2) Have you lived with or spent time with anyone who has been sick with TB in the last 2 years? \_\_\_\_\_
  - 3) Have you ever lived or traveled for more than a month in Africa, Eastern Europe, Russia, Central or South America or the Caribbean? \_\_\_\_\_
  - 4) Do you have AIDS or HIV infection or other immune-compromised condition? \_\_\_\_\_
  - 5) Do you have (or have you had) other medical conditions such as:
    - . Diabetes? \_\_\_\_\_
    - . Cancer? \_\_\_\_\_
    - . Kidney disease? \_\_\_\_\_
    - . Rheumatoid arthritis? \_\_\_\_\_
    - . Stomach or intestinal surgery? \_\_\_\_\_

TB Symptom Screening

Symptoms:

- 1) Have you had a prolonged, unexplained cough lasting more than 3 weeks or a recent change in a chronic cough Yes  No
- If the answer to the question above is "no" then STOP here
- 2) Have you recently lost weight of 10 pounds or more for no apparent reason?
- 3) Have you had a fever of more 100 degrees F for over 2 weeks?
- 4) Do you sweat at night?
- 5) Have you felt unusually tired recently?