



APPLICATION FOR EMPLOYMENT

Lorain County Board of Mental Health
1173 North Ridge Road East, Suite 101, Lorain, OH 44055
440.233.2020 Phone; 440.233.2030 Fax

We consider applicants for all positions without regard to race, color, religion, creed, gender, national origin, age, disability, marital or veteran status, sexual orientation, or any other legally protected status.

Also note that, once submitted to a governmental agency, this completed form will be subject to all applicable public records laws.

PLEASE PRINT

Position Applied For: _____ Date of Application: _____

How did you learn about the position? _____

_____	_____	_____	_____
Last Name	First Name	Middle Name	
_____	_____	_____	_____
Street Address	City	State	Zip Code
_____	_____	_____	_____
Telephone Number	Email Address		

If you are under 18 years of age, can you provide required proof of your eligibility to work? Yes No

Have you ever filed an application with us before? Yes No

If yes, when and for what position(s) did you previously apply: _____

Are you currently employed? Yes No

May we contact your present employer? Yes No

Are you authorized to work in the U.S?
Proof of citizenship or immigration status is a contingency of employment. Yes No

On what date would you be available to work? _____

Expected Salary: \$ _____

Are you currently on layoff status and subject to recall? Yes No

Are you a licensed driver in the state of Ohio? Yes No

EMPLOYMENT EXPERIENCE

Please list your work experience beginning with your most recent employment. To be considered for employment, you must fill in the information below accurately and completely. You may submit a résumé in addition to completing this section.

Employer	Dates Employed		Work Performed:
	From	To	
Supervisor			
Address			
Telephone Number			
Job Title	Hourly Rate		
	From	To	
Reason for Leaving			
May we contact this employer?			

Employer	Dates Employed		Work Performed:
	From	To	
Supervisor			
Address			
Telephone Number			
Job Title	Hourly Rate		
	From	To	
Reason for Leaving			
May we contact this employer?			

Employer	Dates Employed		Work Performed:
	From	To	
Supervisor			
Address			
Telephone Number			
Job Title	Hourly Rate		
	From	To	
Reason for Leaving			
May we contact this employer?			

List professional, trade, business or civic activities and offices held.

EDUCATION

High School	Name and Address	Course of Study	Years Completed	Did you graduate?
				Obtain GED?
Undergraduate College	Name and Address	Course of Study	Years Completed	Diploma /Degree
Graduate Professional	Name and Address	Course of Study	Years Completed	Diploma /Degree
Other (Specify)	Name and Address	Course of Study	Years Completed	Diploma /Degree

Indicate any foreign language(s) you can speak, read and/or write:

Speak **Fluent** _____ **Good** _____ **Fair** _____

Read **Fluent** _____ **Good** _____ **Fair** _____

Write **Fluent** _____ **Good** _____ **Fair** _____

Describe any specialized training and skills.

Computer Software: _____

Computer Programming: Language(s): _____

Office Equipment: _____

Licensure / Certifications:

Please indicate type, number, licensing entity and expiration date, if applicable.

ADDITIONAL INFORMATION
OTHER QUALIFICATIONS/ PUBLICATIONS/ PROFESSIONAL AFFILIATIONS

REFERENCES

1.	<hr/> Name	<hr/> Telephone Number
	<hr/> Address	<hr/> Email
2.	<hr/> Name	<hr/> Telephone Number
	<hr/> Address	<hr/> Email
3.	<hr/> Name	<hr/> Telephone Number
	<hr/> Address	<hr/> Email

RELEASE OF INFORMATION

I, _____, maiden name _____, do hereby request any law enforcement agency, governmental agency, bureau of motor vehicles, military agency, or past employer to release to Lorain County Board of Mental Health, upon their request a copy of any report, document, record, criminal record, medical history, or other information regarding my character, integrity and reputation. Further, I do hereby agree that a photocopy hereof may be used with the same effect as though it were the original.

Signature

Driver's License Number

Address

City

State

Zip Code

Date of Birth*

Social Security Number

Telephone Number

***Date of Birth is optional, however, if lack of a date of birth prevents Lorain County Board of Mental Health from obtaining a creditable background check your opportunity for employment could be affected.**

**PRE-EMPLOYMENT CONTROLLED SUBSTANCES TESTING
AUTHORIZATION FORM**

I understand that all applicants of this company must be tested for controlled substances as a pre-condition for employment.

I authorize the test provider to the drugs-of-abuse urine collection and its testing.

I understand that a minimum detectable level (zero tolerance) for controlled substance(s) will disqualify me for a position with the Lorain County Board of Mental Health.

The review officer will maintain the results of my controlled substance test results and will be forwarded to the Lorain County Board of Mental Health. The results will not be released to any other parties without my written authorization.

I understand the above conditions and hereby agree to comply with them.

Applicant's Name [Please PRINT]

Date

Applicant's Signature

DISCLOSURE STATEMENT / ACKNOWLEDGEMENT AND CONSENT

DISCLOSURE STATEMENT

As part of our employment screening process, LCBMH requires employees to undergo an employment background check following a conditional offer of employment.

Accordingly, LCBMH may obtain a consumer report for employment purposes as part of a background investigation. Inquiry may include, but may not be limited to felony and misdemeanor conviction records.

This disclosure is made pursuant to the Fair Credit Reporting Act, 15 U.S.C. 1681b(b)(2)(A).

ACKNOWLEDGEMENT AND CONSENT

I hereby acknowledge, by my signature below, review and understanding of the above Disclosure Statement.

I additionally hereby grant consent for LCBMH to conduct a background check as a condition of my employment, and for its consumer-reporting agency to release to LCBMH, or its authorized representative, any and all factual information pertaining to my criminal history. I further hereby grant consent for LCBMH, at the discretion of the Executive Director, to share the results of my background check with other organizations, on a need to know basis, for business related reasons.

I release LCBMH and its authorized representatives from all liability related to the release and use of my criminal history records.

Applicant's Signature

_____/_____/_____
Date