Community Supported Outpatient Care for East
Jefferson County Children, Adolescents, Adults and Older Adults-24 Hour Crisis
PO Box 565 ◦ 884 W. Park Avenue ◦ Port Townsend, WA 98368
Phone: 360-385-0321 ◦ 1-877-410-4803 Fax:360-379-5534

Last	First	Middle
Address (Include Complete Mailing Address, City, State & Zip Code)		
Home Phone Number (include area code):	Message Phone and Contact Person:	E-Mail Address:
Cell Phone Number (include area code):	May we contact you at work? ☐ Yes ☐ No	

Positions Applying for: 1.	Beginning Salary Expectations:
2.	How soon would you be available for employment?

Referred by:		
☐ Job Line	☐ Advertisement:	☐ Internet:
☐ Walk-In	☐ DBH Website	☐ Other:
☐ Employment Agency:	☐ Current Employee:	

Memberships in **job related** professional organizations:
Special awards or honors (include dates):

Do you have (please check if applicable to job): ☐ Valid Driver's License ☐ Insured Vehicle

Have you ever been convicted of a crime? ☐ Yes ☐ No
(Note: A "Yes" answer will not necessary disqualify you from consideration.)
Please explain:

Can you provide proof of eligibility to work in the United States? ☐ Yes ☐ No

Can you travel within the area if your position requires it? ☐ Yes ☐ No

Please indicate your availability: ☐ Full Time ☐ Part Time ☐ Overtime ☐ Weekends ☐ Evening Shifts

Please indicate any other work schedule restrictions:

Have you ever been employed by Discovery Behavioral Healthcare (Formerly JMHS)? ☐ Yes ☐ No

If yes, please list the dates and position held:

EMPLOYMENT RECORD

Please list your employment history beginning with your **most recent** position. Use additional sheets as necessary.

Company/Organization:			Phone Number:
Address:			Supervisor's Name:
Dates Employed:	From:	To:	Position:
Duties:			
Reason for Leaving:			May we contact this employer? ☐ Yes ☐ No (We may contact if left blank).

Company/Organization:			Phone Number:
Address:			Supervisor's Name:
Dates Employed:	From:	To:	Position:
Duties:			
Reason for Leaving:			May we contact this employer? ☐ Yes ☐ No (We may contact if left blank).

Company/Organization:			Phone Number:
Address:			Supervisor's Name:
Dates Employed:	From:	To:	Position:
Duties:			
Reason for Leaving:			May we contact this employer? ☐ Yes ☐ No (We may contact if left blank).

Company/Organization:			Phone Number:
Address:			Supervisor's Name:
Dates Employed:	From:	To:	Position:
Duties:			
Reason for Leaving:			May we contact this employer? ☐ Yes ☐ No (We may contact if left blank).

EDUCATION & TRAINING

High School Diploma or GED? ☐ Yes ☐ No If no, indicate highest grade completed: _____

School, Mailing Address, City, State, Zip	Course of Study/Major	Did you graduate?	Date of Graduation (MM/YY)	Degree
College or University:		☐ Yes ☐ No		
College or University:		☐ Yes ☐ No		
Graduate School:		☐ Yes ☐ No		
Business, Trade, Vocational, Other:				
Other Training (Certificates or Job Related Training): Volunteer/Internship Experience: (Please list dates and position held)				

License Type:

☐ Psychologist
☐ LICSW
☐ LICSW-A
☐ LMHC
☐ LMHC-A
☐ LMFT
☐ MD / DO
☐ ARNP
☐ PMHNP
☐ RN
☐ LPN
☐ CMA
☐ CDP
☐ CDPT
☐ Certified Counselor
☐ Agency Affiliated Counselor
☐ Certified Peer
☐ Other: _____

Licensed in Washington? ☐ Yes ☐ No	License #:
Expiration Date:	DEA #: NPI:

Are you currently credentialed with Medicaid, Medicare or any other insurance companies? ☐Yes ☐No ☐Unknown
If yes, please list the companies below:

Medicaid #:
Medicare #:
Other Insurance Panels:

Please list any Electronic Health Record(s) and/or computer software you have used:

Describe any unique abilities or experience which qualifies you for the position(s) you are applying for:

Do you speak any language other than English that might help you perform your job: ☐ Yes ☐ No
If yes, please list:

Are you able to perform the essential functions of the job with or without reasonable accommodation? ☐ Yes ☐ No

CERTIFICATION AND UNDERSTANDING

I certify that all information entered on this application and submitted by me on any other documents in connection with my application to be true and correct. I understand that any misrepresentation, omission or concealment of information required may be reason to disqualify me from further consideration and is grounds for dismissal from employment.

I authorize Discovery Behavioral Healthcare to investigate all statements contained in this application and any other forms completed in connection with my application. I agree and authorize my previous employers to release all relevant information regarding my employment history to Discovery Behavioral Healthcare without liability to my previous employers or Discovery Behavioral Healthcare.

I further understand that if I receive and accept an offer of employment with Discovery Behavioral Healthcare, my employment may be terminated by Discovery Behavioral Healthcare or by me at any time, subject only to applicable requirements of law or labor agreements. The contents of this application do not constitute any express or implied contract of employment.

Prior to my beginning work or during my employment, employer reserves the right to require any lawful form of medical, drug, alcohol, psychological, character, honesty, integrity, aptitude, skill, or other test or examination.

If employed, I understand that my employment is "at-will" and may be terminated with or without cause or notice at my option or at the option of employer. I understand that all company property must be returned and any indebtedness to the company must be paid on or before my last day of my employment. I authorize the company to deduct from my paycheck the necessary amount to satisfy any unpaid obligations or in the event there are not sufficient funds from my paycheck, I agree to pay the debt upon request.

This application is good for ninety (90) days only. Thereafter, consideration for employment, internship, or volunteer position will require that you submit a new application.

I HEREBY ACKNOWLEDGE THAT I HAVE READ THE ABOVE STATEMENT, I UNDERSTAND IT AND AGREE TO THE ABOVE STIPULATIONS.

Applicant's Signature _____ Date _____

Print Name _____

Received By _____ Date _____