



**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:				
<input type="checkbox"/> PART-TIME <input type="checkbox"/> FULL-TIME # HOURS PER WEEK				

DATE MONTH AND YEAR	NAME AND ADDRESS OF EMPLOYER	SALARY	POSITION	REASON FOR LEAVING
FROM:				
TO:				
<input type="checkbox"/> PART-TIME <input type="checkbox"/> FULL-TIME # HOURS PER WEEK				

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FROM:				
TO:				
<input type="checkbox"/> PART-TIME <input type="checkbox"/> 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

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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**