

# ALTERNATIVE OUTLOOK BEHAVIORAL HEALTH

## Employment Application



APPLICANT INFORMATION									
Last Name		First		M.I.		Maiden		Date	
Street Address							Apartment/Unit #		
City				State		ZIP		County	
Phone				E-mail Address					
Cell				Emergency Contact				#	
Date Available				Social Security No.				Desired Salary	
Position Applied for				What shifts can you work?					
Will you accept part time employment?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	Will you accept temporary employment?			YES <input type="checkbox"/>	NO <input type="checkbox"/>	
Are you a citizen of the United States?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	If no, are you authorized to work in the U.S.?			YES <input type="checkbox"/>	NO <input type="checkbox"/>	
Have you ever worked for this company?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	If so, when?					
Do you have friends who work for Alternative Outlook Behavioral Health?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	If so, who?					
Have you ever been convicted of a Misdemeanor or Felony?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	If yes, explain					
Do you possess a Driver License?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	State of Issue		Do you have reliable transportation?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Have you ever been terminated or asked to resign?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	If yes, explain					
Have you been substantiated for Child or Adult Abuse, Neglect or Exploitation?								YES <input type="checkbox"/>	NO <input type="checkbox"/>
***Have you lived outside the state of Kentucky or worked outside the state of Kentucky in the last 12 Months?***								YES <input type="checkbox"/>	NO <input type="checkbox"/>
EDUCATION									
Schools	Name and Address of School	Years		Diploma	Degree	Did you Graduate	Total Hours	Major	
		From	To						
Grade School									
High School/ GED									
Vocational School									
College/ University									
Military/ Grad. School									
Circle highest Grade Completed: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18+									
List Subjects taken which would be related to the position you are applying									
Other Licensure or Certification				Year of First Issue		Year of Last Issue			
List Special Skills you Possess and machines/equipment you can use									

**REFERENCES**

Please list three professional references.

Full Name		Relationship	
Company		Phone	
Address		Years Known	
Full Name		Relationship	
Company		Phone	
Address		Years Known	
Full Name		Relationship	
Company		Phone	
Address		Years Known	
Full Name		Relationship	
Company		Phone	
Address		Years Known	

**PREVIOUS EMPLOYMENT**

Company		Phone	
Address		Supervisor	
Job Title		Starting Salary	\$      Ending Salary \$
Responsibilities			
From	To	Reason for Leaving	
May we contact your previous supervisor for a reference?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Company		Phone	
Address		Supervisor	
Job Title		Starting Salary	\$      Ending Salary \$
Responsibilities			
From	To	Reason for Leaving	
May we contact your previous supervisor for a reference?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Company		Phone	
Address		Supervisor	
Job Title		Starting Salary	\$      Ending Salary \$
Responsibilities			
From	To	Reason for Leaving	
May we contact your previous supervisor for a reference?		YES <input type="checkbox"/>	NO <input type="checkbox"/>

**DISCLAIMER AND SIGNATURE**

I certify that my answers are true and complete to the best of my knowledge. Falsification or failure to answer all questions is sufficient grounds for rejection of this application. I further understand Alternative Outlook Behavioral Health employs at will, which means that either the employee or the employer may terminate with or without cause not prohibited by law. I understand that the Director and Owners of Alternative Outlook Behavioral Health are the only officers who are authorized to enter into employment contracts and may do so only in writing. I authorize Alternative Outlook Behavioral Health to do a thorough investigation of my past employment, education, and activities, which includes fingerprinting and drug testing for the purposes of obtaining information regarding past criminal convictions and I release from all liability all persons, companies, and corporations supplying this information. I release and indemnify Alternative Outlook Behavioral Health against any liability that might result from making such an investigation. I realize that nothing in this application is intended to constitute a contract, in whole or in part.

Signature		Date	
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# PRE-HIRE ASSESSMENT

## QUESTIONS

1. Tell me something interesting about yourself:
2. If Lucy takes Hadol 5mg three times per day, hoy many pills would she have to have to last 4 weeks?
3. You are required to reorder Jane's Medication when she gets down to a 5 day suppl. If she takes Prozac 10mg twice per day, how many pills will she have left when you reorder her medication?
4. If John and Kenny get into an argument, tell me something you might do to try to calm them down:
5. If Kyle takes an anti-biotic three times per day, how many hours should be between each dose of medication?
6. Read the prescription and answer the following questions.

**Karon Patton, DO**  
**Wayland AHE Family Care Clinic**  
 2669 King Kelly Colson Hwy. • Wayland, KY 41266 • (606) 948-4711  
 DEA No. TP1904300 • Ky. License No. 03297  
 NPI No. 17400258148

www.ahe.org

**THIS POLICY IS FOR INFORMATION ONLY AND DOES NOT CONSTITUTE A GUARANTEE OF ACCURACY. IT IS SUBJECT TO CHANGE WITHOUT NOTICE.**

Name: \_\_\_\_\_ Date: 1/6/14  
 Address: \_\_\_\_\_

Methimide 500mg  
mg = 200mg  
#60

1-21  
 25-49  
 50-74  
 75-100  
 101-150  
 151 and over

Plan No. 120143  
 Valid after \_\_\_\_\_ Signature: Karon Patton  
 (Do Not Substitute-Dispense As Written) Prescriptions are valid if more than (1) prescription is written

A. What date should the client begin taking this medication?	
B. What is the name of the medication?	
C. What is the dosage of the medication?	
D. How many times per day should the client take this medication?	
E. How many refills does this medication have?	
F. What date will this medication end?	
G. How many pills did the doctor prescribe on this prescription?	

Employee Candidate Signature		Date	
Employer Signature		Date	