Checklist for Interns:

Name _____ Program _____

Program Chair _____

Requested Start Date _____ End Date _____

Preferred Locations 1) _____ 2) _____ 3) _____

Preferred Age Group _____ Teens _____ Children

Provide or Complete all items (those noted with * are available on MFHS website):

_____ Checklist*

_____ Application for employment*

_____ Clinical experience form*

_____ Background disclosure form*

_____ Prospective employee reference check forms for each employer in past 5 years*

_____ Resume

_____ Unofficial Transcript

_____ Verification of good standing from University

_____ 2 Letters of reference

_____ University background check (sent directly by program chair)

_____ Criminal history/caregiver background (if University background check is unavailable)

_____ Crime checks from other states as needed

Additional Forms given at onset of Internship/Hire

_____ Orientation to Process and Structure in Day Treatment

_____ Staff Orientation

APPLICATION FOR EMPLOYMENT

(Pre-Employment Questionnaire) (An Equal Opportunity Employer)

PERSONAL INFORMATION

DATE

NAME (LAST / FIRST / MIDDLE) — SOCIAL SECURITY NUMBER

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 ❑ _____

EMPLOYMENT DESIRED

POSITION — DATE YOU CAN START — SALARY DESIRED

ARE YOU EMPLOYED NOW? — IF SO MAY WE INQUIRE OF YOUR PRESENT EMPLOYER?

EVER APPLIED TO THIS COMPANY BEFORE? — WHERE? — WHEN?

REFERRED BY

EDUCATION	NAME AND LOCATION OF SCHOOL	*NO OF YEARS ATTENDED	*DID YOU GRADUATE?	SUBJECTS STUDIED
GRAMMAR SCHOOL				
HIGH SCHOOL				
COLLEGE				
TRADE, BUSINESS OR CORRESPONDENCE SCHOOL				

LAST FIRST MIDDLE

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 OF ITS MEMBERS.

U. S MILITARY OR NAVAL SERVICE — RANK — PRESENT MEMBERSHIP IN NATIONAL GUARD OR 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.

(CONTINUED ON OTHER SIDE)

LITHO IN U.S.A.

FORMER EMPLOYERS (LIST BELOW LAST THREE EMPLOYERS, STARTING WITH LAST ONE FIRST).

DATE MONTH AND YEAR	NAME AND ADDRESS OF EMPLOYER	SALARY	POSITION	REASON FOR LEAVING
FROM				
TO				
FROM				
TO				
FROM				
TO				
FROM				
TO				

WHICH OF THESE JOBS DID YOU LIKE BEST?

WHAT DID YOU LIKE MOST ABOUT THIS JOB?

REFERENCES: GIVE THE NAMES OF THREE PERSONS NOT RELATED TO YOU, WHOM YOU HAVE KNOWN AT LEAST ONE YEAR.

NAME	ADDRESS	BUSINESS	YEARS ACQUAINTED
1			
2			
3			

THE FOLLOWING STATEMENT APPLIES IN: MARYLAND & MASSACHUSETTS. [Fill in name of state.)
IT IS UNLAWFUL IN THE STATE OF _____ TO REQUIRE OR ADMINISTER A LIE DETECTOR TEST AS A CONDITION OF EMPLOYMENT OR CONTINUED EMPLOYMENT. AN EMPLOYER WHO VIOLATES THIS LAW SHALL BE SUBJECT TO CRIMINAL PENALTIES AND CIVIL LIABILITY.

Signature of Applicant

IN CASE OF EMERGENCY NOTIFY

NAME ADDRESS PHONE NO.

"I CERTIFY THAT ALL THE INFORMATION SUBMITTED BY ME ON THIS APPLICATION IS TRUE AND COMPLETE, AND I UNDERSTAND THAT IF ANY FALSE INFORMATION, OMISSIONS, OR MISREPRESENTATIONS ARE DISCOVERED, MY APPLICATION MAY BE REJECTED AND, IF I AM EMPLOYED. MY EMPLOYMENT MAY BE TERMINATED AT ANY TIME.
IN CONSIDERATION OF MY EMPLOYMENT, I AGREE TO CONFORM TO THE COMPANY'S RULES AND REGULATIONS, AND I AGREE THAT MY EMPLOYMENT AND COMPENSATION CAN BE TERMINATED, WITH OR WITHOUT CAUSE. AND WITH OR WITHOUT NOTICE, AT ANY TIME, AT EITHER MY OR THE COMPANY'S OPTION. 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 COMPANY. I UNDERSTAND THAT NO COMPANY REPRESENTATIVE, OTHER THAN IT'S PRESIDENT, AND THEN ONLY WHEN IN WRONG AND SIGNED BY THE PRESIDENT, 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.

DATE SIGNATURE

DO NOT WRITE BELOW THIS LINE

INTERVIEWED BY: DATE:

REMARKS:

NEATNESS ABILITY

HIRED: ❑ Yes ❑ No POSITION DEPT.

SALARY/WAGE DATE REPORTING TO WORK

APPROVED: 1. 2. 3
EMPLOYMENT MANAGER DEPT. HEAD GENERAL MANAGER

Marriage & Family Health Services, Ltd.

2925 Mondovi Road • Eau Claire, WI 54701 • 715-832-0238 • 1-800-639-4044 • Fax 715-832-0771

Offices also in Chippewa Falls 715-726-9208 • Durand 715-672-8585 • Hudson 715-381-5437

Marshfield 715-486-8302 • Rice Lake 715-736-5437

Clinical Experience:

1. Please summarize the major characteristics of your practice population (age, sex, etc.)

_____
_____
_____
_____

2. Identify your areas of clinical expertise and summarize your style of practice and clinical orientation.

_____
_____
_____
_____

3. Please list training, education or supervision session (for yourself) which you regularly attend.

_____
_____
_____
_____

Liability Information:

Professional liability/malpractice insurance:

_____

Carrier Expiration Date

Coverage limits (per incident and aggregate):

_____

Per incident Per aggregate

Please respond to each of the following questions. If you answer yes to any of these questions, please explain on a separate sheet.

1. Has your clinical license ever been revoked, suspended or limited? ___ Yes ___ No
   Is there action pending? ___ Yes ___ No

2. Have you ever been subject disciplinary review action by any of the following?

   State Licensing Board ___ Yes ___ No

State: _____ Date: _____

County, State or Professional Society ___ Yes ___ No
State: _____ Date: _____

Hospital Medical or Clinical Staff ___ Yes ___ No
Hospital: _____ Date: _____

Address: _____

3. If you are a physician, has your narcotics license ever been revoked, suspended or limited? ___ Yes ___ No

4. Have you ever been denied professional liability insurance, or had your insurance cancelled? ___ Yes ___ No

5. Has renewal been refused, or have premiums been surcharged because of claims? ___ Yes ___ No

6. Have you ever had a malpractice claim, investigation, or lawsuit filed against you? ___ Yes ___ No

7. Have you ever resigned or been asked to resign from the staff of any hospital or professional organization because of problems regarding privileges, credentials or unprofessional conduct? ___ Yes ___ No

8. Have you ever been denied hospital privileges? ___ Yes ___ No

9. Have you ever been sanctioned (disciplined) by Medicare or Medicaid? ___ Yes ___ No

10. Have you ever been convicted or pleaded guilty to a crime (other than traffic), including those under the Criminal Control Act, or are you currently under indictment for alleged crime? ___ Yes ___ No

11. Do you suffer from any physical or mental condition or substance abuse problem which impairs your ability to practice, with or without accommodation? If recovering from a substance abuse problem, please provide dates of continuous recovery. ___ Yes ___ No

12. Has your authorization to practice in any jurisdiction (state or county) ever been revoked, suspended, or subject to probation any conditions or limitations? ___ Yes ___ No

13. Do you or a member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic or testing center, hospital, surgi-center, or other

business dealing with the provision of ancillary health services, equipment of supplies, other than the facility in which you practice? ___ Yes ___ No

14. Has any information pertaining to you ever been reported to the National Practitioner Data Bank (NPDB)? If yes, attach a copy of the report with an explanation. ___ Yes ___ No

Please attach the following information to this application:

1. Photocopy of state license and DEA certificate (if applicable) with an expiration date clearly visible on the copy.

2. Proof of professional liability coverage indicating coverage of limits and expiration date (Photocopy of face sheet).

3. Curriculum vitae (resume) which includes education, post-graduate training, professional experience, credentials and professional memberships. For each setting in which you have worked or trained, Please Describe in Detail the populations, problems and disorders treated as well as the theoretical orientation of your work.

4. A list of continuing education programs attended over the last 24 months and credits received, including Annual Professional Society certification when possible.

I, the undersigned, hereby attest that the information given in or attached to this application is accurate, complete and fairly represents the current level of my training, experience, capability, and competence to practice at the level requested.

ANY INFORMATION ENTERED INTO THIS APPLICATION WHICH SUBSEQUENTLY IS FOUND TO BE FALSE COULD RESULT IN OUR REFUSAL TO ENTER INTO A CONTRACT WITH YOU OR TERMINATION OF ANY CONTRACT WITH YOU.

Signature_____Date_____

Please Print Name_____

BACKGROUND INFORMATION DISCLOSURE (BID)

- **PENALTY: Knowingly providing false information or omitting information may result in a forfeiture of up to $1,000 and other sanctions as provided in Wis. Admin. Code § DHS 12.05(4).**
- Completion of this form is required under the provisions of Wis. Stat. § 50.065. Failure to comply may result in a denial or revocation of your license, certification, or registration, or denial or termination of your employment or contract.
- Refer to DQA form F-82064A, *BID Instructions,* for additional information.
- Providing your social security number is voluntary; however, your social security number is one of the unique identifiers used to prevent incorrect matches.
- **PRINT OR TYPE YOUR ANSWERS.**

Check the box that applies to you.

☐ Employee / Contractor (including new applicant)
☐ Household member (lives on premises, but is not a client)
☐ Applicant for a license, certification, or registration (including continuation or renewal)
☐ Other – Specify: _____

NOTE: If you are an owner, operator, board member, or non-client resident of a facility regulated by the Division of Quality Assurance (DQA), complete the BID, F-82064 and the Appendix, F-82069, and submit both forms to the address noted in the Appendix Instructions.

Full Legal Name – *First*	*Middle*	*Last*	
Position Title (Complete only if a prospective or current employee or contractor.)		Birth Date *(MM/dd/yyyy)*	Sex ☐ Male ☐ Female
Any Other Names By Which You Have Been Known (Including Maiden Name)			
Race / Ethnicity (Check ONLY one.) ☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Black ☐ White ☐ Unknown			Social Security Number
Home Address	City	State	Zip Code
Business Name and Address – Employer or Care Provider (Entity)			

A "NO" answer to all questions does not guarantee employment, residency, a contract, or regulatory approval.

SECTION A – ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION

1. Do you have any criminal charges pending against you, including in federal, state, local, military, and tribal courts?
   If **Yes**, list each charge, when it occurred or the date of the charge, and the city and state where the court is located.
   You may be asked to supply additional information, including a copy of the criminal complaint or any other relevant court or police documents.
   Yes ☐ No ☐

2. Were you ever convicted of any crime anywhere, including in federal, state, local, military, and tribal courts?
   If **Yes**, list each crime, when it occurred or the date of the conviction, and the city and state where the court is located.
   You may be asked to supply additional information including a certified copy of the judgment of conviction, a copy of the criminal complaint, or any other relevant court or police documents.
   Yes ☐ No ☐

3. **IMPORTANT: Read before completing item 3.**

Wis. Stat. § 48.981 Abused and neglected children and abused unborn children. (7)(a) CONFIDENTIALITY. "All reports made under this section, notices provided under sub. (3) (bm), and records maintained by an agency and other persons, officials, and institutions shall be confidential." Reports and records may be disclosed only to the persons identified in this section.

☐ **If you are the employer or prospective employer of the person completing this form and are entitled to obtain this information per the above, check this box.**

Has any government or regulatory agency (other than the police) ever found that you committed child abuse or neglect? Yes ☐ No ☐

If the above box has been checked, provide an explanation below, including when and where the incident(s) occurred.

4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client? Yes ☐ No ☐

If **Yes,** explain, including when and where it happened.

5. Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client? Yes ☐ No ☐

If **Yes**, explain, including when and where it happened.

6. Has any government or regulatory agency (other than the police) ever found that you **abused an elderly person**? Yes ☐ No ☐

If **Yes**, explain, including when and where it happened.

7. Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients? Yes ☐ No ☐

If **Yes**, explain, including credential name, limitations or restrictions, and time period.

SECTION B – OTHER REQUIRED INFORMATION

1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services? Yes ☐ No ☐

   If **Yes,** explain, including when and where it happened.

2. Has any government or regulatory agency ever denied you permission or restricted your ability to live on the premises of a care providing facility? Yes ☐ No ☐

   If **Yes,** explain, including when and where it happened and the reason.

3. Have you been discharged from a branch of the US Armed Forces, including any reserve component? Yes ☐ No ☐

   If **Yes**, indicate the year of discharge: _____

   Attach a copy of your DD214, if you were discharged within the last three (3) years.

4. Have you resided outside of Wisconsin in the last three (3) years? Yes ☐ No ☐

   If **Yes**, list each state and the dates you resided there.

5. If you are employed by or applying for the State of Wisconsin, have you resided outside of Wisconsin in the last seven (7) years? Yes ☐ No ☐

   If **Yes**, list each state and the dates you resided there.

6. Have you had a caregiver background check done within the last four (4) years? Yes ☐ No ☐

   If **Yes**, list the date of each check, and the name, address, and phone number of the person, facility, or government agency that conducted each check.

7. Have you ever requested a rehabilitation review with the Wisconsin Department of Health Services, a county department, a private child placing agency, school board, or DHS-designated tribe? Yes ☐ No ☐

If **Yes**, list the review date and the review result. You may be asked to provide a copy of the review decision.

Read and initial the following statement.

_____ I have completed and reviewed this form (F-82064, BID) and affirm that the information is true and correct as of today's date.

Name – Person Completing This Form	Date Submitted

Marriage & Family Health Services, Ltd.

2925 Mondovi Road, Eau Claire, WI 54701 (715) 832-0238 (800) 639-4044 Fax (715) 832-0771

Offices also in: Chippewa Falls (715) 726-9208, Marshfield (715) 486-8302, Hudson (715) 381-5437, & Rice Lake (715) 736-5437

REFERENCE CHECK FORM

In signing this form, I recognize that ***Marriage & Family Health Services Ltd.*** is obtaining information concerning my previous employment. Accordingly, I hereby authorize designated representatives (of the following company) to respond to the inquiries that are outlined below. I also understand that my signature herein releases past employers from any and all liability relative to their efforts to verify my previous work related responsibilities and wages, to evaluate my prior job performances, and to comment on my background and/or personal character.

_____ _____

Applicant's Signature *Date*

Applicant Name (printed): _____

Applying to *Marriage & Family Health Services Ltd.* as: CLINICIAN CASE MANAGER CLINICAL SUPPORT OFFICE SUPPORT

Name of Previous Employer: _____ Attn: _____

Address: _____ Telephone Number: _____

_____

Position Held? _____ From: _____ To: _____
month/year *month/year*

Would you re-hire this individual? **YES** **NO** (please circle one) Why / why not? _____

Typical job responsibilities? _____ Wage? _____

Strengths? _____ Areas for Improvement? _____

Do you have any reservations about recommending this individual for employment? **YES** **NO** (please circle one)

On a ten point scale (10 being the highest), please rate the following:

INITIATIVE / MOTIVATION TO SUCCEED	1	2	3	4	5	6	7	8	9	10
ABILITY TO WORK INDEPENDENTLY	1	2	3	4	5	6	7	8	9	10
ABILITY TO WORK WELL WITH OTHERS	1	2	3	4	5	6	7	8	9	10
ORGANIZATIONAL SKILLS	1	2	3	4	5	6	7	8	9	10
COMMUNICATION SKILLS	1	2	3	4	5	6	7	8	9	10
LISTENING SKILLS	1	2	3	4	5	6	7	8	9	10
MOOD MANAGEMENT SKILLS	1	2	3	4	5	6	7	8	9	10
RECEPTIVITY TO FEEDBACK	1	2	3	4	5	6	7	8	9	10
CRISIS INTERVENTION SKILLS	1	2	3	4	5	6	7	8	9	10
PROFESSIONAL DEMEANOR	1	2	3	4	5	6	7	8	9	10

(please circle one number for each of these ratings)

Is there anything else that we should be aware of (regarding this applicant) prior to making a hiring decision? (if yes, please outline below)

_____ _____

Signature of Authorized Representative *Date*
