



EMPLOYMENT APPLICATION

Position Applied For:	Social Security Number:		
Last Name:	First Name:	Middle Initial:	
Address:	City:	State:	Zip:
Daytime Phone #:	Home/Cell Phone #:	Email:	
How soon are you available for employment?	Who Referred you to Consejo?		
Are you able to produce documents that verify your right to work in the US? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Have you ever been convicted of a felony? Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, please provide further information)			
Date: _____		Charge: _____	
City/State: _____		Action Taken: _____	
Are you able to perform the essential functions of the job for which you are applying with reasonable accommodations? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If NO, which functions are you unable to perform?			

EDUCATION AND TRAINING SUMMARY

Colleges, Vocational or Technical Schools, Training Center	Major Subject	Units Completed	Degree Type/Certificate
Licenses and Certificates (State, Professional, Trade, etc., which are related to this position)			
Description	Issued by	Number	Expiration Date

PLEASE PROVIDE 3 PROFESSIONAL REFERENCES; 1 MUST BE A PREVIOUS SUPERVISOR

Name: Title: Phone #: May We Contact? Yes <input type="checkbox"/> No <input type="checkbox"/>
Name: Title: Phone #: May We Contact? Yes <input type="checkbox"/> No <input type="checkbox"/>
Name: Title: Phone #: May We Contact? Yes <input type="checkbox"/> No <input type="checkbox"/>

I hereby certify that all information or omission of any material fact on this application is true to the best of my knowledge and understand that falsification of information on this application may lead to the removal of my name from the eligibility list or termination from employment.

Signature of applicant: _____ Date: _____



I, _____, authorize Consejo Counseling and Referral Service to obtain a consumer report. I understand that inquiry may include, but is not limited to: conviction records, motor vehicle records, credit checks, references, employment verification, education verification and copies of prior personnel files.

Signature of Authorizing Consumer: _____ Date: _____

SSN _____ - _____ - _____

Date of Birth _____

University Name _____

Address _____

Phone Number _____

Month/Yr Start _____ Month/Yr Graduated _____

This authorization is given pursuant to the Fair Credit Reporting Act, 15 U.S.C. 1681b(b)(2)(B).

Note: The FCRA requires that a consumer must authorize in advance the procurement of a consumer report for employment purposes.

WASHINGTON STATE PATROL

Identification and Criminal History Section

PO Box 42633

Olympia WA 98504-2633

(360) 534-2000

<http://watch.wsp.wa.gov>



REQUEST FOR CONVICTION CRIMINAL HISTORY RECORD (RCW 10.97)

INSTRUCTIONS: PLEASE COMPLETE THIS FORM WHEN REQUESTING **CONVICTION** CRIMINAL HISTORY RECORD INFORMATION BASED ON NAME AND DATE OF BIRTH. MAIL REQUEST TO ADDRESS NOTED ABOVE WITH \$16.00 CHECK OR MONEY ORDER. FOR REQUEST BASED ON FINGERPRINTS, MAIL A COMPLETED FINGERPRINT CARD AND FEE OF \$38.00. YOU MAY ALSO COME TO OUR OFFICE AT 3000 PACIFIC AVENUE, OLYMPIA, WA. **NOTE: IT MAY TAKE 7 TO 14 BUSINESS DAYS FOR RESPONSE WHEN MAILED. FOR AN IMMEDIATE RESPONSE, ACCESS OUR WEB SITE LISTED ABOVE TO CONDUCT YOUR CRIMINAL HISTORY REQUEST BY NAME AND DATE OF BIRTH FOR \$12.00 USING A CREDIT CARD.**

NOTARIZED LETTERS ARE AN ADDITIONAL \$10.00 PER NOTARY SEAL _____ Notarized Letter(s)

NOTE: The requested record information is furnished solely on the basis of name and/or description similarity with the subject of your inquiry. Positive identification or non-identification can only be effected upon receipt of fingerprints. Applicant may be advised of inquiry.

A SUBJECT INFORMATION: (Please type or print clearly)

Applicant's Name: _____
Last First Middle

Alias/Maiden Name: _____

Date of Birth: _____ Sex: _____ Race: _____
Month/Day/Year

B REQUESTOR INFORMATION: (Please type or print clearly)

DATE: ____/____/____ (print) Name/Title of Requestor _____ Requestor's Signature _____
Mo. Day Yr.

Provide e-mail to receive background results electronically. Phone No. () _____

E-mail address _____ Password (must be at least 8 characters) _____

REQUESTOR'S ADDRESS: (type or print clearly)

Name _____
Address _____
City _____ State _____ ZIP Code _____

Subject's Right Thumb Print (Optional)

OATH OF CONFIDENTIALITY

As a condition of my employment or service relationship with Consejo Counseling and Referral Service, I agree to the following:

I am bound by 42 Code of Federal Regulations (CFR) Part 2, federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records; by 45 CFR Parts 160 and 164, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and by Revised Code of Washington (RCW) 70.96A, Treatment of Alcoholism, Intoxication, and Drug Addition.

I certify not to divulge to any unauthorized third party any information concerning a client, other than to another Consejo staff member allowed under the law to have access to that information, except when:

- a I have written authorized consent for the release of such information from the client.
- b I am reporting child abuse or neglect per RCW 26.44.
- c I am reporting information concerning a crime, which is threatened to be committed either at the program, or against any person who works for the program.
- d The disclosure is a requirement of a court order, or of federal or state laws and regulations.
- e I am reporting a medical emergency that poses an immediate threat to the health of any individual and requires immediate medical attention.
- f I am ordered by a court order, which satisfies the requirements of 42 CFR Part 2.
- g I am reporting a crime a patient has committed on the premises of/or against agency personnel.
- h I have an executed data sharing agreement for research activity that has been approved by a recognized institutional review board (IRB).

I will consult Consejo's leadership for direction anytime I am unclear as to the interpretation of confidentiality regulations or the legality of requests made of me for information. I agree to be bound by procedures for safeguarding client information, including:

- a All charts, notes, and other written materials will be stored in a secure room or locked up when not in use.
- b Discussions regarding clients will be held in staff offices or in other places providing assurance of privacy.
- c No privileged information will be shared with other agencies, professionals, friends, or family members without prior written authorization from the patient.
- d I will deny requests for access to patient files by anyone not employed by the agency, and refer such requests to Consejo's leadership.

I understand that an unauthorized disclosure of patient information or records may subject me to a civil action for damages of \$1,000 or three times the amount of actual damages sustained by a willful release of confidential information under RCW 71.05.440, or state and federal criminal prosecution in accordance with 42 CFR Part 2 and 45 CFR Parts 160 and 164 as follows:

42 DFR Part 2 Penalties

- ❖ Not more than \$500 for the first offence and up to \$5,000 for each subsequent offense.

45 CFR, Part 160 and 146 Penalties

- ❖ \$100 civil fine per violation, with a maximum of \$25,000 per calendar year for each standard violation, 42 USC 1320d-5(a).
- ❖ \$50,000 maximum criminal fine and up to one year imprisonment if any individual knowingly makes a wrongful disclosure or wrongfully obtains protected information.

42 USC 1320 d.6.

- ❖ \$1,000,000 maximum fine and 5 year's imprisonment if offense is committed under false pretenses.
- ❖ \$250,000 maximum fine and 10 years imprisonment if offense is committed with intent to sell, transfer, or use the protected information for commercial advantage, personal gain or malicious harm.

I understand my Oath of Confidentiality and these requirements do not cease at the time I terminate my relationship with the company. I agree to be permanently bound by this oath and by the regulations of confidentiality henceforth.

Name (Printed) _____ Signature _____
Date _____