



# CIRCLES OF CARE INC.

Your Choice for Quality Behavioral Healthcare Services

\*\*\*THIS APPLICATION MUST BE COMPLETELY FILLED OUT IN ORDER TO BE CONSIDERED FOR EMPLOYMENT\*\*\*

LAST LEGAL NAME		FIRST	MIDDLE	POSITION TITLE ARE YOU APPLYING FOR?
PRESENT STREET ADDRESS			FOR HOW LONG?	SALARY DESIRED
CITY	STATE	ZIP CODE	ARE YOU APPLYING FOR FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> REGULAR <input type="checkbox"/> TEMPORARY <input type="checkbox"/>	
PERMANENT MAILING ADDRESS			FOR HOW LONG?	WOULD YOU CONSIDER WORKING ANY SHIFT? YES <input type="checkbox"/> NO <input type="checkbox"/> WEEKENDS & HOLIDAYS YES <input type="checkbox"/> NO <input type="checkbox"/> ROTATING SHIFTS YES <input type="checkbox"/> NO <input type="checkbox"/> ON CALL YES <input type="checkbox"/> NO <input type="checkbox"/>
CITY	STATE	ZIP CODE		
PLEASE LIST CONTACT NUMBERS				SHIFT PREFERENCE: 1ST <input type="checkbox"/> 2ND <input type="checkbox"/> 3RD <input type="checkbox"/>
HOME PHONE	CELL PHONE	EMAIL ADDRESS		

When are you available for work? \_\_\_\_\_ Are you currently working?  Yes  No

Please explain fully any gaps in your employment history. Be sure to account for all periods of time including military service and any period of unemployment. \_\_\_\_\_

List any other names which you have used and which will be necessary to verify prior to your employment: \_\_\_\_\_

If hired, can you provide proof that you are legally entitled to work in the U.S.?  Yes  No

If not, what steps must be taken for you to begin employment lawfully? \_\_\_\_\_

Have you ever been terminated or asked to resign from any job?  Yes  No

If yes, please explain (use a separate sheet of paper if necessary): \_\_\_\_\_

Have you ever worked for Circles of Care, Inc. (formerly known as Brevard Mental Health Center)?  Yes  No

If yes, please give dates, position and location: \_\_\_\_\_

Do you have any friends or relatives currently working at Circles of Care?  Yes  No

If yes, Name(s), relationship and location: \_\_\_\_\_

How were you referred to us? \_\_\_\_\_

Do you have any commitments to any other employer which may affect your employment?  Yes  No

If yes, explain: \_\_\_\_\_

Do you smoke or use tobacco?  Yes  No

PERSONAL

## CURRENT AND PREVIOUS EMPLOYMENT

Please list the names of your present or previous employers in chronological order with present or last employer listed first. Include part-time, seasonal and all other employment. If self-employed, give Corporation names and supply business references. If you need more space, use a separate sheet of paper.

DO NOT ANSWER "SEE RESUME" - May attach a resume.

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Employer Name: \_\_\_\_\_ Dates Employed \_\_\_\_\_  
Address: \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Last Salary: \_\_\_\_\_  
Immediate Supervisor: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
Your Job Title \_\_\_\_\_ Work Performed: \_\_\_\_\_  
Reason for Leaving: \_\_\_\_\_  
May we contact your current employer?  Yes  No  
If no, please explain: \_\_\_\_\_

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Employer Name: \_\_\_\_\_ Dates Employed \_\_\_\_\_  
Address: \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Last Salary: \_\_\_\_\_  
Immediate Supervisor: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
Your Job Title \_\_\_\_\_ Work Performed: \_\_\_\_\_  
Reason for Leaving: \_\_\_\_\_

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Employer Name: \_\_\_\_\_ Dates Employed \_\_\_\_\_  
Address: \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Last Salary: \_\_\_\_\_  
Immediate Supervisor: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
Your Job Title \_\_\_\_\_ Work Performed: \_\_\_\_\_  
Reason for Leaving: \_\_\_\_\_

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Employer Name: \_\_\_\_\_ Dates Employed \_\_\_\_\_  
Address: \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Last Salary: \_\_\_\_\_  
Immediate Supervisor: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
Your Job Title \_\_\_\_\_ Work Performed: \_\_\_\_\_  
Reason for Leaving: \_\_\_\_\_

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**PREVIOUS EXPERIENCE**

SCHOOL	NAME AND ADDRESS OF SCHOOL	COURSE OF STUDY	DID YOU GRADUATE?	LIST DIPLOMA OR DEGREE
HIGH			<input type="checkbox"/> YES	
			<input type="checkbox"/> NO	
COLLEGE/ UNIVERSITY			<input type="checkbox"/> YES	
			<input type="checkbox"/> NO	
GRADUATE/ PROFESSIONAL			<input type="checkbox"/> YES	
			<input type="checkbox"/> NO	
OTHER Business College, Other Special Courses (include Military Training, Post Graduate and Nursing)				
AREA OF SPECIALIZATION OR MAJOR INTEREST?				
PLEASE CHECK WHICH OF THE FOLLOWING EQUIPMENT YOU ARE SKILLED IN OPERATING:				
<input type="checkbox"/> SCANNER <input type="checkbox"/> CALCULATORS <input type="checkbox"/> COMPUTERS <input type="checkbox"/> OTHER _____				
PLEASE LIST OTHER HEALTH CARE, BUSINESS OR INDUSTRIAL EQUIPMENT OPERATED:				

**PROFESSIONAL LICENSES AND/OR CERTIFICATIONS**

IF LICENSED, REGISTERED OR CERTIFIED	ARE YOU CURRENTLY: ELIGIBLE FOR:	<input type="checkbox"/> REGISTERED	<input type="checkbox"/> LICENSED	<input type="checkbox"/> CERTIFIED
		<input type="checkbox"/> REGISTRATION	<input type="checkbox"/> LICENSURE	<input type="checkbox"/> CERTIFICATION
	TYPE	STATE ISSUED	DATE	NO.
	TYPE	STATE ISSUED	DATE	NO.
	TYPE	STATE ISSUED	DATE	NO.

Have you ever plead no contest, nolo contendere, or guilty to a crime, or been convicted of a crime?  Yes  No

Are any charges currently pending against you?  Yes  No

Has any adjudication ever been withheld?  Yes  No

(NOTE: Answering "yes" to these questions does not constitute an automatic bar to employment.) If you answered yes to any of the preceding questions, please give dates and details:

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**NOTIFY IN CASE OF EMERGENCY**

NAME	RELATIONSHIP	ADDRESS	TELEPHONE
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**APPLICANT'S STATEMENT:** I understand that Circles of Care is committed to providing equal opportunity in all employment practices, including but not limited to selection, hiring, promotion, transfer, and compensation, to all qualified applicants and employees without regard to age, race, color, national origin, sex, gender, religion, handicap or disability, genetic information, citizenship status, marital status, service member status, or any other category protected by federal, state, or local law.

I authorize former and present employers, and professional, work, and personal references listed in the application or interview process and any other individuals I may name, to give Circles of Care or its designee any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release such parties from all liability for any damages that may result from furnishing same to Circles of Care. I also authorize Circles of Care to provide truthful information concerning any employment with it to future employers or as may be required, and I agree to hold it harmless for providing such information.

I understand that Circles of Care reserves the right, to the extent permitted by law, to require drug and alcohol screening tests of an applicant or an employee either prior to employment or any time during employment and I hereby give my consent to any such tests. I consent to the release of the results of any such tests to Circles of Care or its designee. I release Circles of Care and its designee from any and all liability and damages that may result or arise from any drug test or the provision of information in connection with such a test. I understand that any of the following conduct or circumstances associated with drug screening will result in termination of the employment process, or if employed, my immediate termination from Circles of Care: a positive result to any drug screen or test; a sample deemed to have been altered or tampered with by testing authorities; the failure or refusal to submit to any drug screen or testing requested by Circles of Care; the sale, possession, or use of any substance banned by drug screening or testing.

I understand that this employment application and any other Circles of Care documents are not promises of employment. Should I be employed, I understand that my employment will be on a trial period up to ninety days from the date of my hiring and that I will remain an at-will employee thereafter. I further understand that, if I am employed, I can terminate my employment at any time with or without cause and with or without advance notice and that Circles of Care has a similar right. I understand that no manager, representative, or agent of Circles of Care has any authority to enter into any agreement for employment for any specified period of time or to make any agreement contrary to the foregoing, except that the President or his designee may do so in writing. In the event of my employment, with this Circles of Care, I will comply with all rules and regulations of Circles of Care.

I certify that the information given by me on this application and during the interview process is true and complete in all respects, and I agree that if the information is found to be false, misleading, or unsatisfactory in any respect (in Circles of Care's judgment) that I will be disqualified from consideration for employment or subject to immediate termination if discovered after I am hired.

I understand, in compliance with their state contract, Circles of Care will complete a background investigation of my employment, criminal history report, driving records, etc. In adherence with Florida Statutes 408.809 (2) a Level II clearance will be conducted before employment and then every five years thereafter and/or if there is an event that may be disqualifying under a Level II screening. I understand that I am required to uphold a Level II background clearance in order to be employed with Circles of Care.

ARE YOU A U.S. CITIZEN OR AN ALIEN LEGALLY AUTHORIZED TO WORK IN THE UNITED STATES? CIRCLES OF CARE, INC. PARTICIPATES IN E-VERIFY. YES  NO

ARE YOU 18 YEARS OF AGE OR OLDER? YES  NO

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THESE STATEMENTS**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Signature

This application will be considered "active" for a maximum of ninety (90) days. If you wish to be considered for employment after that time, you must reapply.

# Circles of Care, Inc.

Notice to all applicants: This form is to be turned in with the application.

Circles of Care, Inc. is committed to Equal Employment Opportunity/Affirmative Action Plan. It is unlawful for an employer to fail or refuse to hire any individual or deprive any individual of employment opportunities because of race, color, religion, national origin, age, marital status, or disability. Applicants who believe they have been discriminated against may file a complaint with the Florida Commission on Human Relations, Building F Suite 240, 325 John Knox Road, Tallahassee, Florida 32399-1570.

The information required on this insert is requested only so that we may meet our Equal Opportunity/Affirmative Action obligations. Your completion of this form will not, in any way, affect your consideration for employment. This information is for credentialing, tracking of application, and for statistical purposes only. This insert will be separated from your application and will be maintained in the Human Resources Department.

Please select the appropriate information for each category:

- 1) Sex:  Male  Female
- 2) Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_
- 3) Social Security #: \_\_\_\_\_
- 4) Disabling or handicapping condition?  Yes  No
- 5) Race/Ethnicity:  
 Hispanic/Latino  
  
NOT Hispanic/Latino  
 American Indian or Alaska Native  
 Asian  
 Black or African American  
 Native Hawaiian or Other Pacific Islander  
 White or Caucasian  
 Two or more races
- 6) Are you a Veteran?  Yes  No

If yes please select one of the following:

- Vietnam Era Veteran
- Special Disabled Veteran
- Other Veteran

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Applicant's Name (Print)

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Applicant's Signature

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Date

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Position applying for: