



LAKE SHORE

BEHAVIORAL HEALTH, INC.

APPLICATION FOR EMPLOYMENT

This application for employment shall be considered active for a period of time not to exceed 45 days from the date hereof.

We consider applicants for all positions without regard to race, religion, creed, gender, national origin, age, disability, marital or veteran status, sexual orientation, or any other legally-protected status.

Position(s) Applied For	Date Of Application
How Did You Learn About Us?	
<input type="checkbox"/> Advertisement <input type="checkbox"/> Friend <input type="checkbox"/> Walk-In <input type="checkbox"/> Employment Agency <input type="checkbox"/> Relative <input type="checkbox"/> Other	

Last Name	First Name	Middle Initial
Address	Street	City
		State
		Zip Code
Telephone Number(s)	Social Security Number	

If you are under 18 years of age, can you provide required proof of your eligibility to work?

Yes No N/A

Have you ever filed an application with us before?

Yes No If Yes, give date: _____

Have you ever been employed with us before?

Yes No If Yes, give date: _____

Are you currently employed?

Yes No

On what date would you be available for work?

What type of work are you available for?

Full-Time Part-Time Temporary

Are you currently on lay-off status?

Yes No Subject to recall? Yes No

HR Received: _____
Date Initials

WE ARE AN EQUAL OPPORTUNITY EMPLOYER

Have you been convicted of a crime within the last 7 years? Yes No

(A conviction record will not necessarily be a bar from employment. Factors such as age at the time of the offense, seriousness and nature of the violation, and rehabilitation will be taken into account.)

If Yes, Please explain: _____

EDUCATION

	Name and Address of School	Course of Study	Number of Years Completed	Diploma/ Degree
High School				
Undergraduate College				
Graduate/ Professional School				
Other (specify)				

Describe any specialized training, apprenticeships, and skills. _____

List professional, trade, business, or civic activities and offices held. *Do not include memberships which would reveal gender, race, religion, national origin, age ancestry, disability, or other protected status:* _____

EMPLOYMENT EXPERIENCE

Start with your present or last job. Include any job-related military service assignments and volunteer activities. You may exclude organizations that indicate race, color, religion, gender, national origin, disabilities, or other protected status.

Employer #1		<u>Dates Employed</u> From To		Work Performed
Address				
Telephone Number(s)		Hourly Rate/Salary		
Job Title	Supervisor			
Reason For Leaving				
Employer #2		<u>Dates Employed</u> From To		Work Performed
Address				
Telephone Number(s)		Hourly Rate/Salary		
Job Title	Supervisor			
Reason For Leaving				
Employer #3		<u>Dates Employed</u> From To		Work Performed
Address				
Telephone Number(s)		Hourly Rate/Salary		
Job Title	Supervisor			
Reason For Leaving				
Employer #4		<u>Dates Employed</u> From To		Work Performed
Address				
Telephone Number(s)		Hourly Rate/Salary		
Job Title	Supervisor			
Reason For Leaving				

If you need additional space, please continue on the reverse side.

Please indicate by number _____ any of the above employers whom you **DO NOT** wish us to contact.

APPLICANT'S STATEMENT

IT IS VERY IMPORTANT THAT YOU READ THIS SECTION CAREFULLY, AND THAT YOU FULLY UNDERSTAND IT BEFORE YOU SIGN IT. THIS SECTION AFFECTS YOUR LEGAL RIGHTS. IF YOU HAVE ANY QUESTIONS, PLEASE ASK BEFORE YOU SIGN THIS APPLICATION.

I certify that answers given herein are true and complete to the best of my knowledge.

I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision.

This application for employment shall be considered active for a period of time not to exceed 45 days. If I wish to be considered for employment beyond this time period, I should inquire as to whether or not applications are being accepted at that time.

I hereby understand and acknowledge that, unless otherwise defined by applicable law, any employment relationship with this organization is of an "at will" nature, which means that the Employee may resign at any time and the Employer may discharge the Employee at any time with or without cause. It is further understood that this "at will" employment relationship may not be changed by any written document or by conduct unless such change is specifically acknowledged in writing by the President of this organization.

In the event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge. I also understand that I am required to abide by all rules and regulations of the employer.

Proof of citizenship or immigration status will be required upon employment.

Signature of Applicant _____ Date _____

CONSENT AND AUTHORIZATION TO RELEASE EMPLOYMENT / EDUCATIONAL INFORMATION

I, _____, understand and agree that Lake Shore Behavioral Health, Inc., any agent acting on its behalf, as well as any other person responding to a reference request pursuant to this application, can and will seek and/or disclose any and all information about me which said corporation, agent, or person may have. I specifically authorize said disclosure and agree to hold all such corporations, agents, or persons harmless for same. That is, I will not file a lawsuit, claim, or charge against them for such disclosure, nor will I threaten same or otherwise seek any kind of compensation for such disclosure.

Signature _____ Social Security Number _____ Date _____



EMPLOYEE NETWORK SECURITY AGREEMENT

Please read each of the following statements carefully and make sure you understand them completely prior to signing the bottom of this document. A copy of this acknowledgement will be made part of your personnel file. If you have any questions regarding this document, please contact the MIS Department at 819-0881.

- Network passwords will be changed every 42 days or when prompted to do so.
- Passwords will not be written down or shared with anyone.
- When leaving a work area for any duration of time, including leaving for the day, users will log out or lock their workstations.
- The wiring closets found throughout the buildings and network equipment are off limits to all non-MIS employees. Users will not attempt entry into these areas without being instructed by the MIS Department.
- Users will not attempt to gain access to any unauthorized area of the information system. If users find that they need additional access, a request will be made to the MIS Department, which will be granted with Supervisor approval.
- Users will not attempt to disable the system in any way.
- Agency computers contain a basic corporate software package. This package was developed based on what it is expected users will require to complete their day-to-day tasks. In the event that additional software is required, users will contact the MIS Department and request that the software be installed. Under no circumstance will users add or delete any software from their computers without the express consent of the MIS Department.
- Users will not attach any unauthorized device to the computers or network (examples include thumb drives, media devices, etc.).
- All computer equipment purchases must be authorized and purchased by the MIS Department.
- No client information (Protected Health Information) will be stored on any type of removable media, such as thumb drives, disks, etc.
- Use of company electronic equipment (which includes desktops, laptops, printers, cellular phones, and wireless data cards) is for official company business, as explained in the Personnel Policy Manual.
- Use of company equipment for illegal purposes will result in disciplinary action up to and including termination.
- The use of streaming media services is prohibited, with the exception of media that is relevant to job function. This includes, but is not limited to, audio (internet radio) and video (news, YouTube, etc.).
- Use of the internet is provided to individuals who, as part of their job requirements, need access for the development of client programming or services.
- All information stored on any local computer and on network drives is property of Lake Shore Behavioral Health, Inc., and can be accessed without consent at any time. Contents of internet sessions are audited for content, duration, or any other purpose.
- Violation of any of these policies will result in the disabling of network access until the user's immediate supervisor sends a memorandum to the MIS Department which details a plan of corrective action and requests that access be restored. This memorandum will be placed in the user's personnel file.

Employee Name: _____

Witness Name: _____

Signature: _____

Signature: _____

Date: _____

Date: _____

Lake Shore Behavioral Health, Inc.

NEW PROVIDER INFORMATION FORM

The following information must be submitted by all new clinicians who will provide services in programs for which Administration bills directly to all third party pay sources.

Name: _____ SSN: _____ DOB: _____

Discipline (CASAC, LMSW, LCSW, LCSWR, Psy.D., Ph.D., PNP, MD, or other): _____

Program Assigned: _____ Location: _____ Phone: _____

Date of Hire: _____ License #: _____ Start Date of License: _____

DEA# (for PNP or MD): _____ UPIN# (if known): _____

NPI #: _____ Paperwork Completed: YES or NO

YES or NO Do you currently participate with Blue Cross Shield of WNY (BCBS) under private practice or for another agency? If YES, provide BCBS Provider #: _____

YES or NO Do you currently participate with Upstate Medicare Division under private practice or for another agency? If YES, provide Medicare Provider #: _____

YES or NO Do you participate with any other insurance companies under private practice or for another agency? If YES, please list: _____

Please attach following:

- _____ Resume or Vitae (with experience and education information, including dates)
- _____ License Certification
- _____ Diploma(s)
- _____ DEA Certificate (required for MD)
- _____ Malpractice Certificate (required for MD)

Please note that your Resume or Vitae must be updated to include Lake Shore Behavioral Health, Inc. Any breaks/gaps in education or employment must be explained on the Resume or Vitae.

Forward this completed form with attachments to the Human Resources Department. If you have any questions, please contact _____.