



APPLICATION FOR EMPLOYMENT AND CREDENTIALING
An Equal Opportunity Employer

We do not discriminate on the basis of race, color, religion, national origin, sex, age, sexual orientation or disability. It is our intention that all qualified applicants be given equal opportunity and that selection decisions be based on job related factors.

Instructions: Complete the application form in full. Each question should be answered fully and accurately. No action can be taken on this application until all questions have been answered. Use blank paper if you do not have room on the application. *Resumes may not be used for application purposes.* Please print, except for the signature lines. If you need help or a reasonable accomodation in order to complete this form, please notify the Human Resources Department for assistance.

PART 1 – TO BE COMPLETED BY ALL APPLICANTS

IDENTIFYING INFORMATION

Position Applied for: _____ Today's Date: _____

Last Name	First Name	Middle Name	Social Security Number (optional)
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Present Street Address	City	State	County of Residence
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() _____ Home Telephone Number	() _____ Other Telephone Number	_____ E-mail address (optional)
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Dates available for employment _____ () Full time () Part time () Temporary

Shifts/days available: () First () Second () Third () Weekdays () Weekends

County(ies) in which you are able to work: _____

EDUCATION: (Education will be considered only to the extent relevant for the position for which you are applying. List all schools attended.)

High School/GED
Name of School _____ Dates _____
Number of Years Completed _____ Diploma/Degree/Certificate: _____

Vocational / Technical / Specialized Training
Name of School _____ Dates _____
Number of Years Completed _____ Diploma / Degree / Certificate _____
Area of Study and/or Training Received: _____

College/Undergraduate Education
Name of School _____ Dates _____
Number of Years Completed _____ Diploma / Degree _____
Major Area of Study _____ Minor Area of Study _____

EDUCATION (continued)

College/Graduate Education

Name of School _____ Dates _____

Number of Years Completed _____ Diploma / Degree _____

Major Area of Study _____ Minor Area of Study _____

College/Graduate Education

Name of School _____ Dates _____

Number of Years Completed _____ Diploma / Degree _____

Major Area of Study _____ Minor Area of Study _____

The candidate must submit verification of education in the form of an official transcript issued by the institution conferring his/her most advanced diploma and/or degree to the Human Resources Department IF applicable for the position applying for.

EMPLOYMENT HISTORY

List names of employers in consecutive order with present or last employer first. Account for all periods of time including military service And any gaps in employment. Please give month and year. If self-employed, give company names and supply business references.

Employer _____

Address _____ Telephone (____) _____

Dates of Employment: From _____ To _____ (____) Full Time (____) Part Time

Position _____ Starting Salary \$ _____ Ending Salary \$ _____

Name / Title of Supervisor _____ Reason for leaving _____

Specific Duties _____

Employer _____

Address _____ Telephone (____) _____

Dates of Employment: From _____ To _____ (____) Full Time (____) Part Time

Position _____ Starting Salary \$ _____ Ending Salary \$ _____

Name / Title of Supervisor _____ Reason for leaving _____

Specific Duties _____

Employer _____

Address _____ Telephone (____) _____

Dates of Employment: From _____ To _____ (____) Full Time (____) Part Time

Position _____ Starting Salary \$ _____ Ending Salary \$ _____

Name / Title of Supervisor _____ Reason for leaving _____

Specific Duties _____

Additional information / explain any periods of unemployment: _____

ADDITIONAL INFORMATION

Have you worked under any other name? () Yes () No

If yes, give name (s): _____

Have you ever been employed at Arbor Circle? () Yes () No

If yes, state position, location and dates: _____

Are you related to anyone currently working at Arbor Circle? () Yes () No

If yes, who? _____

Have you ever been fired or asked to resign from a job? () Yes () No

If yes, please explain _____

Are you presently employed? () Yes () No

If yes, may be contact your present employer? () Yes () No

Have you been convicted of a felony within the last 5 years? () Yes () No

If yes, please explain: _____

Have you ever been convicted of any other type of offense? () Yes () No

If yes, please explain _____

CITIZENSHIP

Employment at Arbor Circle is allowed but not limited to citizens of the United States. In accordance with Federal Law, only non-citizens with certain alien classifications are authorized for employment. Please answer the following questions in order to determine your eligibility to be employed. Your responses will not necessarily eliminate you from consideration for employment.

Are you a citizen of the United States?..... () Yes () No

If hired, can you furnish proof you are eligible to work in the United States? () Yes () No

CERTIFICANT OF APPLICANT

I certify that all information provided in this employment application is true and complete. I understand that any false information or omission may disqualify me from further consideration from employment and may result in dismissal if discovered at a later date.

I hereby authorize anyone of whom request is made to supply to the company any information concerning my background in connection with employment consideration. I further understand that this application for employment is not a contract of employment.

I have read, understand, and by my signature consent to these statements.

Signature _____ Date: _____

- *This application for employment will remain active for a period of time not to exceed 120 days. The authorization for release of information shall be valid for the same period of time. Any applicant wishing to be considered beyond this time period should reapply.*

PROFESSIONAL REFERENCE CHECK

***Please complete the Authorization to Release Information Box ONLY. ***
The Hiring manager will contact the references listed.

Authorization to Release Information - To Be completed by Applicant

I, _____ an applicant for a position with Arbor Circle, have been asked to furnish information for use in reviewing my background and qualifications. In this connection, I do hereby authorize

Reference Name: _____ Phone _____

Address: _____

Nature of Relationship _____

to release reference information to Arbor Circle and authorize Arbor Circle, by its representative, to investigate my past and present work, education, military and police records to ascertain any and all information which may be pertinent to my employment qualifications. I relieve any individual and/or company giving verbal and/or written reference information from legal liabilities.

Applicant Signature

Date

1. How would you rate the applicant in the following areas? Please explain each rating.

1=Below Average 2=Average 3=Above Average 4=Outstanding 5=Unable to rate 6=Not Applicable for Job

___ Clinical Judgment & Performance _____

___ Professionalism (time management skills, presentation) _____

___ Documentation Skills (timeliness/accuracy) _____

___ Communication Skills _____

___ Technical Skills _____

___ Overall Knowledge and Skills _____

___ Flexibility /Ability to Adapt / Get along with others _____

2. What are areas of strength? _____

3. What are areas of weakness? _____

4. Would you rehire? _____

5. Any additional comments: _____

Signature of Person Completing Reference Check

Date

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_____ Applicant Signature

_____ Date

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3. What are areas of weakness? _____

4. Would you rehire? _____

5. Any additional comments: _____

Signature of Person Completing Reference Check

_____ Date

PART 2 – TO BE COMPLETED BY MASTERS LEVEL AND ABOVE APPLICANTS APPLYING FOR CLINICAL POSITIONS

To be completed by Applicant:

- Application is filled out *completely*, signed and dated.
- Documentation supporting clinical population request is attached.
- Disclosure Statement is signed and dated. (History of action limiting or suspending license in past 5 years (including Medicare/Medicaid sanctions within past 3 years) included.)
- Waiver and release form signed and dated.
- Official transcripts sealed by the Graduate institution are attached
 - If Official transcripts are not attached, Copy of transcripts are attached and Official transcripts have been ordered
 - Date ordered _____ Anticipated date of receipt _____
- Copy of all license and/or certificate from the State of Michigan are attached.
- Copy of resume/vitae that is up to date is attached.

Instructions:

The information requested on this form will be used in the credentialing process. The questions are intentionally worded to solicit as much information as possible for review and consideration. It is important that the information you provide be as complete and accurate as possible because any misstatement or omission of relevant information will constitute grounds for rejection of your application or *summary dismissal* as a participating provider. Thus, it is better to err on the side of inclusion with appropriate explanation, rather than exclusion. In addition, you will be held responsible for all statements written in this application, regardless of whether such statements were prepared by you or by an employee, agent or representative. Finally, the wording of the questions and definitions relating to medical conditions (including substance abuse) may seem peculiar but they are based on provider protections identified under the Americans With Disabilities Act.

Definitions:

“Chemical Abuses” is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber’s direction, as well as those used illegally.

“Currently” does not mean on the day of, or even in the weeks or months preceding, the completion of this application. Rather it means recently enough so that the use of chemical substances may have an ongoing impact on one’s functioning as a licensee, or within the past two (2) years.

“Illegal use of controlled dangerous substances” means the use of controlled dangerous substances obtained illegally (including but not limited to heroin, cocaine, or marijuana) as well as the use of controlled dangerous substances (including but not limited to codeine, meperidine, diazepam, or amphetamines) which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

Provider Information:

Name: _____
Last First Middle Jr, Sr, (etc.)

License/Registration/Certification: _____ License Expires: _____

License/Registration/Certification: _____ License Expires: _____

License/Registration/Certification: _____ License Expires: _____

Internship or Practicum:

Location: _____ Date: _____

Address: _____
Number, Street, Ste. Number, City, State and Zip

Phone Number: _____

Internship or Practicum:

Location: _____ Date: _____

Address: _____
Number, Street, Ste. Number, City, State and Zip

Phone Number: _____

Internship or Practicum:

Location: _____ Date: _____

Address: _____
Number, Street, Ste. Number, City, State and Zip

Phone Number: _____

Accreditation:

Does a recognized body accredit your practice? ___ Yes ___ No

If yes, please identify that accreditation body? _____

Professional Organizations of which you are a member: _____

Languages: Other than English, list the languages you speak fluently: _____

Requested Populations: Please provide detailed evidence of your expertise or professional experience such as certification, work experience, letters from supervisor for all boxes check below. You must have a relevant Masters Degree and:

Young Child (Ages 0-5)

Infant Toddler Development Services

- Level II or above Endorsement with the Michigan Association of Infant Mental Health

All Other Programs

- Relevant Masters Level Course work
 Experience Specific to the growth and development of Young Children
 Experience or training Specific to the Treatment, Care or Services of Young Children
 Other (please Explain) _____
-
-

Child (Ages 5-12)

- At least one of the following (please check box(es) and attach documentation)

- Relevant Masters Level Course work
 Experience Specific to the growth and development of Children
 Experience or training Specific to the Treatment, Care or Services of Children
 Other (please Explain) _____
-
-

Adolescent (Ages 13-17)

- Masters Degree AND at least one of the following (please check box(es) and attach documentation)

- Relevant Masters Level Course work
 Experience Specific to the growth and development of Adolescents
 Experience or training Specific to the Treatment, Care or Services of Adolescents
 Other (please Explain) _____
-
-

Adult (Ages 18 and above)

- Masters Degree AND at least one of the following (please check box(es) and attach documentation)

- Relevant Masters Level Course work
 Experience Specific to Knowledge about adults and / or Families
 Experience or Training Specific to the Treatment, Care or Services of Adults and / or Families
 Other (please Explain) _____
-
-

For what areas are you requesting credentialing? Check box(es) that apply and attach documentation. You must have a relevant Masters Degree and:

- Substance Use Disorder Therapy/Counseling** (at least one of the following)

Outpatient and SUD Programs

- CAAC Certification Certification # _____ Exp Date _____
- CAAC Eligible - Certification achieved in first 6 months of employment
- Development Plan for CAAC(attach Plan) Anticipated completion date _____

All Other Programs

- CAAC Certification - Certification # _____ Exp Date _____
- CAAC Eligible - Certification achieved in first 6 months of employment
- SPADA (Specialty Program in Alcohol and Drug Abuse Certificate)
- CAC-M or CAC- (Certified Addictions Counselor Certification) Attach Copy of Certification Certification # _____ Exp Date _____
- 2 Years Full-Time experience providing Substance Use Disorder Treatment
OR 2000 documented hours providing Substance Use Disorder Treatment

- Co-Occurring Therapy / Counseling** (at least one of the following from Each Category)

Substance Use

- CAAC Certification - Certification # _____ Exp Date _____
- SPADA (Specialty Program in Alcohol and Drug Abuse Certificate)
- CAC-M or CAC- (Certified Addictions Counselor Certification) Attach Copy of Certification Certification # _____ Exp Date _____
- 2 Years Full-Time experience providing Substance Use Disorder Treatment
OR 2000 documented hours providing Substance Use Disorder Treatment
- 2 Years Full-Time experience treating individuals/families with Co-Occurring or Substance Use Disorders AND 12 hours of documented Master's Level Course Work/Post Master's Level Training specific to Substance Use Disorders.

Mental Health

- Relevant Masters Level Course work
- Experience Specific to the increased Knowledge of Mental Health concerns / issues
- Experience or training Specific to the Treatment, Care, or Services of Mental Health concerns / issues

- Mental Health Disorder Therapy/Counseling** (At least one of the following)

- Relevant Masters Level Course work
- Experience Specific to the increased Knowledge of Mental Health concerns / issues
- Experience/training Specific to the Treatment, Care, or Services of Mental Health concerns / issues

- EMDR** (Eye Movement Desensitization and Reprocessing) – supervision plan must be attached

- At least Level 1 of 2 EMDR Training from the EMDR Institute, Inc (17 hours)

- Acupuncture** Must have Both:

- NADA (National Acupuncture Detoxification Association) Certified Training as an Acupuncture Detoxification Specialist
- Meets Credentialing Criteria for Chemical Dependency listed above

Insurance Provider Panels

Please list all Insurance Carriers that you are or have been paneled with in the recent past

- Priority Health
 - Mental Health From _____ To _____ Under what agency _____
 - Substance Abuse From _____ To _____ Under what agency _____
- BCBS
 - Mental Health From _____ To _____ Under what agency _____
 - Substance Abuse From _____ To _____ Under what agency _____
- Medicare From _____ To _____ Under what agency _____
- CompCare From _____ To _____ Under what agency _____
- CIGNA From _____ To _____ Under what agency _____
- CorpHealth From _____ To _____ Under what agency _____
- Value Options From _____ To _____ Under what agency _____
- Other Please list
 - _____ From _____ To _____ Under what agency _____
 - _____ From _____ To _____ Under what agency _____
 - _____ From _____ To _____ Under what agency _____
 - _____ From _____ To _____ Under what agency _____

Attestation:

I attest that the information contained herein is correct and complete.

Signature (no stamp) and Date

Supervisor's Acknowledgment / Recommendation

I have reviewed this applicant's credentials and find them appropriate for the position applied for. I herby recommend this application for credentialing with Arbor Circle Corporation.

Supervisors Signature and Date

Disclosure Statements:

1. Yes No Are you able to perform the essential functions of your job without a risk to patient safety or health?
2. Yes No Has your license to practice or ability to practice in any jurisdiction ever been stipulated, denied, restricted, suspended, reduced, terminated, not renewed, or placed on probation by a licensing agency?
3. Yes No Have you ever had any professional disciplinary action taken against you? This includes, but is not limited to, actions taken by any health care plan, hospital, clinic, and any licensing and regulatory agencies.
4. Yes No Have you ever voluntarily relinquished your professional license as an alternative to disciplinary action or during an investigation into your professional competence or conduct?
5. Yes No Have you had a professional liability case(s) brought and /or sustained against you in the past five years?
6. Yes No Do you have any misdemeanor or felony charges pending, or have you ever been convicted of a misdemeanor or felony other than a minor traffic violation?
7. Yes No Have you ever had a non-professional relationship with a client or former client that was sexual in nature or otherwise in violation of any ethical rules of your profession?
8. Yes No Have you ever been investigated for any acts alleging dishonesty, fraud, deceit or misrepresentation?
9. Yes No Have you ever voluntarily relinquished your membership or participation in any professional organization, including but not limited to any government sponsored health plan (e.g. Medicare or Medicaid), any third party payer or other organization, in lieu of disciplinary action?
10. Yes No Has a professional liability carrier ever refused or canceled your coverage?
11. Yes No Have you ever had action taken against you by any third party payer, insurance company, or HMO including, but not limited to, Medicare and Medicaid, for inappropriate utilization of medical resources?
12. Yes No Have you settled any malpractice or professional negligence claims with or without litigation?
13. Yes No Have you been given notice within the past twelve (12) months of claims or potential claims outstanding against you?
14. Yes No Have you had any complaints registered against you with any licensing authority?
15. Yes No Are you currently engaged in illegal use of controlled substances?

If you answered "Yes" to any question except #1, or if you answered "No" to question #1, please use this space to explain your answers. Attach additional sheets in necessary.

Signature of Applicant: _____ Date: _____

WAIVER AND RELEASE

I hereby apply for appointment as a provider with Arbor Circle. I am willing to make myself available for interviews in regard to this application, if necessary.

I understand that I have the burden of producing adequate information for proper evaluation of my application. I also agree to provide Arbor Circle with updated information regarding all questions on this application form as such information becomes available. Failure to produce this information will prevent any application from being evaluated and acted upon.

By applying for appointment, I accept the following conditions regardless of whether or not my application is approved.

1. **Disclosure.** I extend absolute immunity to and release from liability ARBOR CIRCLE and its authorized representatives, and any third parties, from whom information has been requested, for any communications, reports, records, statements, documents, recommendations, or disclosures involving me, including otherwise privileged or confidential information, relating to my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, or behavior; and any other matter that might directly or indirectly have an effect on my competence or on the clinical care of my clients.
2. **Consultation.** I specifically authorize ARBOR CIRCLE and its authorized representatives to consult with any third party who may have information, including otherwise privileged or confidential information, bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter bearing on my satisfaction of the criteria for appointment. Authorization is also given to inspect or obtain any and all communications, reports, records, statements, documents, recommendations, or disclosures of said third parties relating to such questions. I also specifically authorize said third parties to release said information to ARBOR CIRCLE and their authorized representatives upon request.

If my application is approved, I specifically agree to: (i) refrain from fee splitting or other inducements relating to patient referrals; (ii) refrain from delegating responsibility for diagnoses or care of patients to any other practitioner who is not qualified to undertake this responsibility or who is not adequately supervised; (iii) refrain from deceiving patients as to the identity of any practitioner providing treatment or services; (iv) seek consultation whenever necessary or required; (v) abide by generally recognized ethical principles, applicable to my profession; and (vi) provide continuous care and supervision as needed to all patients for whom I have a responsibility.

The information submitted by me in this application, including all attachments, is true to the best of my knowledge and belief. I fully understand that any misleading statement or omission in this document discovered at any time may constitute grounds for denial of this application or cause immediate termination of my appointment.

Name (Please Print)

Signature

Date