



SPECIALIZED TREATMENT FACILITY

14426 James Bond Road, Gulfport, MS 39503 Phone: (228) 328-6000 Fax: (228) 328-6035

Shannon Y. Bush, MPA, Program Director

Applicant Background / Work Reference Packet

Please fill out this packet completely. This information is necessary to process background checks and work references.

Work references must be for your **current and last two employers**; or if not currently employed, your **last three employers**. The work references must match the work experience listed on your application.

Printed Applicant Name

Previous Name

Date of Birth

Social Security Number

Day-time Phone Number

Applicant Signature

Date



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APPLICANT BACKGROUND QUESTIONNAIRE

Under Federal guidelines, the Specialized Treatment Facility must conduct background checks on all potential applicants. As part of these background checks, we will cooperate with local law enforcement agencies to determine whether or not a criminal conviction is on file. This will aid the Human Resources Department in selecting quality employees.

To assist us in this background check, please answer the following questionnaire.

Have you ever been convicted of a criminal act? _____ Yes _____ No

If yes, please explain: _____

Have you ever been convicted of child abuse or neglect? _____ Yes _____ No

If yes, please explain: _____

Have you ever been convicted of driving under the influence of drugs or alcohol? _____ Yes _____ No

If yes, please explain: _____

Have you ever been convicted of possession, use or sale of narcotics? _____ Yes _____ No

If yes, please explain: _____

Have you ever worked for a DMH facility? (please check below) _____ Yes _____ No

Behavioral Health Programs

	Dates
<input type="checkbox"/> North MS St Hospital	_____
<input type="checkbox"/> South MS St Hospital	_____
<input type="checkbox"/> East MS St Hospital	_____
<input type="checkbox"/> MS State Hospital	_____
<input type="checkbox"/> Central MS Residential Center	_____
<input type="checkbox"/> Specialized Treatment Facility	_____

IDD Programs

	Dates
<input type="checkbox"/> Boswell Regional Center	_____
<input type="checkbox"/> Hudspeth Regional Center	_____
<input type="checkbox"/> North MS Regional Center	_____
<input type="checkbox"/> South MS Regional Center	_____
<input type="checkbox"/> Ellisville State School	_____
<input type="checkbox"/> MS Adolescent Center	_____

Signature: _____

Date: _____



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Top portion to be completed by applicant

Work Reference Inquiry

Applicant's Name _____ Dates of Employment _____

Company/Organization _____ Department _____ Phone Number _____

Street No. or PO Box _____ City _____ State _____ Zip _____

Supervisor _____ Reason for Leaving _____

I hereby authorize the Specialized Treatment Facility to request verification of statements made by me on my employment application and any other job-related information. I also give permission to the above company/organization to release the information requested. I do hereby release the addressed individual, company, organization, and all individuals connected therewith, including the Specialized Treatment Facility, from all liability for any damage whatsoever incurred in furnishing such information.

Applicant's Signature _____ Date _____

.....
To be completed by previous employer

Is the above information correct? ☐ Yes ☐ No If no, please note what information is incorrect.

What is your opinion as to this person's:

	<u>Above Average</u>	<u>Average</u>	<u>Below Average</u>	<u>Unsatisfactory</u>
Attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Honesty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cooperation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dependability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Initiative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Courtesy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality of work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to learn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to work with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Would you re-employ this person? ☐ Yes ☐ No If no, please explain below.

Would you recommend that we employ this person? ☐ Yes ☐ No If no, please explain below.

If you have a Drug/Alcohol Testing Policy, had this person ever tested positive for drugs and/or alcohol or violated the drug/alcohol policies? ☐ Yes ☐ No If yes, please explain below.

Supervisor's Name (please print) _____ Title _____

Supervisor's Signature _____ Date _____



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