

Dear Applicant:

Thank you for your interest in the Bowen Center. Below you will find instructions on what we need to determine your eligibility for employment.

In addition to completing the application below:

- HR will need *Official* Transcripts or High School Diploma/ GED sent to us.
- We will also need 3 *work/experience* related references. If you have any letters of recommendation with follow up contact information that would be beneficial.
- If you have an *out of state* driver's license you will need to obtain a minimum of 3 years driving history and forward that also.

Please submit final application by one of the following options:

1. Fill out, **sign**, and scan the completed application into your pc and then forward it back to HR at hresources@bowencenter.org.

OR

2. Fill out, **sign**, and fax to us at **574-268-2377**.

OR

3. Fill out, **sign**, and drop in the mail. **850 N Harrison St., Warsaw, IN 46580 ATTN: Human Resources** (if you would like this option, We can mail out a self addressed, stamped envelope for your convenience. Just let us know.)

Please remember to sign all **FOUR locations in the application. Applications cannot be processed without your official signatures.**

Thank you,
Bowen Center Employment Specialist

BOWEN CENTER
An Equal Opportunity Employer

Employment Application

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

Instructions: Complete the job application in full. Each question must be answered 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 will not be used in place of the employment application.** PLEASE PRINT, except for the signature line found on the last page of the application. If you need help or reasonable accommodations in order to complete this application, please notify the Human Resources Department.

Today's Date: _____ <input type="checkbox"/> Clinical Position <input type="checkbox"/> Administrative Position			
Specific Position Applying For: _____			
_____	_____	_____	
Last Name	First Name	MI	
_____	_____	_____	_____
Street Address	City	State	Zip
_____	_____	_____	_____
_____	_____		
Home Phone	Cellular Phone		
_____	_____		
Email Address (optional)			

Date Available to Begin Employment: _____			
Shifts/Days Available: <input type="checkbox"/> First <input type="checkbox"/> Second <input type="checkbox"/> Third <input type="checkbox"/> Weekdays <input type="checkbox"/> Weekends <input type="checkbox"/> Holidays <input type="checkbox"/> On Call			
Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Contract <input type="checkbox"/> Temporary			
Area Able to Work: <input type="checkbox"/> Allen <input type="checkbox"/> Huntington <input type="checkbox"/> Kosciusko <input type="checkbox"/> Marshall <input type="checkbox"/> Noble <input type="checkbox"/> Wabash <input type="checkbox"/> Whitley <input type="checkbox"/> LaGrange			

EDUCATION:

High School/GED:	
School:	
Diploma/Degree:	Graduation Date:

Associates/Vocational/Technical/Trade School:	
School:	
Diploma/Degree:	Graduation Date:
Area of Study:	

College/Undergraduate Degree:	
School:	
Diploma/Degree:	Graduation Date:
Area of Study:	

Master's/Graduate Degree:	
School:	
Diploma/Degree:	Graduation Date:
Area of Study:	

TRANSCRIPT REQUIREMENTS:

Original transcripts will be required as a part of the credentialing process. The Bowen Center requires that Colleges/Universities submit original transcripts in a sealed envelope directly to the Human Resources Department before you will be considered.		
Have you applied for original transcripts? <i>(Circle one)</i>	Yes	No
Can you provide original transcripts? <i>(Circle one)</i>	Yes	No

EMPLOYMENT HISTORY:

List names of employers in consecutive order with present or last employer first.

Employer _____
Address _____
Dates of Employment _____ to _____
 Full Time Part Time Contract Temporary
Position _____
Starting Salary _____ Ending Salary _____
Name/Title of Supervisor _____
Specific Duties _____
Reason for Leaving _____
Can We Contact for Employment Verification? Yes No
If no, why? _____

Employer _____
Address _____
Dates of Employment _____ to _____
 Full Time Part Time Contract Temporary
Position _____
Starting Salary _____ Ending Salary _____
Name/Title of Supervisor _____
Specific Duties _____
Reason for Leaving _____
Can We Contact for Employment Verification? Yes No
If no, why? _____

Employer _____
Address _____
Dates of Employment _____ to _____
 Full Time Part Time Contract Temporary
Position _____
Starting Salary _____ Ending Salary _____
Name/Title of Supervisor _____
Specific Duties _____
Reason for Leaving _____
Can We Contact for Employment Verification? Yes No
If no, why? _____

Explain Any Gaps of Employment: _____

PREVIOUS/CURRENT PRIVILEGES: N/A

List any hospital/accredited organizations where you have held/hold privileges

Facility	_____
Location	_____
Privileges	_____
Date Granted	_____
Facility	_____
Location	_____
Privileges	_____
Date Granted	_____
Facility	_____
Location	_____
Privileges	_____
Date Granted	_____

BOARD CERTIFICATIONS: N/A

List all past and present specialty board certifications

Name of Board	_____
Certificate Number	_____
Pending <input type="checkbox"/>	
Expiration Date	_____
Name of Board	_____
Certificate Number	_____
Pending <input type="checkbox"/>	
Expiration Date	_____
Name of Board	_____
Certificate Number	_____
Pending <input type="checkbox"/>	
Expiration Date	_____

LICENSING/CERTIFICATIONS: N/A

List all part and present professional licenses/certifications

Name of License/Certification	_____
State Issued	_____
License/Certification Number	_____
Expiration Date	_____
Name of License/Certification	_____
State Issued	_____
License/Certification Number	_____
Expiration Date	_____

DEA Registration # (MD and APN only)	_____
Expiration Date	_____
Indiana Controlled Substance Registration # (MD and APN only)	_____
Expiration Date	_____
If you are a foreign graduate, please provide your EGFMG #	_____
Expiration Date	_____

PROFESSIONAL LIABILITY COVERAGE:

If applicable, please provide a certificate of insurance which qualifies you as a healthcare provider under the Indiana Patient's Compensation Act

Insurance Carrier	_____
Expiration Date	_____
Have you ever had professional liability insurance denied, canceled, issued on special terms, or renewal refused	<input type="checkbox"/> Yes <input type="checkbox"/> No

CHALLENGES TO LICENSURE/CERTIFICATION, LIABILITY ACTIONS:

Have any of the following ever been, or are any currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed or voluntarily relinquished? If yes, please provide a full explanation on a separate sheet of paper.

<input type="checkbox"/> Yes	<input type="checkbox"/> No	License/certification to practice your profession in any jurisdiction
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other professional license/certification/registration
<input type="checkbox"/> Yes	<input type="checkbox"/> No	DEA or other controlled substance authorization
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Staff membership, status, or rights at any other organization
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Clinical credentials or privileges at any other health organization
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Professional society membership or office

Have there been, or are there currently pending, any malpractice claims, suits, settlements or arbitration proceedings involving your professional practice? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>If yes, please discuss status and final settlements or judgments on a separate sheet</i>	
Have there been or are there currently pending charges of fraud and/or abuse against you?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If yes, please provide a full explanation on a separate sheet.</i>	
Have there ever been any felony criminal charges brought against you? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please provide a full explanation on a separate sheet.	
<i>Bowen Center will complete a full criminal history background check</i>	

Certificate of Applicant and Authorization to Acquire Necessary Employment Information

Please read and initial each paragraph below. If you do not understand any part of this page, please ask the interviewer before signing.

_____ I hereby authorize Bowen Center to thoroughly investigate my references, work records, education, and other matters related to my suitability for employment and, further, authorize my current and former employers, educational institutions and/or licensing/certifying organizations to disclose to Bowen Center any and all letters, reports, and other information pertaining to my employment, academic records and/or status of current license/certification, without giving me prior notice of such disclosure. In addition, I hereby release Bowen center, my current and former employers, and all other persons, corporations, partnerships, and association fro any and all claims, demands or liabilities arising out of or in any way related to such investigation or disclosure.

_____ I understand that nothing contained in the application or conveyed to me during any interview that may be granted is intended to create an employment contract, implied or explicit, between Bowen Center and me. In addition, I understand and agree that if I am employed, my employment relationship with Bowen Center is strictly voluntary and at our mutual will. I understand that if employed, my employment is for no definite period and may be terminated at any time, with or without prior notice, with or without cause or reason, at the option of either the Bowen Center or myself, and that no promises or representations contrary to the foregoing are binding on Bowen Center unless made in writing and signed jointly by the President/Chief Executive Officer and myself.

_____ I understand and agree that any future changes in my title, duties, compensation, working conditions, and/or Bowen Center's benefits, policies and procedures will not alter our at-will and arbitrations agreement

_____ I understand that, as a condition of my employment, on my first day of orientation I will be required to submit proof of my identity and legal right to work in the United States.

_____ I understand that my employment with the Bowen Center is contingent upon the outcome of the criminal background check and license and certification verification. I will also be required to possess a current and valid driver's license and provide proof of insurance. I also understand any offer of employment is contingent on my ability to be covered by Bowen Center's auto insurance.

I hereby certify that I have not knowingly withheld any information that might adversely affect my chances for employment and that the answers given by me are true and correct to the best of my knowledge. I further certify that I, the undersigned applicant, have personally completed this application. I understand that any omission or misstatement on this application or on any documents used to secure employment shall be grounds for rejection of this application or for immediate discharge if I am employed, regardless of the time elapsed before discovery.

My signature below certifies that I have read, understand, and agree to the terms and conditions outlined in this employment application.

Print

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 must reapply.



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NOTIFICATION AND AUTHORIZATION/CONSENT

During the application process and at any time during the tenure of my employment/service with the Otis R. Bowen Center for Human Services (Bowen Center), I hereby authorize Bowen Center to procure a report which I understand may include information regarding my character, general reputation, education, licensure, certification, past employment, criminal history, or personal characteristics. This report may be compiled with information from ChoicePoint, court records repositories, departments of motor vehicles, past or present employer(s), educational institutions, governmental occupational licensing or registration entities, business or personal references, and any other source required to verify information that I have voluntarily supplied. I understand that I may request a complete and accurate disclosure of the nature and scope of the background verification; to the extent such investigation includes information bearing on my character, general reputation, or personal characteristics.

You are hereby advised pursuant to the Fair Credit Reporting Act ("FCRA") that a report may be obtained on you providing information about your prior employment, educational background, criminal convictions, and/or driving record for use in making decisions about your employment. It may be an "investigative consumer report" involving reference checks regarding your prior employment. You have a right to request disclosure of the nature and scope of any investigative consumer report, and you may also request a summary of your rights under the FCRA. Information obtained from this report shall be held confidential by the requesting employer and will be used only for employment-related purposes.

To Whom It May Concern:

I hereby authorize the Otis R. Bowen Center for Human Services, Inc. to obtain such a report. I understand this authorization is to be part of the written employment application, which I sign. I have been given a copy of my Rights under the Fair Credit Reporting Act. I agree to provide proof of insurance and understand I must be insurable under Bowen Center's auto insurance carrier if my position requires driving.

Date of Birth*: _____ Social Security Number*: _____

Driver's License State: _____ Driver's License Number: _____

First Name Middle Name Last Name

If name changed (through marriage or otherwise) print former name here:

Previous Name(s) Used

Signature

Date

PROFESSIONAL REFERENCES

As part of the Bowen Center credentialing process, you will be required to submit three professional references. Professional references are classified as individuals who have first hand knowledge of your work or educational career who are not related to you. There references include: former supervisor, former internship supervisor, or professor. Co-workers, friends, and/or family members are not acceptable references. Failure to provide references will disqualify you from the hiring process.

Reference #1

Name _____
Title _____
Phone Number _____
Email Address _____

Reference #2

Name _____
Title _____
Phone Number _____
Email Address _____

Reference #3

Name _____
Title _____
Phone Number _____
Email Address _____



INDIANA REQUEST FOR A CHILD PROTECTION SERVICES (CPS) HISTORY CHECK

State Form 52802 (R4 / 1-11) / CW 2128
DEPARTMENT OF CHILD SERVICES

All spaces must be completed and typed or printed in all capital letters.

* **PLEASE NOTE:** If Indiana CPS history is required prior to 1998, the request form must be sent to the DCS local office in the count(ies) of interest. When more than one county is included in the search period prior to 1998, the request must be sent to each DCS local office. All DCS local offices can also perform statewide CPS searches for dates January 1, 1998, through the present. Contact information of each of Indiana's DCS local offices can be found at the DCS website, www.in.gov/dcs. On the left hand side of the page, click on Contact Us, and then click on Local.

SECTION A – TO BE COMPLETED BY REQUESTING ORGANIZATION

1. Legal first name of applicant		Legal middle name of applicant (If none, indicate "no middle")		Last name of applicant	
2. Reason for history check (check all that apply) *					
<input type="checkbox"/> Foster care <input type="checkbox"/> Adoption <input type="checkbox"/> Employment <input type="checkbox"/> Volunteer <input type="checkbox"/> Unlicensed relative placement <input type="checkbox"/> Other (please explain) _____					
3. Type of requesting organization					
<input type="checkbox"/> Agency licensed / contracting with Indiana Department of Child Services (insert name of agency) _____ <input type="checkbox"/> State Social Service Agency, other than Indiana (insert name of state) _____ <input type="checkbox"/> Other (insert name of company / requestor) _____					
4. Name of contact person for organization			5. Telephone number (include area code)		6. Fax number (include area code)
			() ()		() ()
7. Mailing address of organization (number and street, city, state, and ZIP code)				8. E-mail address of requestor	

SECTION B – TO BE COMPLETED BY APPLICANT OR APPLICANT'S REPRESENTATIVE

I hereby consent to a release of information to the above-named requesting organization regarding any prior child protection service history. I understand that this information is necessary to ensure the safety of children. **This authorization is valid for sixty (60) days from the date of consent below.**

9. Signature of applicant or applicant's legal representative		10. Relationship to applicant		11. Date signed (mm/dd/yyyy)		12. Gender of applicant	
						<input type="checkbox"/> Male <input type="checkbox"/> Female	
13. Typed or printed name of applicant or applicant's legal representative (as signed above)			14. Date of birth of applicant (mm/dd/yyyy)		15. Race of applicant		
16. Current residential address of applicant (number and street, city, state, and ZIP code)				17. Last four digits of applicant's Social Security Number			
				(List all numbers ever used.) XXX-XX-____			
18. Please list all Indiana counties in which the applicant has resided, beginning with the most recent or current in 18a and descending to the oldest. Provide the month and year that residency began and ended in each county listed. For special or unusual situations, please explain (use additional paper if necessary).							
County		Year Began	Year Ended	County		Year Began	Year Ended
XYZ County		02/1992	Current	18a.			
18b.				18c.			
18d.				18e.			
19. Has applicant ever used an alias, including different first, middle, or last name or combination of names in lifetime?						If yes, complete 19a through 19e. If no, please stop.	
<input type="checkbox"/> Yes <input type="checkbox"/> No							
Please list all aliases applicant ever used. Each listing should indicate type of alias with a label including but not limited to maiden, previous married, hyphenated, shortened first names or use of middle names, change of middle name, nicknames, or pre-adoptive names.							
19a. Maiden name (if ever married)				19b. Other last name(s)			
19c. Nickname or shortened first name				19d. Pre-adoptive name or other alias name / how used			
19e. Other alias name / how used							

SECTION C – TO BE COMPLETED BY INDIANA DEPARTMENT OF CHILD SERVICES ONLY (Complete 20, 21, & 23-27; complete 22 when applicable.)

20. Has the above-named applicant ever applied for or been licensed as a foster parent in Indiana?		If yes, was there ever any negative action taken on the foster care application or license?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A – Minor, Employee, or Volunteer		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If there is history of any negative action, for each negative action provide the type of action and the month and year the action was effective.			
21. Does the above-named applicant have a record of substantiated child abuse or neglect as a perpetrator within Indiana?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, for each substantiation list the type of case (i.e. neglect, physical abuse and/or sexual abuse), the month and year of the substantiation approval, the DCS local office that conducted the assessment, and that DCS local office's telephone number. The requestor should contact the DCS local office at the telephone number provided for more detail.			

22. * The search was completed using electronic statewide records that include the dates January 1, 1998, through the date indicated in item 25 below.			
<input type="checkbox"/> If this box is checked, the search also includes paper records retained by the DCS Local Office in _____ County, Indiana, for the time period prior to 1998, as permitted by Indiana Law.			
23. Signature of staff member completing check		24. Title of staff member completing check	
25. Date (mm/dd/yyyy)			
26. Printed name of staff member completing check		27. Indiana Department of Child Service office completing check	
		_____ County Local Office / Central Office Background Check Unit	





Better Counseling... Better Life.

The Otis R Bowen Center for Human Services, Inc

P.O. Box 497
850 N. Harrison Street
Warsaw, IN 46581-0497
(800) 342-5653
www.bowencenter.org

VOLUNTARY SELF-IDENTIFICATION INFORMATION

Thank you for your interest in our open position. We are currently evaluating your resume. If it is determined that your skills, education and experience match our job requirements, you will receive further consideration for this position. As part of the application process, we are requesting that you complete this Voluntary EEO Identification Information form. Submission of this information is voluntary and will not be used in any decision affecting employment consideration.

VOLUNTARY EEO IDENTIFICATION INFORMATION

Various agencies of the United States Government require employers to maintain information on applicants pertaining to factors such as race, gender, and type of position for which an individual applies. The information requested on this form is for compliance with certain record keeping requirements. The Company believes all persons are entitled to equal employment opportunities and does not discriminate against its employees or applicants for employment because of race, color, sex, religion, national origin, disability, veteran status, age, marital status or any other protected group status. This form will be maintained in a separate confidential file.

Print Name: _____ Date: _____

Position Applied For: _____

Please Check One: Male Female

Please check as applicable

HISPANIC OR LATINO - A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

WHITE (Not Hispanic or Latino) - A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

BLACK OR AFRICAN AMERICAN (Not Hispanic or Latino) - A person having origins in any of the black racial groups of Africa.

NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER (Not Hispanic or Latino) - A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

ASIAN (Not Hispanic or Latino) - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

AMERICAN INDIAN OR ALASKA NATIVE (Not Hispanic or Latino) - A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

TWO OR MORE RACES (Not Hispanic or Latino) - All persons who identify with more than one of the above five races.

Regulations issued by the U.S. Department of Labor, with respect to disabled individuals, disabled veterans, and Vietnam Era veterans, require that federal contractors provide an opportunity for self-identification to candidates seeking employment. Such self-identification is submitted on a voluntary and confidential basis, for use only in accordance with regulations, and without subjecting the individual to adverse treatment.

DISABLED INDIVIDUAL — Federal regulations define a disabled person as one who (1) has a physical or mental impairment which substantially limits one or more of such person's major life activities, (2) has a history of such impairment, or (3) is regarded as having such an impairment.

VIETNAM VETERAN — An individual who has served in active duty for a period of more than 180 days, between 8/6/64 to 5/7/75, and was discharged or released with other than a dishonorable discharge.

SPECIAL DISABLED VETERAN — An individual who is entitled to disability compensation under laws administered by the Veterans Administration for a disability rated at 30 percent or more, or was discharged or released from active duty because of a service-connected disability.

OTHER ELIGIBLE VETERAN – Defined as any veteran who served in a “war” declared by Congress, in a campaign or on an expedition for which a campaign badge, a service medal, or an expeditionary medal has been awarded.

I have read the above and voluntarily provide the requested information.

I have read the above and decline to provide the requested information.

Signature of Applicant

Date

THANK YOU FOR YOUR INFORMATION
This form will be maintained in a separate confidential file.

Fax Cover Sheet for Otis R Bowen Center Employment

ATTN: Human Resources

Subject: Application for Employment

Fax # 574-268-2377

Total Number of Pages including cover sheet _____

From: _____

Contact Phone Number: _____