



Ability Behavioral Health Inc

14440 Cherry Lane Ct., Suite 201A

Laurel, Maryland 20707

Phone: (240)-294-6682 Fax: (240)-294-6692

Employment Application

Ability Behavioral Health Inc. is an equal opportunity employer. This application will not be used for limiting or excluding any applicant from consideration for employment on a basis prohibited by local, state, or federal law. Should an applicant need reasonable accommodation in the application process, he or she should contact a company representative.

Date of Application: _____

Please fill out all the sections below:

Applicant Information:

Applicant Name: _____

Address: _____

City, State, Zip Code: _____

Telephone Number: _____

Email Address: _____

Employment Position:

Position (s) applying for: _____

How did you hear about this position: _____

On what date can you start working if you are hired? _____

Personal Information:

Are you a U.S. citizen or approved to work in the United States? _____

What documentation can you provide as proof of citizenship or legal status?

Job Skills/Qualifications:

Please list below the skills and qualifications you possess for the position for which you are applying.

Education and Training:

High School

Name	Location (City, State)	Year Graduated	Degree Earned

College/University

Name	Location (City, State)	Year Graduated	Degree Earned

Vocations School/Specialized Training

Name	Location (City, State)	Year Graduated	Degree Earned

Military:

Are you a member of the Armed Service? _____

What branch of the military did you enlist? _____

What was your military rank when discharged? _____

How many years did you serve in the military? _____

What military skills do you possess that would be an asset for this position? _____

Previous Employment:

Employers Name: _____

Job Title: _____

Supervisor Name: _____

Employer Address: _____

City, State, Zip Code: _____

Employer Telephone: _____

Dates Employed: _____

Reason for leaving: _____

Employer Name: _____

Job Title: _____

Supervisor Name: _____

Employer Address: _____

City, State, Zip Code: _____

Employer Telephone: _____

Dates Employed: _____

Reason for leaving: _____

Employer Name: _____

Job Title: _____

Supervisor Name: _____

Employer Address: _____

City, State, Zip Code: _____

Employer Telephone: _____

Dates Employed: _____

Reason for leaving: _____

AT-WILL Employment:

The relationship between you and ***Ability Behavioral Health Inc.*** is referred to as ‘employment at will.’ This means that your employment can be terminated at any time for any reason, with or without cause, with or without notice, by you or ***Ability Behavioral Health Inc.*** No representative of Ability Behavioral Health Inc. has authority to enter into any agreement contrary to the foregoing “employment at will” relationship. You understand that your employment is “at will”, and that you acknowledge that no oral or written statement or representations regarding your employment can alter your at-will employment status, except for a written statement signed by you and either our Executive Vice President/Chief Operations Officer or the Company’s President.

Applicant Signature: _____

Date: _____

HIPPA

The employee agrees to comply with all applicable federal and state laws and regulations governing the privacy and security of protected health information, including the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") and its implementing regulations as modified and amended from time to time, and including the federal regulations governing Substance Abuse Confidentiality codified at Title 42 C.F.R. Part 2, and (b) execute all necessary agreements and documents required under HIPAA and it's implementing regulations.

Applicant Signature: _____

Date: _____