

Commonwealth Clinical Group, Inc.
**APPLICATION FOR GRADUATE LEVEL PRACTICUM/
INTERNSHIP**

NAME: _____ DATE: _____
LAST FIRST MI

PRESENT ADDRESS: _____
STREET CITY STATE ZIP CODE

PHONE #: _____
HOME CELL PHONE

EMAIL ADDRESS: _____

What level of field experience are you applying for? Practicum Internship

PROGRAM INTEREST(S): Mental Health Outpatient Specialized Outpatient
 IBHS Program *Dauphin & Berks County

How Did You Learn About Us? Advertisement Job Fair (Specify): _____ CCG Website
 Relative/Friend CCG Employee _____ Walk-In Other: _____

Date Available to Start: _____ Are there limitations to your schedule? YES NO

Please state day/time available for work: _____

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: _____

Do you have a valid driver's license? YES NO

Do you have a dependable vehicle available for work if a vehicle is required? YES NO

List any professional license(s): _____ License number(s): _____

If you have a professional license, has your professional license ever been revoked? YES NO

If yes, please explain: _____

List any relevant certifications or special skills (Ex- CPR, Sign Language, etc.): _____

List any foreign languages you can speak, read and/or write: _____

GENERAL INFORMATION:

1. Have you ever been an adjudicated delinquent of any offense and/or convicted (or plead guilty) of a summary, misdemeanor, or felony offense in this state or any other state? YES NO

If yes, please explain: _____

(Information regarding convictions will not necessarily disqualify you for practicum/internship, but will be reviewed in light of duties and responsibilities of the position being sought.)

2. Have you ever received Accelerated Rehabilitative Disposition (ARD) for any offense? YES NO

3. Have you ever been terminated from any job for any reason? YES NO

4. To your knowledge, are you related to a current employee of Commonwealth Clinical Group? YES NO

If yes, please state the name of the individual: _____

What is your relationship to him/her? _____

5. To your knowledge, do you, a family member, or anyone living in your household currently receive services at Commonwealth Clinical Group? YES NO

6. To your knowledge, have you, a family member, or anyone living in your household previously received services at Commonwealth Clinical Group? YES NO

If yes, who was the individual: _____ and when: _____

7. Are you a US citizen, US national, lawful permanent resident, lawful temporary resident, asylee, or refugee? YES NO

(The term "Lawful Temporary Resident" refers to aliens granted temporary resident status under amnesty programs, not to aliens holding short-term visas such as the H-1B, J, or F).

If "Yes", do not answer question 8. If "No", please answer question 8.

8. a) What is your current immigration status? _____

When does this status expire? _____
Month/Day/Year

b) Do you have an Employment Authorization Document? YES NO

If "yes", when does it expire? _____
Month/Day/Year

My signature below reflects my agreement that the above information is true to the best of my knowledge. I understand that any false answers, statements or representations made by me in this application shall constitute sufficient cause for dismissal. I understand that, if accepted for practicum/internship, I must abide by the rules and policies of Commonwealth Clinical Group.

Signature

Date