



205 East Park Street  
 Anaconda, Montana 59711  
 1-800-432-6145  
 Fax: 406-563-5956  
 www.aware-inc.org

◆ Employee Salary & Benefits ◆ Health & Safety ◆ Recruitment & Retention ◆ Performance & Training

Name: \_\_\_\_\_  
Last Name First Name MI

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Message Phone: ( ) \_\_\_\_\_

Are you 18 or older? Yes  No

Position applying for: \_\_\_\_\_

City/Town: \_\_\_\_\_

<b>POSITION</b>  <u>Check all service areas that you are interested in.</u>  At a later date, your application may also be submitted for <i>open</i> positions in that service area	<b>Youth Service</b> <input checked="" type="checkbox"/>	<b>Adult Service</b> <input checked="" type="checkbox"/>	<b>Administrative</b> <input checked="" type="checkbox"/>
	<input type="checkbox"/> Residential	<input type="checkbox"/> Residential	<input type="checkbox"/> Training
	<input type="checkbox"/> School Based	<input type="checkbox"/> Work Services	<input type="checkbox"/> Maintenance
	<input type="checkbox"/> Support Services	<input type="checkbox"/> Transportation	<input type="checkbox"/> Human Resources
	<input type="checkbox"/> Case Management	<input type="checkbox"/> Case Management	<input type="checkbox"/> Accounting
	<input type="checkbox"/> Early Head Start		<input type="checkbox"/> IT
	<input type="checkbox"/> Other Service of interest:		<input type="checkbox"/> Administration

<b>How did you hear about the position:</b>	<input type="checkbox"/> Job Service	<input type="checkbox"/> Newspaper	<input type="checkbox"/> AWARE employee
	<input type="checkbox"/> AWARE web page	<input type="checkbox"/> Family/Friend	<input type="checkbox"/> College Career Service
	Other		

Have you ever worked for A.W.A.R.E., Inc.? Yes  No

If yes Name Used: \_\_\_\_\_ Location: \_\_\_\_\_

Dates worked: \_\_\_\_\_

**Military Services:**

Branch of Service: \_\_\_\_\_ Dates of Service: \_\_\_\_\_

Duties/Special Training: \_\_\_\_\_



## Employment History

Please start with your **present employer**.

<b>Employer</b> Name:  Address:		Phone:	
Job Title:	Employment Date	/ /	to / /
Supervisor	Starting/Ending Wage	\$	\$
Duties:			
Reason for Leaving:			

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<b>Employer</b> Name:  Address:		Phone:	
Job Title:	Employment Date	/ /	to / /
Supervisor	Starting/Ending Wage	\$	\$
Duties:			
Reason for Leaving:			

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<b>Employer</b> Name:  Address:		Phone:	
Job Title:	Employment Date	/ /	to / /
Supervisor	Starting/Ending Wage	\$	\$
Duties:			
Reason for Leaving:			

**You may print additional employment history pages if needed.**



## PERSONAL REFERENCES

Please **do not list relatives or former employers**

<b>Name</b>	Phone - Work	
	Phone - Home	
Relationship		

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<b>Name</b>	Phone - Work	
	Phone - Home	
Relationship		

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<b>Name</b>	Phone - Work	
	Phone - Home	
Relationship		

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Related Information:

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1) Have you ever been convicted of a felony?                | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2) Have you ever received a vehicular citation?             | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3) Have you had a valid Driver License for 3 or more years? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If you answered yes to questions 1 or 2 above, please explain:

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Names of friends/relatives employed by A.W.A.R.E., Inc.: \_\_\_\_\_

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**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## EDUCATION

<b>High School</b>			
Name/Address:			
Phone:			
Did you receive a high school diploma or equivalency certificate (GED)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>College, University or additional schooling</b>	Major/Minor	Degree Received	
Name, Location, and Dates of Attendance		B.S.	B.A.
Name used while attending:			
<b>Post Graduate</b>		Degree Received /Date	
Name, Location, and Dates of Attendance			
Name used while attending:			
<b>Training Courses</b>	Title of Course	Date completed	Current
Name, Location, and Dates of Attendance			

**I AUTHORIZE THE INSTITUTION(S) NAMED ABOVE TO RELEASE STATED INFORMATION TO A.W.A.R.E., INC.**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_



## **AUTHORIZATION FORM**

### **Personnel Department**

**In order to complete your application file, it is necessary for us to complete a criminal, motor vehicle, child/adult protective services, education and employment background check and reference.**

**Please sign and date the authorization release below.**

**AUTHORIZATION: I, the undersigned, hereby authorize any agency, to include state and federal, institution or business, including my present employer to furnish any and all information contained in my records for the purpose of an employment background investigation.**

**I also authorize personal references to furnish the requested information they may have concerning me, and do hereby release such persons from all liability and damage for issuing such information.**

**SIGNED:** \_\_\_\_\_

**DATE:** \_\_\_\_\_



DPHHS-QUAD/CLR-005  
(Rev 3/00)

STATE OF MONTANA  
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES  
Quality Assurance Division  
**COMMUNITY RESIDENTIAL LICENSING PROGRAM**  
**PERSONAL STATEMENT OF HEALTH FOR LICENSURE**

NAME (Please Print)

Phone Number

**A.W.A.R.E., Inc**

Facility Name

**205 East Park Street**

**Anaconda, Montana 59711**

Address

City,

State, Zip

Social Security Number

Birth Date

Pursuant to ARM 37.97.130(3) A personal statement of health for licensure form provided by the department must be completed for each person subject to requirements of this real. This form must be submitted to the department with the initial application for licensure and annually thereafter.

The Licensing Specialist completing the licensure study and the Community Residential Licensing Program Manager who issues the license will review this form. In some cases, The Answer "yes" to a question may require an evaluation or a statement from your physician or other appropriate professional to support your response. The purpose of he questions is to help determine if you have health issues that may affect your ability to safely provide care.

Please answer the following questions by entering an "X" in the appropriate box for each question.

1.     Yes    No            Do you have any physical or mental health problems which might affect your ability to provide care. (If yes please explain in Section 6 on reverse side.)
2.     Yes    No            Have you been convicted of a crime involving child or elder abuse or neglect, including sexual abuse, physical assault, or other acts of violence? (If yes please explain in Section 6 on reverse side.)
3.     Yes    No            Have you ever been named as a perpetrator in a substantiated report of child or adult abuse or neglect (or exploitation of an adult?) (If yes please explain in Section 6 on reverse side.)
4.     Yes    No            Are you currently diagnosed or receiving therapy or medication for mental health problem which might affect your ability to provide care? (If yes please explain in Section 6 on reverse side.)
5.     Yes    No            Have you received counseling or treatment related to chemical dependency on drugs or alcohol within the past three years? (If yes please explain in Section 6 on reverse side.)

**YOUR SIGNATURE IS REQUIRED ON THE BACK SIDE OF THIS FORM**

