



# Application For Employment

Date \_\_\_\_\_

An Equal Opportunity Employer

## Personal Information

NAME(FIRST)		NAME(LAST)		SOCIAL SECURITY #	
CURRENT STREET ADDRESS			CITY	STATE	ZIP CODE
CELL PHONE #	2ND PHONE #		REFERRED BY:		

## Employment Desired

POSITION APPLYING FOR	AVAILABLE START DATE	SALARY DESIRED
ARE YOU LEGALLY AUTHORIZED TO WORK IN THE U.S.? <input type="checkbox"/> NO <input type="checkbox"/> YES	ARE YOU CURRENTLY EMPLOYED? <input type="checkbox"/> NO <input type="checkbox"/> YES	MAY WE CONTACT YOUR CURRENT EMPLOYER FOR A REFERENCE? <input type="checkbox"/> NO <input type="checkbox"/> YES

## Education History

SCHOOL LEVEL	NAME AND CITY/STATE	# OF YRS. ATTENDED	DID YOU GRADUATE?
HIGH SCHOOL			<input type="checkbox"/> NO <input type="checkbox"/> YES <i>DEGREE</i>
COLLEGE			<input type="checkbox"/> NO <input type="checkbox"/> YES
GRADUATE SCHOOL			<input type="checkbox"/> NO <input type="checkbox"/> YES
TRADE/BUSINESS SCHOOL			<input type="checkbox"/> NO <input type="checkbox"/> YES

## Licensure and Certification Information

LICENSE/Certification Held	LICENSE/Certification Held	LICENSE/Certification Held	LICENSE/Certification Held
<input type="checkbox"/> RN	<input type="checkbox"/> MA	<input type="checkbox"/> LMSW/LCSW	<input type="checkbox"/> CPR
<input type="checkbox"/> LVN	<input type="checkbox"/> PHARMACY TECH	<input type="checkbox"/> LPC/LPCI	<input type="checkbox"/> CPI
<input type="checkbox"/> C.N.A.	<input type="checkbox"/> BILLER/CODER	<input type="checkbox"/> PA/NP	<input type="checkbox"/> OTHER

## General Information

SPECIAL TRAINING	SPECIAL SKILLS
U.S. MILITARY OR NAVAL SERVICE	RANK

## Employment History

DATES OF EMPLOYMENT	EMPLOYER NAME/CITY, STATE	SALARY	POSITION	REASON FOR LEAVING
FROM TO				
FROM TO				
FROM TO				
FROM TO				

## References (no relatives, please)

NAME	RELATIONSHIP TO APPLICANT	PHONE #

(continued on next page...)

(...continued from previous page)

**AUTHORIZATION**

Applicant Initials	"I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed, falsified statements on this application shall be grounds for dismissal."
Applicant Initials	"I authorize investigation of all my statements contained herein."
Applicant Initials	"I understand and agree that no representative of the company has any authority to enter into any agreement for employment unless it is in writing and signed by an authorized company representative."

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date of Application

\*\*\*\*\*

**Steps in Application Process:**

1. Turn in application to LSBH staff member
2. Give an LSBH staff member a copy of your driver's license and social security card or other 2<sup>nd</sup> form of identification
3. Ask for information regarding the required pre-employment drug test and TB test
4. Wait for LSBH staff member to call you to schedule an interview

Thank you for your interest in employment opportunities with Lone Star Behavioral Health.

Sincerely,

*Erin Jankowski*  
COO

\*\*\*\*\*

Interviewer Remarks	Interviewed by:
<input type="checkbox"/> Appearance	<input type="checkbox"/> Neatness
<input type="checkbox"/> Personality	<input type="checkbox"/> Character
<input type="checkbox"/> Ability	<input type="checkbox"/> One word description:
Hire? <input type="checkbox"/> Yes <input type="checkbox"/> No	Salary offer made: \$

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Lone Star Behavioral Health

PERMISSION AND RELEASE FORM FOR BACKGROUND INVESTIGATIONS
(C & I Holdings, LLC dba Lone Star Behavioral Health)

The information contained in this form will only be used for completion of the background investigation.

Table with 4 columns: First Name, Middle Name, Last Name, Former Name(s) or Alias; Number, Street Address, City, State, Zip Code; Social Security Number, Driver's License Number, State.

I hereby authorize the organization to obtain the following information in connection with my employment: criminal and/or motor vehicle records, employment records, educational records, consumer reports (may include credit reports obtained through a consumer reporting agency).

If an adverse employment decision is made based on a consumer report, I have the right to be informed of the name and address of the consumer-reporting agency.

Any offers of employment are contingent upon a satisfactory background investigation. I authorize the reinvestigation of any of the above information, at any time, during my employment. If I am employed in a position that requires a satisfactory driving record, I understand that if my driving record is or becomes unsatisfactory, it may be a basis for termination of employment.

Place of Birth: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Listed below are cities/states where I have lived in the past seven (7) years.

Table with 3 columns: City/State, Date: From, Date: To. Rows 1-5 for listing living locations.

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_\_\_

# Lone Star Behavioral Health

## Consent for Education Verification

Lone Star Behavioral Health is required by the Joint Commission to verify all statements of education levels. Lone Star Behavioral Health utilizes the following for verification of education of staff members:

National Student Clearinghouse  
2300 Dulles Station Blvd. Suite 300  
Herndon, VA 20171

*The National Student Clearinghouse is the nation's trusted source for degree verification and enrollment verification and student educational outcomes research by automating degree verifications, improving office productivity and reducing credentials fraud.*

Please provide the following information so that we may verify your education level:

**\*\*PLEASE PRINT\*\***

<b>First Name</b>	<b>Middle Name</b>	<b>Maiden Name</b>	<b>Last Name</b>

<b>School Attended</b>	<b>School Location</b>
<b>Degree Earned</b>	<b>Major</b>
<b>Date of Birth</b>	<b>Completion/Graduation Date</b>

I understand that Lone Star Behavioral Health is required to conduct education verification and I attest to the validity of my statements made above. I further consent to the use of the National Student Clearinghouse for my education verification.

\_\_\_\_\_  
Signature of LSBH Staff Member

\_\_\_\_\_  
Date



C & I Holdings, LLC dba Lone Star Behavioral Health  
**APPLICANT/EMPLOYEE QUESTIONNAIRE**

*Please fill out questionnaire. If any question does not apply, mark NA.*

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_ State Licensed: \_\_\_\_\_

Certification/Specialty(s): \_\_\_\_\_

Telephone #: \_\_\_\_\_

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Medical/Technical School Attended: \_\_\_\_\_ Graduated: \_\_\_\_\_

1. List your current professional licenses, the state of issuance and expiration date.

\_\_\_\_\_  
\_\_\_\_\_

2. Have you ever had your license suspended or revoked? \_\_\_\_\_

3. Have you ever been convicted of a felony or misdemeanor (including a plea bargain or other arrangement with prosecuting authorities)? If so, please explain:

\_\_\_\_\_

4. Have you ever been excluded, suspended or debarred from the Medicare or Medicaid programs or any other federally-funded health care program? \_\_\_\_\_

5. List any health care or related business in which you, or a member of your family or household, has a direct or indirect ownership or controlling interest of 5% or more. Include Medicare or Medicaid provider numbers for each (attach extra pages if necessary). \_\_\_\_\_

\_\_\_\_\_

6. Have any of the entities which you listed in response to question #5 above been excluded, suspended or debarred from Medicare, Medicaid, or any of the federally funded health care programs? \_\_\_\_\_

7. Have you ever defaulted on a Health Education Assistance Loan? If so, please explain.

\_\_\_\_\_



# Employment Eligibility Verification

Department of Homeland Security  
U.S. Citizenship and Immigration Services

USCIS  
Form I-9  
OMB No.1615-0047  
Expires 07/31/2026

**START HERE:** Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the instructions.

**ANTI-DISCRIMINATION NOTICE:** All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

**Section 1. Employee Information and Attestation:** Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.

Last Name (Family Name)		First Name (Given Name)		Middle Initial (if any)	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address			Employee's Telephone Number
<b>I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.</b>		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
		<input type="checkbox"/> 1. A citizen of the United States				
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)				
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)				
		<input type="checkbox"/> 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any)				
		If you check Item Number 4., enter one of these:				
		USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance
Signature of Employee				Today's Date (mm/dd/yyyy)		

If a preparer and/or translator assisted you in completing Section 1, that person **MUST** complete the Preparer and/or Translator Certification on Page 3.

**Section 2. Employer Review and Verification:** Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

List A		OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)		<b>Additional Information</b>			
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority		<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.			
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
<b>Certification:</b> I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.					First Day of Employment (mm/dd/yyyy):
Last Name, First Name and Title of Employer or Authorized Representative			Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name			Employer's Business or Organization Address, City or Town, State, ZIP Code		

For reverification or rehire, complete Supplement B. Reverification and Rehire on Page 4.



C& I Holdings, LLC dba Lone Star Behavioral Health  
**PRE-EMPLOYMENT DRUG SCREEN AUTHORIZATION**

Applicant Name: \_\_\_\_\_

Position applied for: \_\_\_\_\_

Date: \_\_\_\_\_ DOB: \_\_\_\_\_

According to our licensing authority, DSHS we are required to subject employees to a pre-employment drug test. The method of testing used shall preserve the privacy of the individual tested and ensure the integrity and identity of the specimen collected. In addition, "chain of custody" procedures are in place and documentation on the handling and storage of a specimen is maintained. All information gained from drug testing shall be held in the strictest of confidence in accordance with all federal and state privacy regulations.

I, \_\_\_\_\_, do hereby give my consent  
(Printed applicant name)  
to allow LSBH to conduct a pre-employment drug test. I understand that documented results from this test will be used to evaluate my future employment with LSBH. If hired, I understand that this information will be placed in my personnel record, accessible only by the management of LSBH.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## **Thank you for applying with Lone Star Behavioral Health!**

**To verify your identity and eligibility for  
employment we will need the following to complete  
your application:**

- 1) Current Texas Driver's License or Texas ID**
  - 2) Social Security Card and/ or Passport**
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