Wellness Connections
P.O. Box 2648
Sierra Vista, AZ 85636
Send email to: admin@wellness-connections.org
(520) 452-0080; Fax (520) 452-0090; Toll Free (866) 455-0080

Employment Application

Date: _____ /_____ /_____

Position(s) Applying for (1) _____ (2) _____

Name (Last) _____ (First) _____ (Middle Initial) ___

Address (Physical) _____
(STREET) (City) (STATE) (ZIP)

Address (Mailing) _____
(STREET) (City) (STATE) (ZIP)

Phone Number(s) _____
(DAY) (EVENING) (CELL)

Email address _____

Are you 21 years of age or older? _____ Social Security # _____

Driver's License: # _____ State_____

When will you be available to start: _____ Are you willing to travel in state? _____

Are you prevented from lawfully becoming employed in this country because of VISA or Immigration Status? YES __ NO__ Are you able to obtain a Fingerprint Card? YES__ NO__

Signify location preference(s) (1, 2, 3, 4)

(Sierra Vista) _____ (Safford) _____ (Douglas)_____ (Nogales)_____

Other (specify) _____

Signify time preference(s) (1, 2, 3 and 4)

Full Time_____ ¼ Time_____ ½ Time_____ ¾ Time_____

Signify the hours you are available to work:

	Sun	Mon	Tue	Wed	Thu	Fri	Sat
From:							
To:							

Name (Last) _____ (First) _____ (Middle Initial) ___

How did you hear about SEACRS dba Wellness Connections?_____

Do you know anyone in our employ? NO ☐ YES ☐ If yes, who? _____

Are you related to anyone in our employ? NO ☐ YES ☐ If yes, who? _____

Have you ever worked/volunteered with any one of the Wellness Connections Programs or Centers?

NO ☐ YES ☐ If yes, please specify_____

EDUCATION*	Name & Location	# of Years	Did You Graduate?	Subjects Studied/ Major
Grammar School				
High School				
College				
College				
Trade, Business				

Certificates/Military/Special Skills etc. (please list)*

Do you have your Peer Support Specialist Certificate? ___ Yes? ___ No?

What date were you certified? _____ / _____ / _____

Are you CPR/First Aide Certified? ☐ Yes Expires When? _____ / _____ / _____ ☐ No

EMPLOYMENT** (List last 3)*	Name/Location & Contact	Salary	Position	Reason for Leaving
From:_____ (Present/Most Recent) To:_____				
From:_____ To:_____				
From:_____ To:_____				

*Use Supplied Supplemental Page if needed.

**Please attach your current Resume.

Name (Last) _____ (First) _____ (Middle Initial) ___

Should be professional References (No family members). At least one former employer.

REFERENCES*	Name & Address	Phone	Relationship	Years Acquainted
1				
2				
3				

Do you speak and/or write languages other than English? NO ☐ YES ☐

If yes, please list _____

Do you identify as a peer in the mental health arena, if so, what is your personal expeience:

_____

_____

Have you worked with people with disabilities?_____

How many months/years' experience do you have in the behavioral health field? _____

If you have been through a recovery experience, do you have 18 months of being clean and sober?

☐ Yes ☐ No ☐ N/A

Why do you want to work for us?*

_____

_____

_____

"I certify that all of the information submitted by me on this application is true and complete, and I understand that if any false information, omissions, or misrepresentations are discovered, my application may be rejected and, if I am employed, my employment may be terminated at any time. In consideration of my employment, I agree to conform to the company's rules and regulations, and I agree that my employment and compensation can be terminated, with or without cause, and with or without notice, at any time, at either my or the company's option. I also understand and agree that the terms and conditions of my employment may be changed, with or without cause, and with or without notice, at any time by the company."

_____/_____/_____

(SIGNATURE) (DATE)

*Use Supplied Supplemental Page if needed.

Name (Last) _____ (First) _____ (Middle Initial) ___

Supplemental Information: