Another Chance Treatment Center

Employment Application

PLEASE NOTE: It is important that you complete all parts of the application. If your application is incomplete or does not clearly show the experience and/or training required, your application may not be accepted. If you have no information to enter in a section, please write N/A.

Applicant Information	
Name (First, MI, Last)	Last 4 of SS#
Mailing Address	
City, State, and Zip Code	
Telephone	DOB
Are you authorized to work in the United States?	Email

Job Type							
Days/hours available to work							
☐ I have no preference.	☐ Mon.	☐ Tues.	☐ Wed.	☐ Thurs.	☐ Fri.	☐ Sat.	☐ Sun.
I am seeking a:		☐ Full-time job		☐ Part-time job		☐ Contractual	
How many hours can you work weekly?				Can you work nights?		Date available to begin	

Additional Information		
Have you ever been employed by this organization in the past?	☐ Yes	☐ No
I certify that I am a U.S. citizen, permanent resident, or a foreign national with authorization to work in the United States.	☐ Yes	☐ No
Have you ever been convicted of, or entered a plea of guilty, no contest, or had a withheld judgment to a felony?	☐ Yes	☐ No
If Yes, please explain:		

Do you have a driver license? Yes No	Driver license number	Issued in what state?
Have you had any accidents during the past three years?		How many?
Have you had any moving violations during the past three years?		How many?

Education				
School	Location (mailing address)	Years Completed	Major	Degree or Diploma
High School				
College or Business/Trade School				

Military			
Have you even been in the Armed Forces?	☐ Yes	☐ No	Date entered
Are you now a member of the National Guard?	☐ Yes	☐ No	Discharge date
Specialty			

Work Experience		
Please list ALL work experience beginning with your most recent job held. Include Population Served.		
Company	Name of last supervisor	Hrs./week
Address	Start Date	Starting Salary
City, State, and Zip Code	End Date	Final Salary
Phone number	Your last job title	
Reason for leaving (be specific)		
List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company.		
May we contact this employer? Yes No		
Company	Name of last supervisor	Hrs./week
Address	Start Date	Starting Salary
City, State, and Zip Code	End Date	Final Salary
Phone number	Your last job title	
Reason for leaving (be specific)		
List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company.		
May we contact this employer? Yes No		

Work Experience (continued)		
Company	Name of last supervisor	Hrs./week
Address	Start Date	Starting Salary
City, State, and Zip Code	End Date	Final Salary
Phone number	Your last job title	
Reason for leaving (be specific)		
List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company.		
May we contact this employer? Yes No		

Skills and Training
Please circle the following skills and experience in which you have: Word Excel Database Desktop Publishing Windows Other
Special training programs and seminars you have completed:
Licenses and Certifications (list dates and sources of issuance):
Any additional information pertaining to skills, training, and certifications:
I certify that all answers and statements on this application are true and complete to the best of my knowledge. I understand that, should this application contain any false or misleading information, my application may be rejected or my employment with this company terminated. ***(Please attach resume)***

Signature	Date

APPLICANT PROFESSIONAL REFERENCES

THE STATE REQUIRES 3 PROFESSIONAL REFERENCES FOR A VARIETY OF SERVICES

NAME:____ **YEARS KNOWN:** __________

RELATIONSHIP:____

JOB TITLE: ____

COMPANY:____

TELEPHONE NUMBER: ____

EMAIL ADDRESS:____

NAME:____ **YEARS KNOWN:** __________

RELATIONSHIP:____

JOB TITLE: ____

COMPANY:____

TELEPHONE NUMBER: ____

EMAIL ADDRESS:____

NAME:____ **YEARS KNOWN:** __________

RELATIONSHIP:____

JOB TITLE: ____

COMPANY:____

TELEPHONE NUMBER: ____

EMAIL ADDRESS:____

COMMENTS/NOTES:

____

____

____

____

Another Chance Treatment Center

Criminal Background Check Authorization

I,_____, In connection with my application for employment (including contract for services) with ACTC INC., I undersigned, understand and consent that a consumer and criminal background report, which may contain public record information, will be requested. This report may include the following types of information: name and dates of previous employers, reasons for termination of employment, work experience, accidents, etc. I further understand that such a report may contain public information concerning my driving record, workers compensation claims, credit, bankruptcy proceedings, criminal records, etc., from federal, state, and other agencies which maintain such records.

I authorize without reservation, any party or agency contacted by this employer to furnish the above-mentioned information. A facsimile or other copy of this release/consent bearing my signature is as valid as the original. For purposes of gathering this information, I agree to supply the following information:

First Name:_____Middle Name:_____Last Name: _____

Maiden Name: _____

Have you been known or currently known by other names?

YES_____NO_____

Please list other names:

_____ _____

_____ _____

Social Security Number: _____/_____/_____ DOB: _____/_____/_____

Please list your addresses for the last 7 years:

Street: _____ City: _____ State: _____ Zip Code: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Street: _____ City: _____ State: _____ Zip Code: _____

I hereby fully release, and discharge above named employer, their respective affiliates, subsidiaries, officers, employees, agents, and attorneys thereof, and each of them, and any individual, organization, entity, agency, or other source providing information to above named employer, from all claims and damages arising out of or relation to any investigation of my background for employment purposes. I have the right to make a request, upon proper identification of all the information obtained from the consumer report agency.

Printed Name: _____

Signature:_____Date: _____

NORTH CAROLINA DIVISION OF
MOTOR VEHICLES

Driver Privacy Protection Act Authorization
To Disclose Personal Information Form DPPA-2

I understand that personal information contained in my Motor Vehicle Record is protected by the federal Driver Privacy Protection Act and N.C. General Statue 20-43.1. I hereby authorize the release of my personal information to the person named below.

Print your full name as it appears on your driver license

Your signature (MUST BE SIGNED)

Your N.C. driver license number, SSN or ITIN & date of birth

Date signed

Person to receive information: James Jones, Managing Partner/VP

Mailing address: Another Chance Treatment Center, 236 N. Mebane Street Suite: 106 Burlington, NC 27217

Fees: Certified Complete History - $15.00 Uncertified Complete History -$10.75 Uncertified Limited History - $10.75

Circle one of the above to indicate the type of MVR to be released. Make checks payable to "NCDMV".
Mail this form and fees to: NCDMV, Driver License Records, 3113 Mail Service Center, Raleigh, NC 27697-3113.
*Please allow **10 business days processing time**, this does not include US Postal service delivery time to or from the DMV.*

Form DPPA-2, Revised July 1, 2020
Previous editions are obsolete, DO NOT USE

NORTH CAROLINA DIVISION OF
MOTOR VEHICLES

Driver Privacy Protection Act Authorization
To Disclose Personal Information Form DPPA-2

I understand that personal information contained in my Motor Vehicle Record is protected by the federal Driver Privacy Protection Act and N.C. General Statue 20-43.1. I hereby authorize the release of my personal information to the person named below.

Print your full name as it appears on your driver license

Your signature (MUST BE SIGNED)

Your N.C. driver license number, SSN or ITIN & date of birth

Date signed

Person to receive information: James Jones, Managing Partner/VP

Mailing address: Another Chance Treatment Center, 236 N. Mebane Street Suite: 106 Burlington, NC 27217

Fees: Certified Complete History- $15.00 Uncertified Complete History -$10.75 Uncertified Limited History - $10.75

Circle one of the above to indicate the type of MVR to be released. Make checks payable to "NCDMV".
Mail this form and fees to: NCDMV, Driver License Records, 3113 Mail Service Center, Raleigh, NC 27697-3113.
*Please allow **10 business days processing time**, this does not include US Postal service delivery time to or from the DMV.*

Form DPPA-2, Revised July 1, 2020
Previous editions are obsolete, DO NOT USE