COMMUNITY BEHAVIORAL HEALTH

www.communitybehavioralhealth.net

Phone: (844) 224-5264

Human Resources Fax (443) 230-4324 **Main Fax: (888) 509-0010** **Billing/Financial Fax (410) 824-1323**

Dear Potential New Intern,

Thank you for considering Community Behavioral Health, LLC as your new place of study.

Before you join CBH, the Human Resources Department can aid you in filling out the paperwork and determine a start date: Please complete the background check as soon as possible. Orientation cannot be scheduled without clearance.

1. CJIS Background Check (Federal and State)
2. Physical Check Form signed by a medical provider.
3. PPD / TB Test Results
4. Flu Vaccination Form
5. Three professional references
6. Health Internship In-take form
7. Unpaid Internship Contract (you can start to fill this out but will be complete by HR)

All forms to be sent to HR@cbh.clinic

Best wishes,

Human Resources

426 Dorchester Ave
Cambridge, MD 21613

809, 811, 817 & 821 Eastern Shore Drive
Salisbury, MD 21804

138 Coursevall Drive
Centreville, MD 21617

30519 Prince William Street
Princess Anne, MD 21853

10774 & 10810 Hickory Ridge Road
Columbia, MD 21044

300 Scheeler Rd
Chestertown, MD 21620

STATE OF MARYLAND
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES
CRIMINAL JUSTICE INFORMATION SYSTEMS – CENTRAL REPOSITORY

LIVESCAN PRE-REGISTRATION FORM

APPLICANT INFORMATION *(PLEASE TYPE OR PRINT CLEARLY)*

Name:

Date of birth: SSN: Gender: ☐ Male ☐ Female *(Please check)*

Height: ft. inches Weight: lbs. Eye Color: Hair Color:

Race: ☐ Black ☐ White ☐ Asian/Pacific Islander ☐ Native American ☐ Other *(Please check)*

Place of Birth: Citizenship:

Current address:

City: State: ZIP Code: -

Daytime Phone: Evening Phone: ---------- Driver's License #:

AGENCY INFORMATION

Agency Authorization #: 1100007451

ORI # (if required): Reason fingerprinted? Background Check

Position Applied for:

Request Type: *(Choose one ONLY)*

- ☐ Adult Dependent Care
- ☐ Attorney/Client
- ☒ Child care
- ☐ Criminal Justice
- ☐ Gold Seal/ Adoption
- ☐ Gold Seal/Letter/VISA
- ☐ Government Employment
- ☐ Government Licensing or Certification
- ☐ Immigration/VISA
- ☐ Individual Challenge
- ☐ Individual Review
- ☐ MSP Licensing
- ☐ Private Party Petition
- ☐ Public Housing

Mail Response to:

(Mailing option only available for Visa Gold Seal and/or Individual Review)

Name: _____

Address: _____

City, State, Zip code: _____

COMMUNITY BEHAVIORAL HEALTH

426 Dorchester Ave.
Cambridge, MD 21613
Phone: 410-228-3929
Fax: 410-228-3810

821 Eastern Shore Dr.
Salisbury, MD 21801
Phone: 410-334-6687
Fax: 410-334-6700

142 Coursevall Dr.
Centreville, MD 21617
Phone: 410-758-1787
Fax: 410-758-1789

Background Checks – CJIS Approved Sites:

3M Cogent Fingerprinting Services c/o Anne Arundel County Community College Department of Public Safety	Central Services Building 101 College Parkway Arnold, Maryland 21012	410.777.2440
3M Cogent Fingerprinting Services c/o Bay Shore Services, Inc.	1235 Pemberton Dr. Salisbury, MD 21801	410.341.0307 x106
3M Cogent Fingerprinting Services Main-One (M-1) Solutions, Inc	4300 Forbes Blvd. Suite 220 Lanham, MD 20706	301.702.7200
3M Cogent Fingerprinting Services c/o Fairmount Heights Police Department	6100 Jost Street Fairmount Heights, MD 20743	301.883.9472
3M Cogent Fingerprinting Services c/o Xecutive Security Investigations Group	821 E. Baltimore St. Baltimore, MD 21202	410.800.8844
911 Security & Investigations, LLC	850 Sligo Avenue #502D Silver Springs, MD 20910	301.755.6138
Absolute Investigative Service	604 E. Joppa Road Towson, MD 21286	410.828.6460
Absolute Investigative Services, Inc.	139 N. Main Street #103 Bel Air, Maryland 21014	410.420.6923
Allied Barton Security Services	7939 Honeygo Blvd. Suite 203 Nottingham, MD 21236	410.931.5061 (by appointment only)
All American Protective Services, LLC	6701 Democracy Blvd. Suite 110 Bethesda, MD 20817	301.296.4499
All American Protective Services, LLC	12501 Prosperity Drive Suite 200 Silver Spring, MD 20904	240.670.7952
All American Protective Services, LLC	7361 Calhoun Place Suite 485 Rockville, MD 20855	301.296.4499
American Fingerprinting Services	7272 Wisconsin Avenue Suite 300 Bethesda, MD 20814	301.941.1916
Apex Investigative Services	1916 Crain Hwy S. Ste. 11	410.590.3700

	Glen Burnie, MD 21061	
Biometrics Identity Verification System	5010 Sunnyside Avenue #300 Beltsville, Maryland 20705	301.477.3210
Biometrics Identity Verification System	6214 Reisterstown Road Baltimore, MD 21215	443.213.8245 443.213.8625 (f)
Broadway Services, Inc.	3709 E. Monument St. Baltimore, Maryland 21205	410.563.6949
E House Executive Security Professionals, Inc	4710 Auth Pl Suite 420 Suitland, MD 20746	301.899.2828
Elite People Protective Services	5602 Baltimore National Pike Catonsville, MD 21228	410.788.0111
Essential Support Services	2030 Liberty Road Unit #10 Eldersburg, MD 21784	443.223.2080
FYI Fingerprints	3696 Park Avenue Ellicott City, MD 21043	410.418.4657
Grand Mission Consult	7515 Annapolis Rd #203 Hyattsville, MD 20784	301.429.0525
Hughes Barney Investigations	9315 Largo Drive West Suite 210 Largo (Upper Marlboro), MD 20774	301.333.1728
Inquiries, Inc.	129 N. West Street Easton, MD 21601	866.987.3767
Inquiries, Inc. c/o Pinkerton	11019 McCormick Rd Ste 200 Hunt Valley, MD 21031	800.635.1649
MorphoTrust USA (L-1) c/o ABCO Investigations	10545 Friendship Road Berlin, MD 21811	877.467.9215
MorphoTrust USA (L-1) c/o BITHGROUP Technologies	113 Monument Street Baltimore, MD 21201	877.467.9215
MorphoTrust USA (L-1) c/o Securitas Security Services	1101 Opal Court Suite 211 Hagerstown, MD 21740	877.467.9215
MorphoTrust USA (L-1) c/o Securitas Security Services	7004 Security Boulevard Suite 200 Baltimore, MD 21244	877.467.9215
Maryland Livescan, Inc.	The Empire Towers Building 7310 Ritchie Hwy. Suite 610 Glen Burnie, MD 21061-3290	410.761.6700
Mid-Atlantic Regional Investigations, LLC	1202 West Street Annapolis, MD 21401	888.320.7775
Optimal Health Care	6 West Washington Street Hagerstown, MD 21740	301.790.4962
Positive I.D., Inc.	103 Sudbrook Lane #4 Pikesville, MD 21208	410.602.2479
Prevent First	3710 Riviera Street #1A Temple Hills, MD 20748	301.423.5414
Quick Fingerprints	11605 Crossroads Circle Suite F Middle River, MD 21220	855.463.7226
Renoxx Group, LLC	ID Solutions 9500 Annapolis RD	301.850.1148

	Suite B2 Lanham, MD 20706	
Scotty's Investigations, Inc.	515 Regina Avenue Cumberland, MD 21502	301.777.0232
Securpros	9300 Annapolis Road #103 Lanham, MD 20706	301.459.8322
Thomas Security	1325 Mt. Hermon Road Salisbury, MD 21804	410.548.5029
Three Brothers	3061 Frederick Avenue Baltimore, MD 21223	410.566.9112
United Security & Communications, Inc.	5415 Southern Maryland Blvd. Wayson's Corner (Lothian), MD 20711	301.952.8724
Worldwide Investigations, LLC	312 N.Charles Street Suite # 300	410.244.1756
Worth-A-Shot, Inc.	8424 Veterans Highway #5 Millersville, MD 21108	443.688.6521

COMMUNITY BEHAVIORAL HEALTH INTERNSHIP IN-TAKE FORM

To be completed and given to Human Resources to determine intern eligibility

FIRST NAME:_____ MIDDLE NAME: _____ LAST NAME: _____

ADDRESS: _____ HOME PHONE: _____

CELL PHONE: _____ DATE OF BIRTH: _____ EMAIL: _____

IS THE PERSON CURRENTLY EMPLOYED: **Y/N** EMPLOYER: _____

IS THE PERSON CURRENTLY A STUDENT: **Y/N** SCHOOL: _____

IS THE INTERNSHIP A GRADUATION REQUIREMENT? **Y/N**

IS THE PERSON RELATED TO AN EMPLOYEE: **Y/N**

HAS THE PERSON BEEN EMPLOYED OR INTERNED HERE BEFORE: **Y/N**

DESIRED ASSIGNMENT DURATION: _____ (START DATE) TO _____ (END DATE)

INTERN AVAILABILITY:

	SUN	MON	TUES	WED	THURS	FRI	SAT
TIMES AVAILABLE							

WHAT SPECIFIC ACTIVITIES WILL THE PERSON PERFORM?

_____

_____

_____

_____

_____

HOW WILL THE INTERN'S ACTIVITY BENEFIT HIM/HER?

_____

_____

_____

_____

_____

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____ PHONE: _____

INTAKE EMPLOYEE SIGNATURE: _____ DATE: _____

UNPAID INTERNSHIP AGREEMENT

This agreement ("Agreement") is between _____ ("Intern") and Community Behavioral Health LLC ("CBH"). The purpose of this educational internship is for Intern to learn about CBH's business and to gain valuable insight and experience. The term of this internship begins on _____ and ends on _____. The internship's duration shall be limited to the period in which it provides Intern with beneficial learning.

SECTION 1 – DESCRIPTION OF INTERNSHIP

I. TITLE AND SCOPE OF INTERNSHIP

Intern's title at CBH will be: _____. Intern will report to _____ whose title is _____. Intern acknowledges that Intern will receive similar and supplementary training as to what is found in an educational setting. Intern will have access to training opportunities and have involvement with professional organizations. Intern acknowledges that the internship is for Intern's benefit to receive training, mentoring, and to provide valuable experience for future job selection, application, and performance in the field of _____. If Intern is enrolled in an educational program, CBH will certify and comply with any reasonable requirements or forms from the educational program in order to ensure Intern receives any earned academic credit. Although Intern is committing to _____ hours per week, CBH will accommodate Intern's academic commitments and adjust schedules accordingly. CBH acknowledges that providing training to Intern will not necessarily improve the business in any manner, and at times, operations of CBH may be impeded. Any activities Intern performs will complement, rather than displace, the work of paid employees, while providing significant educational benefit to Intern. Intern shall not operate any heavy equipment, including vehicles. Intern is not authorized to enter into any contract on behalf of CBH. Intern agrees to be in direct and close supervision while interning at CBH. Intern may not transfer responsibilities under this Agreement to anyone else. Intern will perform the following specific activities:

_____

_____

_____

_____

_____

II. INTERN'S INSURANCE AND LEGAL REQUIREMENTS

Although Intern is not an employee, Intern shall be covered by CBH's workers' compensation insurance. Workers' compensation insurance will provide coverage in case Intern is injured during the internship or develops a medical problem or illness because of the internship. If Intern is injured, Intern must immediately notify the human resources department or Intern's manager.

CBH shall require a State and Federal finger printing and criminal background check that Intern shall have completed the background check with favorable results no later than the beginning of the Agreement term. Intern assumes all financial responsibility for services provided in obtaining this information. CBH will determine if Intern is authorized to be a part of CBH's internship program, in accordance with State, Federal, and local policies.

CBH requires a photo ID of Intern. This photo ID will be printed onto a Badge. A Badge must be worn by Intern while performing activities under the supervision of CBH.

Intern must acknowledge and sign the HIPAA and Maryland Child Abuse, Child Neglect and Discipline forms provided by CBH prior to _____.

III. NONPAYMENT OF INTERN

Intern will not be paid. All CBH internships are unpaid, regardless of immigration status or employment eligibility. Intern acknowledges that the internship is related to an educational purpose and there is no guarantee or expectation that the activity will result in employment with the Company. Should Intern ever become an employee of CBH in the future, Intern will not be compensated retroactively for activities performed while interning at CBH. Intern specifically understands and agree to the fact that this internship is educational in nature and there is no guarantee or expectation that the internship will result in employment.

IV. TERMINATION

CBH or Intern may terminate this Agreement, for any reason, upon at least 2 (two) calendar day notice in writing to Intern or CBH respectively.

SECTION 2 – INTERNSHIP CONDITIONS AND ACKNOWLEDGEMENTS

The Intern specifically agrees to and acknowledges the following: (1) Intern will maintain a regular internship schedule determined by the Intern and their supervisor based on Intern's academic commitments if applicable; (2) Intern will demonstrate honesty, punctuality, courtesy, cooperative attitude, proper health and grooming habits, appropriate dress, and a willingness to learn; (3) Intern will obey the policies, rules, regulations, and social media guidelines of the CBH site and comply with CBH's business practices and procedures; (4) Intern will furnish Intern's supervisor with all necessary information pertaining to Intern's unpaid internship, including related assignments and reports; (5) Under no circumstances will Intern leave the internship without first conferring with Intern's supervisor; (6) Transportation to and from the internship site is the responsibility of the Intern; and (7) Intern assumes all of the risks of participating in the internship program. In consideration of the opportunity afforded to the Intern to participate in the internship program, Intern hereby agrees that Intern, Intern's assignees, heirs, guardians, and legal representatives, will not make a claim against CBH or any of its affiliated organizations, or either of their officers or directors collectively or individually, or any of its employees, for the injury of death to Intern or damage to Intern's property, however caused, arising from Intern's participation in the internship program. Without limiting the generality of the foregoing. Intern hereby waives and releases any rights, actions, or causes or action resulting from personal injury or death to Intern, or damage to Intern's property, sustained in connection with Intern's participation in the internship program.

CBH is a smoke-free environment with no tobacco permitted on the CBH property premises including walkways and stairwells. CBH prohibits the possessions, use, manufacture, distribution, dispensing, or consuming of all forms of alcohol as well as tobacco including, but not limited to, chewing tobacco, cigarettes, cigars, electronic cigarettes, vapes, and other combustible materials.

CBH is a firearm-free environment. No person is permitted to carry or possess a firearm or other dangerous weapon or device on CBH property. Smoke-free and firearm-free policies apply to interns.

SECTION 3 – CONFIDENTIALITY

Intern agrees to honor its obligations under the HIPAA and Maryland Child Abuse, Child Neglect and Discipline forms provided by CBH during the Agreement term. Intern shall also continue to honor those obligations of confidentiality after the termination of the Agreement.

SECTION 4 – CONTRACT CLAUSES

I. EQUAL OPPORTUNITY

CBH certifies that it shall not discriminate against any intern for employment because of race, color, religion, sex, age, national origin, marital status, sexual orientation, gender identity, or disability.

II. INDEMNIFICATION

To the extent permitted by law, Intern shall indemnify and save Community Behavioral Health, LLC harmless from and against all actions, liability, claims, suits, damages, costs, statutory penalties, or expenses or any kind which may be brought or made against Community Behavioral Health, LLC, its agents and employees, or which CBH may pay or incur by reason of or in any manner resulting from injury, loss or damage to person or property and caused by Intern's willful or negligent performance of or failure to perform any of its obligations under the terms of this Agreement.

III. ORAL MODIFICATION

No oral statements of any person whosoever shall, in any manner or degree, modify or otherwise affect the terms of the Agreement.

IV. SEVERABILITY

If any clause or provision of this Agreement is illegal or unenforceable under present or future laws, then such clause or provision shall be deemed separable and shall not affect the validity of any other provision.

V. APPLICABLE LAW

This Agreement shall be subject to and governed by the interpreted and construed in accordance with the laws of the State of Maryland.

VI. LIMITATION OF ACTION

No action or proceeding shall lie or be maintained by Intern against CBH upon any claim, counterclaim or cross-claim arising out of or based upon this Agreement, or by reason of any act or omission or any requirements relating to the giving of notices or information required hereunder, unless such action or proceeding shall be commenced within six (6) months after the termination of this Agreement or, if earlier terminated, within six (6) months following the date of such earlier termination.

This Agreement is in effect from: _____

Date of termination: _____

I understand that this unpaid, learning experience is not employment and that Intern is not entitled to wages or a promise of employment at the completion of the unpaid structured learning experience.

_____ _____

Intern **For Community Behavioral Health LLC**

Name: _____ Name and Title: _____

Date: _____ Date: _____

COMMUNITY BEHAVIORAL HEALTH

www.communitybehavioralhealth.net
Phone: (844) 224-5264 ; Fax: (888) 509-0010

Payroll Information & Emergency Contact Form

PERSONAL INFORMATION

First Name : _____

Middle Name : _____

Last Name : _____

SSN No : _____ - _____ - _____

Date of Birth : _____ / _____ / _____ (MM/DD/YYYY)

Are you a Tobacco User ? Yes / No *(Please circle one. Data required by our insurance company)*

Do you have Medicare ? _____

Do You Have Medicaid ? _____

Your Current Address : _____

_____

City _____ State _____ Zip _____

Your Permanent Address : _____

_____

City _____ State _____ Zip _____

Home Phone No: _____ - _____ - _____ / _____ - _____ - _____

Cell Phone Nos : _____ - _____ - _____ / _____ - _____ - _____

Your working personal Email Address : _____

VOLUNTARY SELF IDENTIFICATION

Gender : Male ☐ Female ☐ Do not wish to identify ☐ Other _____

Marital Status : _____

Race / Ethnicity :

- □ Hispanic/Latino ☐
- □ Black/African American ☐
- □ White ☐
- □ American Indian/Alaskan Native ☐
- □ Asian ☐
- □ Native Hawaiian or Other Pacific Islander ☐
- □ Two or More Races (Not Hispanic or Latino) ☐
- □ Do Not Wish to Identify ☐

Race/Ethnic Definitions:

• *Hispanic/Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.*

• *Black/African American (not Hispanic or Latino): A person having origins in any of the black racial groups of Africa.*

• *White (not Hispanic or Latino): A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.*

• *American Indian/Alaskan Native (not Hispanic or Latino): A person having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment.*

• *Asian (not Hispanic or Latino): A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.*

• *Native Hawaiian or Other Pacific Islander (not Hispanic or Latino): A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.*

• *Two or More Races (not Hispanic or Latino): A person who identifies with two or more race categories named above.*

Are you a Veteran ? Yes / No *(Circle One)*

OR select the box(s) that apply to your veteran status.

I am not a veteran. (I did not serve in the military.) ☐

I belong to the following classifications of protected veterans (Choose all that apply):

DISABLED VETERAN ☐

RECENTLY SEPARATED VETERAN ☐

Military Discharge Date (MM/DD/YYYY): _____/_____/_____

ACTIVE WARTIME OR CAMPAIGN BADGE VETERAN ☐

ARMED FORCES SERVICE MEDAL VETERAN ☐

I am NOT a protected veteran. (I served in the military but do not fall into any veteran categories listed above.) ☐

I choose not to identify my veteran status. ☐

EMERGENCY CONTACTS :

Name of Primary Emergency Contact : _____

Relationship to Primary Emergency Contact : _____

Primary Emergency Contact's Address : _____

_____ City _____ State _____ Zip _____

Primary Emergency Contact's Working Phone Numbers : _____ - _____ - _____ (Home)

_____ - _____ - _____ (Cell 1)

_____ - _____ - _____ (Cell 2)
(Put N/A if not applicable)

Primary Contact's Email Address : _____
(please provide a personal working email for your secondary emergency contact)

Name of Secondary Emergency Contact : _____

Relationship to Secondary Emergency Contact : _____

Secondary Emergency Contact's Address : _____

_____ City _____ State _____ Zip _____

Secondary Emergency Contact's Phone Numbers : _____ - _____ - _____ (Home)

_____ - _____ - _____ (Cell 1)

_____ - _____ - _____ (Cell 2)
(Put N/A if not applicable)

Secnodary Contact's Email Address : _____
(please provide a personal working email for your secondary emergency contact)

DIRECT DEPOSIT :

Do you wish to enroll in Direct Deposit ? Yes ☐ / No ☐

If yes Please fill out the ADP Direct Deposit form.

Do you wish to receive Health / Dental / Vision Coverage ? Yes ☐ / No ☐

Do you wish to receive Supplemental Coverage (AFLAC) ? Yes ☐ / No ☐

DECLARATION :

I solemnly affirm that the information provided above is true and accurate to the best of my knowledge. I understand that CBH requires this information on file to be used in emergency and contingent situations.

I further agree that it is my responsibility to update the payroll and HR department with changes to any information requested in this form within 15 working days. Deviation to the 15 day rule will require written waiver from my supervisor and/or Dr. Mr. or Mrs. Jani.

In the event of my failure to provide updated information regarding changes to my personal information to the CBH Payroll and HR department as soon as reasonably possible, I understand that CBH and its personnel or successors will not be held liable in any circumstances that may result out of my non compliance.

Employee Signature: _____ **Date:** _____

For Official Use Only

Employee Name : _____

First date of employment: _____/_____/_____ (MM / DD / YYYY)

Wage Type :	Salaried	☐	Other *(Pl. Specify)*: _____
	Hourly	☐	
	Guaranteed Pay	☐	
	Fee for Service	☐	
Status :	Full Time	☐	Other *(Pl. Specify)*: _____
	Part Time	☐	
	Fee for Service	☐	

Signature Finance Director: _____ Date: _____ / _____ / _____

COMMUNITY BEHAVIORAL HEALTH

PROFESSIONAL REFERENCE CHECK FORM

Please provide us with at least 3 professional references per details below. Your employment with CBH is contingent upon a clear reference and background check.

PROFESSIONAL REFERENCE

1	Name	
	Title of Reference	
	Phone	
	E-mail	
	Years Known	
	Relationship To You	

2	Name	
	Title of Reference	
	Phone	
	E-mail	
	Years Known	
	Relationship To You	

3	Name	
	Title of Reference	
	Phone	
	E-mail	
	Years Known	
	Relationship To You	

Candidate Name _____

Candidate Signature _____

COMMUNITY BEHAVIORAL HEALTH

PROFESSIONAL REFERENCE CHECK FORM

Date _____

Candidate Address _____

Contact (Phone & E-mail) _____

_____

HR Department Notes : _____

COMMUNITY BEHAVIORAL HEALTH

Applicant Reference Release

I hereby authorize **COMMUNITY BEHAVIORAL HEALTH** ("the Company") to contact any company, person, or educational institution I listed as a reference on my employment application. I hereby allow any company, person, or educational institute I listed as a reference on my employment application to disclose any information they may have regarding my qualifications for employment, including but not limited to employment dates, descriptions of jobs performed, salary and wage rates and personal attributes.

I agree to release and discharge _____ successors, employees, officers, and directors as well as any company, person or educational institution I have listed as a reference for all claims, liabilities, and causes of action, known or unknown, fixed or contingent, for providing or receiving any information regarding my qualifications for employment. This release includes, but is not limited to, claims of defamation, libel, slander, negligence, or interference with contract or profession.

_____

Print Name

_____

Signature

_____

Date

AGENCY PRIVACY REQUIREMENTS FOR NONCRIMINAL JUSTICE APPLICANTS

Authorized governmental and non-governmental agencies/officials that conduct a national fingerprint-based criminal history record check on an applicant for a noncriminal justice purpose (such as employment or a license, immigration or naturalization matter, security clearance, or adoption) are obligated to ensure the applicant is provided certain notice and other information and that the results of the check are handled in a manner that protects the applicant's privacy. These obligations are pursuant to the Privacy Act of 1974, Title 5, United States Code (U.S.C.) Section 552a, and Title 28, Code of Federal Regulations (CFR), Section 50.12, among other authorities.

- Officials must provide to the applicant written notification[1] that his/her fingerprints will be used to check the criminal history records of the FBI.
- Officials must ensure that an applicant receives, and acknowledges receipt of, an adequate Privacy Act Statement when the applicant submits his/her fingerprints and associated personal information.[2]
- Officials using the FBI criminal history record (if one exists) to make a determination of the applicant's suitability for the employment, license, or other benefit must provide the applicant the opportunity to complete or challenge the accuracy of the information in the record.
- Officials must advise the applicant that procedures for obtaining a change, correction, or update of an FBI criminal history record are set forth at 28 CFR 16.34.
- Officials should not deny the employment, license, or other benefit based on information in the criminal history record until the applicant has been afforded a reasonable time to correct or complete the record or has declined to do so.
- Officials must use the criminal history record solely for the purpose requested and cannot disseminate the record outside the receiving department, related agency, or other authorized entity.[3]

The FBI has no objection to officials providing a copy of the applicant's FBI criminal history record to the applicant for review and possible challenge when the record was obtained based on positive fingerprint identification. If agency policy permits, this courtesy will save the applicant the time and additional FBI fee to obtain his/her record directly from the FBI by following the procedures found at 28 CFR 16.30 through 16.34. It will also allow the officials to make a more timely determination of the applicant's suitability.

Each agency should establish and document the process/procedures it utilizes for how/when it gives the applicant notice, what constitutes "a reasonable time" for the applicant to correct or complete the record, and any applicant appeal process that is afforded the applicant. Such documentation will assist State and/or FBI auditors during periodic compliance reviews on use of criminal history records for noncriminal justice purposes.

Name_____ Date_____

[1] Written notification includes electronic notification, but excludes oral notification.

[2] See https://www.fbi.gov/services/cjis/compact-council/privacy-act-statement

[3] See 5 U.S.C. 552a(b); 28 U.S.C. 534(b); 42 U.S.C. 14616, Article IV(c); 28 CFR 20.21(c), 20.33(d), 50.12(b) and 906.2(d).

"Challenge For Change"

COMMUNITY BEHAVIORAL HEALTH

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Phone: (844) 224-5264

Human Resources Fax (443) 230-4324 **Main Fax: (888) 509-0010** **Billing/Financial Fax (410) 824-1323**

Annual Safety and Cultural Competency Training

- Safety Orientation for Healthcare (21 minutes)
- Workplace Bloodborne Pathogens for Healthcare (16 minutes)
- HIPAA Privacy and Security Awareness (14 minutes)
- Workplace Violence (17 minutes)
- Conflicts in the Workplace (17 minutes)
- Driving Safety (28 minutes)
- Harassment and Diversity Training (15 minutes)

I have attended the annual OSHA-Compliant safety training.
I have attended the annual cultural competency training.

Name: _____ Date: _____

INFECTION CONTROL
AND
BIOHAZARD SPILL CLEAN UP
PROCEDURE

1. WEAR GLOVES. Gown, mask or goggles may also be necessary if splashing of blood or body fluids is likely.
2. DO NOT pick up glassware by hand. Use a brush and dust pan, tong or forceps.
3. WIPE UP THE SPILL with a disposable towel and dispose of the towel in a leak proof plastic bag marked with a biohazard symbol.
4. DECONTAMINATE THE SPILL AREA BY APPLYING A MIXTURE OF:
   - 1 part bleach to 10 parts water, or
   - An EPA approved antimicrobial

   Apply until surface is glistening wet.
5. PLACE A CAUTION sign over the wet area and allow the surface to air dry completely.
6. DISPOSE OF GLOVES and any contaminated materials in a leak proof plastic bag marked with a biohazard symbol.
7. WASH YOUR HANDS thoroughly using hand soap.

I, _____ have read and understand the Infection Control and Biohazard Spill Clean Up Procedure.

_____ _____

SIGNATURE DATE

COMMUNITY BEHAVIORAL HEALTH

HIPAA Training Acknowledgment Form

I, _____ am a user of one or more Community Behavioral Health's information technology devices or systems that may include electronic Protected Health Information (ePHI).

I hereby certify That:

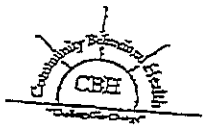
1. I have viewed the CBH "HIPAA Privacy Training and Security Awareness Training" DVD.
2. I have received the CBH "HIPAA Policy".
3. I agree to abide by the CBH policies and procedures as explained in the "HIPAA Privacy Training and Security Awareness Training" DVD and the HIPAA Policy.
4. I recognize the importance of maintaining the confidentiality and integrity of the ePHI that I work with for my job duties.
5. I understand that, by not following Community Behavioral Health policies and procedures on HIPAA, I could be subject to disciplinary actions or civil or criminal penalties.

My signature on this form acknowledges my completion of HIPAA Privacy Training and Security Awareness Training Program, and that I have received information pertaining to HIPAA and Corporate Compliance that are applicable to Community Behavioral Health.

I agree to maintain the policies and standards of HIPAA Compliance.

_____ _____

Signature Date



Community Behavioral Health
HIPAA Confidentiality Agreement

SUMMARY OF HIPAA PRIVACY RULES FOR EMPLOYEES/CONTRACTORS

The Department of Health and Human Services has adopted privacy regulations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). These "Privacy Rules" require most doctors, hospitals and health insurers ("Covered Entities") to develop procedures to limit the use and disclosure of patients' protected health information ("PHI") as well as notify patients of their rights with respect to such information.

Confidentiality and Privacy Agreement:

Employees, contractors and partners of the practice will have access to confidential information, both written and oral, in the course of their employment and job responsibilities. It is imperative that this information is not disclosed to any unauthorized individuals to maintain the integrity of the patient information. An unauthorized individual would be any person that is not currently an employee of the practice. Any other disclosures may only occur at the direction of the patient by authorization.

This obligation of this Agreement shall remain in effect even after my time at Community Behavioral Health has ended.

Acknowledgement

I have read and understand the practice's policies with regards to privacy and security of personal health information. I agree to maintain confidentiality of all information obtained in the course of my time at Community Behavioral Health including, but not limited to, financial, technical, or proprietary information of the organization and personal and sensitive information regarding patients, employees, and vendors.

Printed Name_____

Signature_____ Date_____

MARYLAND'S LAW
ON CHILD ABUSE, CHILD NEGLECT, DISCIPLINE

In Maryland, the child abuse and neglect law requires that all persons, including all professionals, make a report as soon as possible to the Department of Social Services, when they SUSPECT a child has been or is being mistreated. (In cases of child abuse, a report may be made to Social Services or the police department).

Any professional who knowingly fails to make a required report of child abuse may be subjected to certain professional sanctions. The professionals identified in Maryland Law include: health practitioners, police officers, educators and human service workers.

Child Abuse is defined as he physical injury of a child by any parent or other person who has permanent or temporary care or custody or responsibility for supervision of a child or by any household or family member, under circumstances that indicate that the child's health or welfare is significantly harmed or at risk of being significantly harmed or sexual abuse of a child, whether physical injuries are sustained or not. Sexual abuse means any act that involves sexual molestation or exploitation of a child and includes: fondling, incest, rape or sexual offense in any degree, sodomy and unnatural or perverted practices.

Child Neglect is defined as the failure to give proper care and attention to a child including leaving the child unattended by the child's parents, guardian or custodian under circumstances that indicate that the child's health or welfare is significantly harmed or placed at risk of significant harm.

Discipline is an essential aspect of child rearing. It should be viewed as a learning experience so that the child will develop accepted patters of behavior and an understanding of responsibility as well as accepted rules of control and character which will enable him/her to become a mature and responsible adult and should be administered within the context of a positive, caring relationship.

Corporal punishment has limited value as a disciplinary method. Any type of corporal punishment has the potential of doing physical damage t the child and it therefore prohibited.

I have read, understand and agree to adhere to the above stated policies in reference to child abuse, neglect and discipline.

Name: _____

Signature: _____

Position: _____

Date: _____

NON-DISCLOSURE AGREEMENT

This Non-Disclosure Agreement covers financial and proprietary information belonging to Community Behavioral Health, LLC with a principal place of business at 426 Dorchester Avenue, Cambridge MD 21613-2446 ("Disclosing Party") that is currently made available to the party signing this agreement ("Receiving Party"). This Agreement is created for the purpose of preventing the unauthorized disclosure of the confidential, financial, and proprietary information regarding the finances, methods, and workflow of Disclosing Party providing psychiatry services so as to protect the business goodwill, business interests, and proprietary rights of Disclosing Party as a growing business. In no way does this Agreement supersede or discharge Receiving Party's obligations and responsibilities to protect patient protected health information as defined by the Health Insurance Portability and Accountability Act of 1996 ("PHI").

For the purposes of this Agreement, the term "Confidential Information" shall include, but not be limited to, PHI, business plans, financial statements, customers or users, economic and business analyses, models, strategies, projections, promotion methods, trade secrets, blueprints, supplier lists, works-in-progress, analytical data, software products, software source code or any related codes in all formats, documentation, and correspondences that have not otherwise been made publicly available. However, Confidential Information does not include: (1) information generally available to the public; (2) widely used programming practices or algorithms; (3) information rightfully in the possession of the parties to this Agreement prior to signing this Agreement; (4) information independently developed without the use of any of the provided Confidential Information; and (5) information approved for release by written authorization of an officer or representative of the Disclosing Party.

Disclosing Party shall have sole ownership and control of the Confidential Information with the Receiving Party being prohibited from disclosing, manipulating, transferring, or destroying confidential, financial, and proprietary information learned from Receiving Party's time working at Disclosing Party in consideration of Receiving Party's continued at-will employment. This Agreement neither alters the Receiving Party's at-will status nor imposes any obligation on Disclosing Party or Receiving Party regarding continued employment other than Receiving Party's obligations specifically set forth in the confidentiality agreement.

Receiving Party agrees to hold and maintain the Confidential Information in the strictest of confidence at all times. Receiving Party shall have the obligation to not use the Confidential Information for any personal gain or detrimentally to Disclosing Party. Receiving Party shall have the obligation to take all steps necessary to protect the Confidential Information from disclosure and to implement internal procedures to guard against such disclosure. If any such Confidential Information shall reach a third party or become public, all liability will be on the Party that is responsible. Receiving Party shall not publish, copy, or use the Confidential Information for their sole benefit without the written approval of Disclosing Party. If requested, Receiving Party shall be bound to return any and all materials to the Disclosing Party within three (3) business days.

In the event that Receiving Party receives a request or if required, by deposition, interrogatory, request for documents, subpoena, civil investigative demand, or similar process, to disclose all or any part of the Confidential Information, Receiving Party agrees, if legally permissible, to: (1) promptly notify Disclosing Party of the existence, terms, and circumstances surrounding such request or requirements; (2) consult with Disclosing Party of the advisability of taking legally available steps to resist or narrow such request or requirement; and (3) assist Disclosing Party in seeking a protective order or other appropriate remedy; provided however, that Receiving Party shall not be required to take any action in violation of applicable laws. In the event that such protective order or other remedy is not obtained or that Disclosing Party waives compliance with the provisions hereof, Receiving Party shall not be liable for such disclosure unless disclosure to any such tribunal was caused by or resulted from a previous disclosure by Receiving Party not permitted by this Agreement.

Receiving Party's obligation not to disclose information stated in this Agreement shall remain in effect in perpetuity, or to the greatest extent permitted by law if indefinite time periods are no longer allowed due to changes in the law, even after Receiving Party's time or work at Disclosing Party has ended. If future law renders

the time period of this Agreement not to exist in perpetuity, Receiving Party shall immediately return all documents and other tangible objects, both originals and copies, containing or representing Confidential Information which are in the possession of the Receiving Party as all objects thereof are and shall remain the property of Disclosing Party.

This Agreement is personal in nature, and neither party of this Agreement may directly or indirectly assign this Agreement or any rights or obligations under it, without prior written consent by both parties, and any attempt to do so is void; and neither grants the other any licenses under any patents or copyrights. Any provision of this Agreement held or determined by a court or other legal authority of competent jurisdiction to be illegal, invalid, or unenforceable in any jurisdiction shall be deemed separate, distinct, and independent, and shall be ineffective to the extent of such holding or determination without: (1) invalidating the remaining provisions of this Agreement in that jurisdiction; or (2) affecting the legality, validity, or enforceability of such provision in any other jurisdiction.

Receiving Party acknowledges and agrees that due to the unique and sensitive nature of the Confidential Information, any breach of this Agreement would cause irreparable harm for which damages and equitable relief may be sought including, but not limited to, injunctive relief, liquidated damages, attorney's fees, and disciplinary action. Such relief shall include the Disclosing Party enjoining Receiving Party in a court of equity for violating or threatening to violate this Agreement. Receiving Party must inform prospective future employers that Receiving Party is subject to a confidentiality agreement, but may only disclose the existence that such Agreement exists. The harmed Party shall be entitled to all remedies available at law. This Agreement shall be governed under the laws in the State of Maryland, the United States, and any applicable international law.

Receiving Party acknowledges and understands this Agreement and further acknowledges that Receiving Party has had full opportunity to have counsel of their choosing review this Agreement. Any modifications to this Agreement must be in a signed writing by both parties to this Agreement.

DISCLOSING PARTY

RECEIVING PARTY

COMMUNITY BEHAVIORAL HEALTH

EMPLOYEE PHYSICAL FITNESS FORM

FULL NAME	DATE OF BIRTH	SOC.SEC. #	AGE
ADDRESS: (STREET #, CITY, STATE, ZIP)			SEX
HAVE YOU EVER HAD , OR HAVE YOU NOW, ANY OF THE FOLLOWING (check all that apply)			

_____ HEADACHE	_____ HEART PROBLEMS
_____ DIZZINESS	_____ HIGH BLOOD PRESSURE
_____ UNCONSCIOUSNESS	_____ STOMACH PROBLEMS
_____ EYE TROUBLE	_____ KIDNEY STONE (BLOOD IN URINE)
_____ ALLERGIES	_____ ASTHMA
_____ DIABETES	
_____ TEETH/GUM TROUBLE	_____ CONVULSIONS
_____ HERNIA	_____ BACK TROUBLE
_____ ARTHRITIS (RHEUMATISM)	_____ ANXIETY DISORDER
_____ DRUG/ALCOHOL DEPENDENCY	_____ DEPRESSION
_____ SKIN PROBLEMS	_____ TYPHOID FEVER
_____ SMOKER	_____ VENEREAL DISEASE
_____ SURGERY	_____ PROBLEM PREGNANCY
_____ HIGH CHOLESTEROL	_____ MENSTRUAL PROBLEMS
_____ PROSTATE PROBLEMS	_____ OTHER

DESCRIBE ANY ITEMS CHECKED ABOVE

_____

_____

_____

NAME OF PERSONAL PHYSICIAN: ADDRESS OF PHYSICIAN:	
LIST MEDICATIONS YOU ARE CURRENTLY TAKING:	
HEIGHT: WEIGHT: PULSE: BLOOD PRESSURE:	
PPD RESULTS:	
PHYSICAL EXAMINATION RESULTS: HEENT _____ CHEST _____ CV _____ ABD _____ M/S _____ EXT _____	
EMPLOYEE PRESENTS TO BE FREE OF HEALTH, EMOTIONAL, OR PSYCHOLOGICAL IMPAIRMENTS WHICH WOULD ENDANGER THE PHYSICAL AND PSYCHOLOGICAL WELL BEING OF CHILDREN: _____ YES, QUALIFIED FOR EMPLOYMENT _____ NO, DISQUALIFIED RECOMMENDATIONS: _____ _____	
MEDICAL EXAMINER'S SIGNATURE: PRINT EXAMINER'S NAME: EXAM DATE :	

Tuberculosis Skin Test Form

Healthcare Professional/Patient Name: _____

Testing Location: _____

Date Placed: _____

Site: ☐ Right ☐ Left

Lot#: _____ Expiration Date: _____

Signature (administered by): _____

☐ RN ☐ MD Other: _____

Date Read (within 48-72 hours from date placed): _____

Induration (please note in mm): _____mm

PPD (Mantoux) Test Result: ☐ Negative ☐ Positive

Signature (results read/reported by): _____

☐ RN ☐ MD Other: _____

Declination of Influenza Vaccination

Community Behavioral Health has recommended that I receive influenza vaccination to protect the patients I serve.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands of people in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to protect this facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.
- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't change, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including
    - all patients in this healthcare facility
    - my co-workers
    - my family
    - my community

Despite these facts, I am choosing to decline influenza vaccination right now for the following reasons: _____

_____

I understand that I can change my mind at any time and accept influenza vaccination, if vaccine is still available.

I have read and fully understand the information on this declination form.

Signature: _____ Date: _____

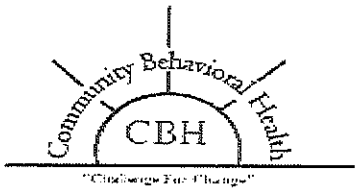
Name (print): _____

Department: _____

Reference: CDC. Prevention and Control of Influenza with Vaccines— Recommendations of ACIP at www.cdc.gov/flu/professionals/acip/index.htm

Technical content reviewed by the Centers for Disease Control and Prevention, October 2011.

www.immunize.org/catg.d/p4068.pdf • Item #P4068 (10/11)



Flu Vaccine Confirmation Form

Healthcare Professional/Patient Name:

Testing Location:

Date Placed:

Sight: Left or Right?

Lot#:

Expiration Date:

Signature (administered by):

Qualification of administrator: