

**INSTRUCTIONS TO APPLICANTS FOR NON-COMPETITIVE  
STATE SERVICE APPLICATIONS**

1. You may take this application packet home with you today.
2. Read carefully the instructions on this sheet before starting your application.
3. Complete the application by giving as much information as possible regarding the name, address, telephone number and supervisor's name of your present or former employers. List all jobs you have held *starting with* the most recent position *and going back* to the first job you had.
4. Sign your name in the spaces provided.
5. *Please read and complete the attached forms: Reference Check Consent Form, Acknowledgement of Receipt of Notice of Privacy Practices, and Pre-Employment Drug Testing Agreement Form.*
6. Take the enclosed two (2) character reference forms that are provided in the packet. These forms should be completed by someone who has known you more than one (1) year. Relatives and former employers cannot be used as references.
7. **Return the completed application packet to the NMRC Personnel Office Monday thru Friday between 8:00 A.M. and 4:00 P.M. Bring with you a valid driver's license or State issued ID card, your original Social Security card, proof of high school graduation, college transcripts, or GED Certificate, and two completed character reference forms.**
8. Male applicants between the ages of 18 and 26 years of age are required to register with the Federal Military Selective Service prior to beginning employment.
9. All applications are kept on file for three (3) years. It is not necessary to complete another application each year.
10. Be prepared to visit with someone in Personnel when you return your application. We would like the opportunity to meet you and review your application in detail. If you do not provide all of the before mentioned items, your application cannot be *processed*.
11. After submitting your completed application, you will be contacted when we have an opening for which you are qualified. Telephoning to check on your application only slows the process of completing your background check.

Revised January 2, 2008

North Mississippi Regional Center  
Notice of Privacy Practices for Protected Health Information (PHI)  
Effective Date of this Notice: April 14, 2003.

**THIS NOTICE DESCRIBES HOW MEDICAL/HEALTH INFORMATION ABOUT YOU OR ABOUT THE INDIVIDUAL FOR WHOM YOU ARE AN AUTHORIZED PERSONAL REPRESENTATIVE MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW IT CAREFULLY.**

North Mississippi Regional Center (Center) is dedicated to protecting your medical information. North Mississippi Regional Center is required by law to maintain the privacy of your protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. North Mississippi Regional Center collects health information from you and stores it in a chart or file and on a computer. This is your health record. The health record is the property of North Mississippi Regional Center, but the information in the record belongs to you. If you have questions about any part of this Notice or if you want more information about the privacy practices at North Mississippi Regional Center, please contact:

*Privacy Officer - Director of Privacy Standards  
North Mississippi Regional Center  
967 Regional Center Drive  
Oxford, MS 38655*

*Phone number: (662) 234-1476*

North Mississippi Regional Center is required to abide by the terms of the Notice currently in effect.

**Changes to the Notice:** North Mississippi Regional Center reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that we maintain. If North Mississippi Regional Center makes a material change in this Notice, we will post the revised Notice at the Center and will make a copy of the revised Notice available to you upon request.

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**Section I: Description of how North Mississippi Regional Center may use or disclose your health information and examples of each.**

The law permits North Mississippi Regional Center to use or disclose your health information without your written consent or authorization for the following purposes:

**Treatment:** We may use health information about you to provide treatment and services. We may disclose your health information to doctors, nurses, technicians, or other staff at North Mississippi Regional Center who are involved in taking care of you or when we refer you to another health care provider for treatment or services.

**Examples:** Your physician may ask a nurse to give you certain medications or information related to your condition or treatment. Another example is that if you had heart problems that required us to consult with a heart specialist (cardiologist) outside of the Center, your doctor at the Center may refer you to a cardiologist in the community for your care. The Center would share information from your health record needed by the staff at the cardiologist's office for your continued care. We may also release your information to another treatment facility for your continued care after your discharge from this facility.

**Payment:** We may use and disclose your health information to third party payers, such as insurance companies, Medicaid, or Medicare, when needed to determine your eligibility for benefits, for reimbursement, or for other requirements related to payment for treatment or services.

**Examples:** Information on or accompanying a bill to your insurance company or a claim form to the Division of Medicaid may include information, such as your diagnosis, the dates you received the services for which payment is requested or claimed, and the procedures or services you received. Information may be disclosed and used as part of utilization review activities, such as precertification and preauthorization of services and concurrent and retrospective review of services.

**Healthcare Operations:** We may use your health information for the purposes of North Mississippi Regional Center operations. These uses and disclosures are necessary to run or operate the Center and to make sure that all individuals we serve receive quality care.

**Examples:** Your records may be copied by a secretary to send them to another healthcare provider for your continued treatment. Members of the medical/nursing staff and other staff at the Center may review your health information to assess the care, outcomes, and quality of services you and others at the Center receive.

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**Section II: Other purposes for which we are permitted or required to use or disclose your health information without your consent or authorization:**

1. We may contact you to provide or remind you of an appointment, information about treatment alternatives, or other health related benefits and services that may be of interest to you. Examples of how we may contact you include:
  - Telephone calls (Messages to call the Center may be left on an answering machine)
  - Written correspondence
  - Facsimile (fax)
  - Electronic mail
  - Written correspondence or telephone calls asking you to help identify what services might be beneficial to you, to ask about your satisfaction with our services, or to ask about your ongoing treatment after discharge.
2. We may disclose your health information to you or your authorized personal representative, except as restricted under applicable laws and regulations.
3. Information may be released about you for **public health activities**, such as:
  - To prevent or control diseases.
  - To report death.
  - To report abuse or neglect.
  - To track products as regulated by the federal Food and Drug Administration (FDA) and to report problems or reactions to medications or products.
  - To provide notification and communication about product recalls, replacements and look-backs.
4. Information may be released to **health oversight agencies** for activities authorized by law. These activities may include investigations, inspections and licensure, and other lawful activities. These activities may also include providing access to your health information on a need-to-know basis by members of the Human Rights Advocacy Committee for approved activities. All specific information gained by the Human Rights Committee shall remain confidential.
5. Information may be disclosed in the course of any **administrative or judicial proceeding**:
  - In response to a court order.
  - Under certain restricted circumstances, in response to a subpoena or a similar process.
6. Information may be disclosed for **law enforcement purposes** under certain circumstances, such as reporting of certain types of physical injuries, locating persons, and reporting and investigating of crimes.
7. Information may be disclosed to a **coroner, medical examiner, or funeral directors**, consistent with applicable law.

8. **If you are an organ, eye or tissue donor**, your health information may be disclosed to organizations involved in procurement, banking or transplantation to facilitate organ, eye or tissue donation or transplantation.
9. Information may be disclosed for **public safety reasons** to appropriate persons in order to prevent or lessen a serious and/or imminent threat to the health or safety of a particular person or the general public.
10. Information may be disclosed as necessary to comply with **Workers Compensation laws**.
11. Information may be disclosed for **research purposes**, only as approved by the facility's research committee that serves as an Institutional Review Board and/or privacy board.
12. We may disclose your health information for other purposes as **required or permitted by law**.

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### **Section III: Other Uses or Disclosures**

1. Unless you object or we are otherwise restricted by law, we may disclose relevant health information about your location, your general condition, or in the event of your death, if it is needed to notify or assist in **notifying a family member**, your authorized personal representative or another person responsible for your care.

If you are available and able to agree or object prior to our disclosing this information, we will provide you the opportunity to object or otherwise obtain your agreement prior to disclosing the information. If you are unable or unavailable to agree or object, our health professionals will use their best judgement to determine if disclosing the information to your family member or others involved in your care is in your best interest. If they decide that disclosure is in your best interest, they will disclose only the health information that is relevant and necessary to that person's involvement in your care.

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### **Section IV: When North Mississippi Regional Center may not use or disclose your health information.**

Except as provided in this Notice of Privacy Practices, North Mississippi Regional Center will not use or disclose your health information, including, except under certain conditions, psychotherapy notes, without your written authorization. If you do authorize the Center to use or disclose your information for purposes other than as provided in this Notice, you may revoke your authorization in writing at any time.

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### **Section V: Your Health Information Rights**

You have the following rights with respect to your Protected Health Information (PHI):

1. **The right to request restrictions on certain uses and disclosures of protected health information.**  
North Mississippi Regional Center is not required to agree to your requested restriction. If the Center does agree to your requested restriction, we will comply with your request, unless the information is needed to provide you with emergency treatment.
2. **The right to receive confidential communications of protected health information.**  
You have the right to request in writing to the Privacy Officer that the Center only communicate to you in a certain format (for example, in writing) and/or at a certain location (for example, only at your work address). We will accommodate all reasonable requests.
3. **The right to inspect and copy protected health information**, subject to certain restrictions as provided for by law. You may be charged a fee for copying and/or postage.
4. **The right to amend protected health information.** You have a right to request that North Mississippi Regional Center amend or change your health information. North Mississippi Regional Center is not required to change your health information under certain conditions. You must make requests for amendments in writing and include the reason(s) for your request.

5. **The right to receive an accounting of disclosures of protected health information.** You have a right to receive an accounting of disclosures of your health information made by the Center, except for disclosures such as treatment, payment, healthcare operations, and certain other disclosures as provided for by law.
6. **The right to receive a paper copy of this Notice of Privacy Practices.** If you agreed to receive this Notice electronically, you also have the right to request a paper copy.

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**Section VI: How you can exercise your health information rights.**

You may exercise your rights described in this Notice or receive additional information by contacting:

Privacy Officer-Director of Privacy Standards  
Jon Crawford  
North Mississippi Regional Center  
967 Regional Center Drive  
Oxford, MS 38655  
(662) 513-7818

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**Section VII: Complaints**

If you believe your health information privacy rights have been violated, you may contact:

Privacy Officer-Director of Privacy Standards  
Jon Crawford  
North Mississippi Regional Center  
967 Regional Center Drive  
Oxford, MS 38655  
(662) 513-7818

OCR Regional Manager  
Office for Civil Rights  
U.S. Department of Health and Human Services  
Atlanta Federal Center, Suite 3B70  
61 Forsyth Street, S.W.  
Atlanta, GA 30303-8909

Office for Civil Rights  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Room 515F HHH Bldg.  
Washington, D.C. 20201.

**You will not be retaliated against for filing a complaint.**

**Approval Date of Revision: 08/22/05**



# NORTH MISSISSIPPI REGIONAL CENTER

Edith M. Hayles, Director

967 Regional Center Drive, Oxford, Mississippi 38655

Phone: 662-234-1476 • Fax: 662-234-1699 • [www.nmrc.state.ms.us](http://www.nmrc.state.ms.us)

## DISCLOSURE REGARDING BACKGROUND INVESTIGATION

The North Mississippi Regional Center ("the Company") may obtain information about you from a consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews with sources such as your neighbors, friends or associates. These reports may contain information regarding your criminal history, credit history, motor vehicle records ("driving records"), verification of your education or employment history or other background checks. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by Scott-Roberts and Associates, LLC, 2290 10 Ave. N., Lake Worth, Florida 33461, (888)605-4265, [www.scottrobertsassociates.com](http://www.scottrobertsassociates.com), or another outside organization. You should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**A Mississippi Department of Mental Health Facility**

"Enhancing the abilities and promoting the independence of individuals with intellectual and related developmental disabilities by providing quality care, comprehensive services, and family support with dignity and respect."

**REFERENCE CHECK CONSENT FORM**

I hereby give my consent and authorization for the North Mississippi Regional Center to contact individuals, former employers, Law Enforcement Agencies, and any other public or private agency, company or institution having knowledge of my qualifications and fitness for the position for which I am applying. I further release any and all parties providing information, including the North Mississippi Regional Center, from all liability for any damage whatsoever incurred in the provision or receipt of such information.

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

Witness: \_\_\_\_\_

This is to certify that I have nothing in my past history relating to any confirmed allegation of abuse/neglect of any person nor any undisclosed criminal convictions. I realize that any misrepresentations of the facts may lead to the rejection of my application and/or my dismissal from employment. I further authorize and verification as may be required.

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

Witness: \_\_\_\_\_

**PREVIOUS EMPLOYMENT WITH DEPARTMENT OF MENTAL HEALTH**

I have \_\_\_\_\_, have not \_\_\_\_\_ been employed by the North Mississippi Regional Center or any facility of the Department of Mental Health. List name of program and immediate supervisor if applicable: \_\_\_\_\_

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

Witness: \_\_\_\_\_

14.6-18  
NORTH MISSISSIPPI REGIONAL CENTER

Employee Biographical Supplement Information

NAME: \_\_\_\_\_  
FIRST MIDDLE LAST MAIDEN

SSN: \_\_\_\_\_ DATE OF BIRTH : \_\_\_\_\_  
MONTH/DAY/YEAR

Please list by city, county and state all places where you have lived, worked and attended school since the age of 18.

	CITY	COUNTY	STATE
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____
11.	_____	_____	_____
12.	_____	_____	_____
13.	_____	_____	_____
14.	_____	_____	_____
15.	_____	_____	_____
16.	_____	_____	_____



NORTH MISSISSIPPI REGIONAL CENTER  
CHEMICAL TESTING PROGRAM

By signing below, you are acknowledging that you have been made aware of the Department of Mental Health=s Chemical Testing Policy, as revised and implemented on February 19, 2007, copies of which are available for your review at the facility=s Personnel office during normal business hours. This policy is being adopted pursuant to House Bill of the 1994 Mississippi Legislature (Section 71-7-1 et. seq., Mississippi Code of 1972, Annotated, as amended), and is implemented pursuant to regulations as promulgated by the Mississippi Department of Health, June 1994.

It shall be the policy of the Department of Mental Health and its facilities that a chemical testing program exist to provide reasonable assurance that all employees are not under the influence of chemical substances, either legal or illegal, which might impair their performance and to insure compliance with this agency=s policy to maintain a drug-free workplace. Chemical testing may be required for all employees for illegal drugs, alcohol, and prescription/over-the-counter drugs either by random selection, for cause if there is cause to believe they may be engaged in drug/alcohol abuse, as a follow-up to a drug/alcohol re-entry agreement, because of a change in job status, or because of an accident at work. Pre-employment testing shall be conducted for all individuals who are applicants for permanent employment.

Personal information collected and maintained in accordance with the Chemical Testing shall be protected from disclosure pursuant to Mississippi Law and Health Department regulations and the Health Insurance Portability and Accountability Act of 1996. Confidentiality of this information shall be assured by making it available only to those individuals with an established need to know. The Department of Mental Health or management having access to such information shall not disclose it to persons other than those on the following list without written approval and authorization of the subject individual: (1) Medical Review Officer; (2) appropriate law enforcement officials under court order; (3) the subject of the information or his/her representatives, when authorized in writing by the subject; (4) Department of Mental Health or Facility or duly authorized employees who have a need to have access to the information in performing assigned duties; (5) Department of Mental Health employees performing audits of the Chemical Testing program; (6) Department of Mental Health/Facility employees deciding matters on review or appeal; or (7) other persons pursuant to a court order.

The Department of Mental Health/Facilities include in its drug and alcohol testing protocols: marijuana, cocaine, opiates, amphetamines, phencyclidine, alcohol and other controlled substances. However, if testing for controlled substances other than those specifically named above is conducted, testing for such substances can be done only if the United States Department of Health and Human Services has established an approved protocol and positive threshold for such substance, which has been adopted by the Mississippi Department of Health.

Refusal by an employee to participate in testing may result in disciplinary action, up to and including termination.

A confirmed positive test for illegal drugs shall result in termination.

Any appeals regarding the Chemical Testing Policy shall be made through the grievance process and Employee Appeals Board as set out in the Mississippi State Employee Handbook.

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I hereby acknowledge being notified of the Chemical Testing Policy at the North Mississippi Regional Center.

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

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

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

21.6-03

**North Mississippi Regional Center**

**Acknowledgment of Receipt of Notice of Privacy Practices**

**Name of Employee/Volunteer:** \_\_\_\_\_

**Department:** \_\_\_\_\_

I acknowledge that I have received the **Notice of Privacy Practices for North Mississippi Regional Center**, effective April 14, 2003.

\_\_\_\_\_  
Signature of Employee/Volunteer

\_\_\_\_\_  
Date

Please return this form to:

Privacy Officer-Director of Privacy Standards  
Jon Crawford  
North Mississippi Regional Center  
967 Regional Center Drive  
Oxford, MS 38655  
(662) 513-7692

**CHARACTER REFERENCE**

Name of Applicant: \_\_\_\_\_ Address: \_\_\_\_\_

City/Job Location: \_\_\_\_\_ Department: \_\_\_\_\_ Position: \_\_\_\_\_

The above applicant has made application for employment at the North Mississippi Regional Center. In order to give adequate consideration to the application, we would appreciate your honest evaluation of the applicant as far as character, experience, and ability is concerned.

Name of Reference: \_\_\_\_\_ Phone#: \_\_\_\_\_

Address of Reference: \_\_\_\_\_

How long have you known this applicant? \_\_\_\_\_

Would you recommend this applicant for employment with North Mississippi Regional Center?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

Please check the spaces which best describe the applicant:

Personal Evaluation of Applicant	Above Average	Average	Below Average
1. Attendance			
2. Cooperation			
3. Dependability			
4. Neatness and Appearance			
5. Ability to learn			
6. Ability to work with others			

**COMMENTS**

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Signature of Reference \_\_\_\_\_ Date \_\_\_\_\_

Do you believe it would be advisable to discuss this applicant further by telephone:  
\_\_\_\_\_ Yes \_\_\_\_\_ No

Please return to: North Mississippi Regional Center  
Personnel Office  
967 Regional Center Drive  
Oxford, Mississippi 38655

**CHARACTER REFERENCE**

Name of Applicant: \_\_\_\_\_ Address: \_\_\_\_\_

City/Job Location: \_\_\_\_\_ Department: \_\_\_\_\_ Position: \_\_\_\_\_

The above applicant has made application for employment at the North Mississippi Regional Center. In order to give adequate consideration to the application, we would appreciate your honest evaluation of the applicant as far as character, experience, and ability is concerned.

Name of Reference: \_\_\_\_\_ Phone#: \_\_\_\_\_

Address of Reference: \_\_\_\_\_

How long have you known this applicant? \_\_\_\_\_

Would you recommend this applicant for employment with North Mississippi Regional Center?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

Please check the spaces which best describe the applicant:

Personal Evaluation of Applicant	Above Average	Average	Below Average
1. Attendance			
2. Cooperation			
3. Dependability			
4. Neatness and Appearance			
5. Ability to learn			
6. Ability to work with others			

**COMMENTS**

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

Signature of Reference \_\_\_\_\_ Date \_\_\_\_\_

Do you believe it would be advisable to discuss this applicant further by telephone:  
\_\_\_\_\_ Yes \_\_\_\_\_ No

Please return to: North Mississippi Regional Center  
Personnel Office  
967 Regional Center Drive  
Oxford, Mississippi 38655

# STATE OF MISSISSIPPI APPLICATION



Return Completed Application to:  
 Mississippi State Personnel Board  
 210 East Capitol Street, Suite 800  
 Jackson, MS 39201  
 www.mspb.ms.gov

For Staff/Official Use Only

Received: \_\_\_\_\_

## Important! Please Read Before you begin the application process:

Applicants must complete and attach the "Supplemental Questions" page when applicable. This page is located on the MSPB website Job Openings screen. Scroll down to the bottom of the screen and click the preferred job; when the description is displayed, click "Print Job Information." Applications failing to include this page or lacking sufficient information will be returned to the applicant as invalid. Please ensure your application is received by the closing date as indicated on the job posting.

-TYPE OR PRINT IN BLACK INK-

### JOB INFORMATION

POSITION #:	POSITION TITLE:
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### PERSONAL INFORMATION

FIRST NAME	MIDDLE INITIAL	LAST NAME
ADDRESS		
CITY	STATE	ZIP
HOME PHONE	ALTERNATE PHONE	
MONTH AND DATE OF BIRTH	WHICH METHOD DO YOU PREFER TO BE NOTIFIED ABOUT YOUR APPLICATION STATUS? <input type="checkbox"/> EMAIL OR <input type="checkbox"/> PAPER	
EMAIL ADDRESS		

### EDUCATION

WHAT IS YOUR HIGHEST LEVEL OF EDUCATION:

<input type="checkbox"/> Some High School	<input type="checkbox"/> Some College	<input type="checkbox"/> Associate's Degree	<input type="checkbox"/> Master's Degree	<input type="checkbox"/> Doctorate Degree
<input type="checkbox"/> High School	<input type="checkbox"/> Technical College	<input type="checkbox"/> Bachelor's Degree	<input type="checkbox"/> Specialist's Degree	

### HIGH SCHOOL EDUCATION

DID YOU GRADUATE FROM HIGH SCHOOL/RECEIVE A G.E.D.? YES  NO

IF NO, WHAT WAS THE HIGHEST GRADE LEVEL COMPLETED? 7  8  9  10  11  12

### COLLEGE/UNIVERSITY EDUCATION

SCHOOL NAME	DEGREE RECEIVED
DATES ATTENDED	DID YOU GRADUATE? YES <input type="checkbox"/> NO <input type="checkbox"/>
# OF UNITS COMPLETED: <input type="checkbox"/> SEMESTER <input type="checkbox"/> QUARTER	
SCHOOL LOCATION (CITY/STATE)	MAJOR

SCHOOL NAME	DEGREE RECEIVED
DATES ATTENDED	DID YOU GRADUATE? YES <input type="checkbox"/> NO <input type="checkbox"/>
# OF UNITS COMPLETED: <input type="checkbox"/> SEMESTER <input type="checkbox"/> QUARTER	
SCHOOL LOCATION (CITY/STATE)	MAJOR

SCHOOL NAME	DEGREE RECEIVED
DATES ATTENDED	DID YOU GRADUATE? YES <input type="checkbox"/> NO <input type="checkbox"/>
# OF UNITS COMPLETED: <input type="checkbox"/> SEMESTER <input type="checkbox"/> QUARTER	
SCHOOL LOCATION (CITY/STATE)	MAJOR

**CERTIFICATES & LICENSES**

TYPE	DATE ISSUED (MONTH/YEAR)	EXPIRATION DATE (MONTH/YEAR)
LICENSE NUMBER	ISSUING AGENCY	SPECIALIZATION
TYPE	DATE ISSUED (MONTH/YEAR)	EXPIRATION DATE (MONTH/YEAR)
LICENSE NUMBER	ISSUING AGENCY	SPECIALIZATION
TYPE	DATE ISSUED (MONTH/YEAR)	EXPIRATION DATE (MONTH/YEAR)
LICENSE NUMBER	ISSUING AGENCY	SPECIALIZATION

**WORK HISTORY**

DATES From _____ To _____	EMPLOYER	POSITION TITLE
ADDRESS, CITY, STATE		
PHONE NUMBER	SUPERVISOR (NAME & TITLE)	
HOURS PER WEEK	SALARY	MAY WE CONTACT THIS EMPLOYER? YES <input type="checkbox"/> NO <input type="checkbox"/>
DUTIES		

DATES From _____ To _____	EMPLOYER	POSITION TITLE
ADDRESS, CITY, STATE		
PHONE NUMBER	SUPERVISOR (NAME & TITLE)	
HOURS PER WEEK	SALARY	MAY WE CONTACT THIS EMPLOYER? YES <input type="checkbox"/> NO <input type="checkbox"/>
DUTIES		

## WORK HISTORY

DATES From _____ To _____	EMPLOYER	POSITION TITLE
ADDRESS, CITY, STATE		
PHONE NUMBER	SUPERVISOR (NAME & TITLE)	
HOURS PER WEEK	SALARY	MAY WE CONTACT THIS EMPLOYER? YES <input type="checkbox"/> NO <input type="checkbox"/>
DUTIES		

DATES From _____ To _____	EMPLOYER	POSITION TITLE
ADDRESS, CITY, STATE		
PHONE NUMBER	SUPERVISOR (NAME & TITLE)	
HOURS PER WEEK	SALARY	MAY WE CONTACT THIS EMPLOYER? YES <input type="checkbox"/> NO <input type="checkbox"/>
DUTIES		

### AGENCY WIDE QUESTIONS

1. ARE YOU CURRENTLY EMPLOYED WITH THE STATE OF MS? YES  NO
2. IF YOU ANSWERED "YES" TO THE PREVIOUS QUESTION, INDICATE WHICH AGENCY AND YOUR CURRENT JOB TITLE. (IF YOU PREVIOUSLY INDICATED "NO", PROCEED TO THE NEXT QUESTION.)
- \_\_\_\_\_
- (AGENCY NAME) (CURRENT JOB TITLE)
3. HAVE YOU BEEN SEPRATED WITHIN THE LAST 12 MONTHS FROM THE STATE OF MS DUE TO A REDUCTION IN FORCE (RIF)? YES  NO
4. IF YOU ANSWERED "YES" TO THE PREVIOUS QUESTION, INDICATE WHICH AGENCY, YOUR PREVIOUS JOB TITLE, AND THE DATE OF YOUR RIF SEPARATION. (IF YOU PREVIOUSLY INDICATED "NO", PROCEED TO THE NEXT QUESTION.)
- \_\_\_\_\_
- (AGENCY NAME) (PREVIOUS JOB TITLE) (DATE OF RIF)
5. ARE YOU A VETERAN OF THE ARMED FORCES?  YES  NO  
(IF YOU INDICATED "YES", YOU MUST ATTACH A COPY OF YOUR DD214 OR OTHER PROOF OF SERVICES.)
6. IF YOU ARE A VETERAN, WERE YOU DECLARED DISABLED?  YES  NO
7. ARE YOU AN ADULT MALE BORN ON OR AFTER JANUARY 1, 1960 WHO REGISTERED FOR SELECTIVE SERVICE BETWEEN THE AGES OF 18 AND 25?  
 YES  NO

TO MEET THE REQUIREMENTS OF FEDERAL REGULATIONS, MSPB NEEDS TO COLLECT INFORMATION ON THE QUESTIONS BELOW FOR REPORTING PURPOSES ONLY. THIS INFORMATION WILL NOT BE USED FOR MAKING EMPLOYMENT DECISIONS. (OPTIONAL)

8. INDICATE YOUR RACE

- AMERICAN INDIAN  
 WHITE  
 HISPANIC  
 BLACK  
 ASIAN  
 Other

9. INDICATE YOUR GENDER

- MALE  
 FEMALE

10. AGE GROUP:

- UNDER 18  
 18-25  
 26-39  
 40-54  
 55-69  
 70+

### ADDITIONAL INFORMATION

Additional Information (other schools or training; special qualifications; honors and awards; etc.):

### APPLICANT DECLARATIONS

By signing this application, I certify that all statements made herein and on any attached documents are true and complete to the best of my knowledge. I authorize the verification of this information by the Mississippi State Personnel Board and any agency considering me for employment. I know that any misrepresentation herein may lead to rejection of my application, removal of my name from the list of eligibles, and/or dismissal from state service. I understand that, as a condition of employment, I will be required to present documentation which verifies both my identity and my employment eligibility pursuant to federal immigration law.

X \_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

