

APPLICATION FOR EMPLOYMENT

SANILAC MEDICAL CARE FACILITY

Have you ever filed an application with us before? yes no

If yes, when _____

POSITION APPLIED FOR:

DATE:

Name (Last, first, middle)

Address (Street, city, state, zip code)

How many years?

Telephone

Social Security Number

Previous address (Street, city, state, zip code)

How many years?

Pay Expectation

Date Available for Work

Status: Full Time
 Part Time
 Temporary

Have you ever been employed by Sanilac Medical Care Facility

Yes No

Date of Employment

From: _____ To: _____

In what Department?

What Position?

Reason for Leaving?

Are you a U.S. Citizen?

Yes No

If you are not, do you have a legal right to remain permanently and work in the U.S.? Yes No

If employed, can you submit verification of your legal right to remain and work in the U.S. ? Yes No

What prompted your application?

Do you have a telephone at your place of residence? Yes No

Do you have reliable transportation available to you to go to and from work? Yes No

Do any of your friends or relatives work here? Yes No

MILITARY SERVICE

Service

Branch

Date of Service

From: _____ To: _____

Reserve Status

Describe any specialized training and duties

EMPLOYMENT HISTORY - List your last three employers. Also list and explain any period(s) of unemployment.

Please answer all inquiries. "See Resume" is not acceptable.

Employer's Name		Dates (month and year)	
		FROM:	TO:
Address (Street, city, state, zip code)		Telephone	
Supervisor (Name and Title)	Your Title	Salary	
Duties/Responsibilities			
Reason for Leaving			

Employer's Name		Dates (month and year)	
		FROM:	TO:
Address (Street, city, state, zip code)		Telephone	
Supervisor (Name and Title)	Your Title	Salary	
Duties/Responsibilities			
Reason for Leaving			

Employer's Name		Dates (month and year)	
		FROM:	TO:
Address (Street, city, state, zip code)		Telephone	
Supervisor (Name and Title)	Your Title	Salary	
Duties/Responsibilities			
Reason for Leaving			

May we contact your present employer? Yes No
 Are you currently on "layoff" status and subject to recall? Yes No
 Have you ever been discharged by an employer or resigned in lieu of discharge? Yes No
 If yes, please explain on an attached signed sheet, including facts, dates, actions you took and any if there was any resolution.
 Do you have a valid drivers license? Yes No

EDUCATION

SCHOOL AND LOCATION	YEARS COMPLETED	DIPLOMA/DEGREE
High School		
Business School		
College/University		
Trade/Vocational School		
Extracurricular activities and honors received in school		

PROFESSIONAL LICENSES, REGISTRATIONS, AND/OR CERTIFICATIONS

List all states in which you are or have been licensed or certified and any national certifications. Indicate professional license, registration or certification number. Attach additional pages if necessary.

Have you ever had any professional license or certification placed under investigation, disciplined, suspended, revoked or put on probation? Yes No

Have you ever been denied a license or certification? Yes No

If you answered yes to either of the above questions, explain in detail on an attached signed statement.

Do you have any other specialized skill?

List any computer software you have worked with:

MISCELLANEOUS

Do you have any felony charges pending against you? _____ Yes _____ No
Have you ever been convicted or pled guilty or nolo contendere to a crime? _____ Yes _____ No
If you answered yes to either of the two preceding questions, explain by giving the dates, nature of the offense and circumstances on an attached, signed statement. Conviction of a crime will not necessarily disqualify an applicant from employment.
Are you 18 years of age or older? _____ Yes _____ No
Are you able to perform the duties of the job for which you have applied with or without a reasonable accomodation? _____ Yes _____ No
References: If we should ask for personal references, would any be available? _____ Yes _____ No

CERTIFICATION

I understand that I may be required to submit to a physical examination, which may included a drug test, prior to beginning employment and that I must satisfactorily pass such an examination to obtain employment.

I have read and fully understand the questions on this application for employment. I have completely, truthfully, and accurately answered each and every question to the best of my knowledge. I understand that all the inquiries on this application are subject to verification and authorize any schools that I have attended, licensing and certification boards and current and previous employers to release any requested information to **Sanilac Medical Care Facility**. I also specifically waive written notice from any and all former employers regarding their disclosure to **Sanilac Medical Care Facility** of any prior disciplinary action and waive any claim against **Sanilac Medical Care Facility** and current or former employers arising from such investigation or disclosure. I understand that any misrepresentation of the information I have supplied or failed to supply in the Application or during interview (s), including any false or misleading information, can result in a rejection of this application or, if I have been hired, an immediate dismissal at the sole discretion of **Sanilac Medical Care Facility**.

I understand and agree that in the absence of an express written contract or agreement to the contrary, signed by an authorized official of **Sanilac Medical Care Facility** and by me or my authorized representative, any employment I accept shall be for an indefinite term and may be terminated at any time with or without cause either by me or at the will and sole discretion of **Sanilac Medical Care Facility** regardless of any contrary provisions in any other forms, manuals, handbooks or other documents. Similarly, such employment shall be at the wages, benefits, hours and conditions as **Sanilac Medical Care Facility** may determine and change from time to time and I agree to abide by any rules, regulations, policies and procedures that may be established from time to time. I understand that no one, other than an authorized official of **Sanilac Medical Care Facility** has any authority to enter into an agreement with me contrary to the provisions of the paragraph and that any such agreement must be in writing and signed by such authorized official or it shall not be effective.

It is with full understanding and agreement with the provisions of the Certification that I will accept any employment offered to me.

Signature of Applicant

Date



LONG TERM CARE WORKFORCE BACKGROUND CHECK APPLICATION FORM

Part 1 – Consent
Part 2 – Applicant Information
Part 3 – Disclosure
Part 4 – Conditional Employment
Part 5 – Applicant Rights
Part 6 – Disclaimer

Effective April 1, 2006 MCL 333.20173a and MCL 330.1134a require that a health facility/agency that is a:

- psychiatric facility
- ICF/MR
- nursing home
- county medical care facility
- hospital that provides swing bed services
- home for the aged
- home health agency
- hospice

Shall not employ, independently contract with, or grant clinical privileges to an individual who regularly has direct access to or provides direct services to patients or residents in the health facility/agency until the health facility or agency conducts a fingerprint-based criminal history check.

An individual who applies for employment either as an employee or as an independent contractor or for clinical privileges with a health care facility/agency and has received a good faith offer of employment, an independent contract, or clinical privileges shall give written consent at the time of application for the health care facility/agency to conduct a criminal history check, and shall give a written statement disclosing that he or she has not been convicted of a crime that would prohibit employment.

NOTE: Throughout this form "employee" includes persons independently contracted with and/or those granted clinical privileges.

Health Facility or Agency

Date: _____

Employment Applicant Name: _____

Facility Name: _____

The health facility/agency:

- a. May not knowingly employ a worker, having direct access to patients or residents, who has been convicted of a relevant crime or has been the subject of a state or federal agency substantiated finding of patient or resident neglect, abuse, or misappropriation of property. "Direct access" means regular access to a patient or resident, or to a patient's or resident's property, financial information, medical records, treatment information, or any other identifying information.
- b. May terminate the background check or may determine not to hire the individual at any stage of the process.
- c. Must ensure that any background check information provided will only be used for the purpose of determining an individual's suitability for employment in a long-term care setting.
- d. Must retain verification of compliance with background check requirements.
- e. Will make the final employment decision.



Part 1 – Consent to Conduct Background and Criminal Record Checks

As a condition of being considered for employment:

- a. I hereby consent to and authorize the health facility/agency to conduct a background check that includes a search of state and federal abuse and neglect registries and databases, in addition to a fingerprint-based search of state and federal criminal history records. I understand that this consent extends to the release and sharing of such information with the Michigan Departments of Community Health, Human Services, Corrections, and State Police.
- b. I hereby authorize the release of any relevant information to the health facility/agency to be used to conduct the background check as required under MCL 333.20173a and MCL 330.1134a.
- c. I understand, except for a knowing or intentional release of false information, the health facility/agency has no liability in connection with a background check conducted under MCL 333.20173a and MCL 330.1134a, or the release of criminal history record information for the purposes of making an employment decision.
- d. I understand that the health facility/agency will make the final employment determination. I also understand that the health facility/agency may terminate the background check or determine not to hire at any stage of the process.
- e. I understand that the health facility/agency, in denying employment to an applicant, and reasonably relying on information obtained through a background check, is provided immunity from any action brought by an applicant due to the employment decision.
- f. I agree to provide the information necessary to conduct a criminal background check.

Signature of Applicant

Date

Part 2 – This employment applicant information is required to process a complete and accurate criminal record check.

EMPLOYEE PERSONAL INFORMATION

First Name:
Middle Name:
Last Name: Suffix:

OTHER NAME (S) USED (MAIDEN NAME, ALIAS)

First Name:
Middle Name:
Last Name: Suffix:

Date of Birth: Country of Citizenship:

Place of Birth (City, State/Province):

Height: Weight: Hair Color: Eye Color: Gender: Female Male

Race: Asian Black Hispanic Native American Pacific Islander White All

Social Security Number:

ADDRESS

Street Address:
City: State: Zip Code: County:

Phone Number:

Job Title: Conditional Hire Date:

RESIDENCY

Driver's License or State/Canadian ID Number: State/Prov. License/ID Number

Has this employment applicant resided in Michigan continuously for the past 12 months? YES NO

PROFESSIONAL LICENSE(S) /CERTIFICATION(S)

1. License/Certification Number:
2. License/Certification Number:
3. License/Certification Number:

Part 3 – Employment Applicant Disclosure Statements

The following convictions and/or findings may disqualify you from working in long-term care facility/agency:

- a. **Relevant Crime Described under 42 USC 1320a-7** – 42 USC 1320a-7 is a statutory provision within the Federal Social Security Act which describes a number of crimes for which a conviction will exclude an individual from participation in any federal health care program. The crimes include patient abuse, health care fraud, as well as any crimes related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.
- b. **Felony** – Any felony, or an attempt or conspiracy to commit any felony.
- c. **Misdemeanor** - Any state or federal crime that is substantially similar to the misdemeanors described below:
 - Any misdemeanor involving the use of a firearm or dangerous weapon with the intent to injure, the use of a firearm or dangerous weapon that results in a personal injury, or a misdemeanor involving the use of force or violence or the threat of the use of force or violence.
 - Any misdemeanor for assault if there was no use of a firearm or dangerous weapon and no intent to commit murder or inflict great bodily injury.
 - Any misdemeanor involving criminal sexual conduct.
 - Any misdemeanor involving abuse or neglect, torture, or cruelty.
 - Any misdemeanor involving home invasion.
 - Any misdemeanor involving embezzlement, larceny, fraud, theft or second or third degree retail fraud.
 - Any misdemeanor involving negligent homicide.
 - Any misdemeanor involving the possession, use or delivery of a controlled substance.
 - Any misdemeanor involving the creation, delivery, or possession with intent to manufacture or deliver a controlled substance.
- d. **Any finding of Not Guilty by Reason of Insanity**
- e. **Any substantiated finding of patient or resident neglect, abuse, or misappropriation of property**

Listed below are all offenses that I have been convicted of, including all terms and conditions of sentencing, parole and probation, and/or any substantiated finding of patient or resident neglect, abuse, or misappropriation of property.

Offense	Date of Conviction/Finding	City	State	Sentence	Date of Discharge

I certify that the above statements are correct and complete to the best of my knowledge.

Signature of Applicant

Date



Part 4 – Conditional Employment

If the health facility/agency determines it necessary to employ me pending the results of the state and federal criminal history background check, I understand the following:

- a. If the background check does not confirm my disclosure statement made above, my employment will be terminated for good cause, unless and until I successfully prove that the disqualifying information is inaccurate, expunged or set aside.
- b. If I knowingly provided false information regarding my identity, criminal convictions, or substantiated findings of patient or resident neglect, abuse, or misappropriation of property, I may be guilty of a misdemeanor punishable by imprisonment for not more than 93 days and/or a fine of not more than \$500.00.
- c. As required by MCL 333.20173a and MCL 330.1134a, I agree that as a condition of continued employment, I shall report in writing to the health facility/agency immediately upon being arraigned on a felony charge or convicted of one or more of the criminal offenses as described in MCL 333.20173a and MCL 330.1134a, or upon becoming the subject of an order or dispositional finding of "Not Guilty by Reason of Insanity", or upon being the subject of a state or federal agency substantiated finding of patient or resident neglect, abuse, or misappropriation of property. Reporting of an arraignment is not cause for termination or denial of employment.

Signature of Applicant

Date

Part 5 – Applicant Rights

- a. I understand that upon my request, the health facility/agency can provide a copy of any disqualifying record information found on any of the relevant registries or databases.
- b. I understand that if I believe the results of any disqualifying information found on any relevant registry is inaccurate, it is my responsibility to contact the agency that maintains the registry to correct the registry information.
- c. I understand that if I believe the results of the criminal history fingerprint record are inaccurate, or if the conviction contained in the criminal history record is one that may be expunged or set aside, I may file an appeal with the Department of Community Health.

Signature of Applicant

Date

Part 6 – Disclaimer

The State of Michigan is not responsible for any additional information, requirements, or use of any substitute forms that the above named health facility/agency provides to the applicant.

Sanilac Medical Care Facility

137 North Elk Street
Sandusky, Michigan 48471

Phone (810) 648-3017

WORK REFERENCE

INSTRUCTIONS TO APPLICANT

Complete all items above dotted line. Your signature authorizes the present or past employer to release information about you and releases them from all liability for any damages that may result from furnishing this to Sanilac Medical Care Facility.

"I have applied for the position of _____ at Sanilac Medical Care Facility and hereby grant the Sanilac Medical Care Facility permission to verify the information below and to solicit and secure other information which may be required to determine my suitability for employment. I further authorize the below named employer to release to Sanilac Medical Care Facility such information as may be requested for the purpose of evaluating me for possible employment. A copy of this authorization bearing my correct signature has the same force and effect as the original."

Applicant's Signature _____

Name Printed _____

Date _____

Please indicate any previous name(s) used in current/previous employment records: _____

APPLICANT'S INFORMATION. BELOW TO BE COMPLETED BY SMCF :

EMPLOYER'S NAME: _____

EMPLOYER'S ADDRESS: _____

DATES OF EMPLOYMENT FROM _____

TO _____

POSITION(S) HELD: _____

TRAINING RECEIVED FROM EMPLOYER LISTED ABOVE: _____

REQUEST TO EMPLOYER LISTED ABOVE:

The person named above has applied for employment with us and has authorized release of the information requested on this form. Please complete the form below and return to us in the enclosed envelope. All information is confidential. Thank you for your assistance.

Authorizing Signature/Position Title _____

Date _____

Is the above information correct? Yes No. If not, please explain: _____

Reason for leaving: _____

Would you rehire? Yes No Please explain: _____

<u>Please rate Applicant on the following</u>	<u>Above Average</u>	<u>Average</u>	<u>Below Average</u>	<u>No Knowledge</u>
Appearance (dress/attire).....	_____	_____	_____	_____
Attendance.....	_____	_____	_____	_____
Cooperation.....	_____	_____	_____	_____
Dependability.....	_____	_____	_____	_____
Initiative.....	_____	_____	_____	_____
Job Knowledge.....	_____	_____	_____	_____
Relationships with others.....	_____	_____	_____	_____
Quality of work.....	_____	_____	_____	_____
Quantity of work.....	_____	_____	_____	_____

COMMENTS: _____

Signature: _____

Date: _____

Position: _____

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Sandusky, Michigan 48471

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WORK REFERENCE

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Applicant's Signature _____

Name Printed _____

Date _____

Please indicate any previous name(s) used in current/previous employment records: _____

APPLICANT'S INFORMATION BELOW TO BE COMPLETED BY SMCF:

EMPLOYER'S NAME: _____

EMPLOYER'S ADDRESS: _____

DATES OF EMPLOYMENT FROM _____ TO _____

POSITION(S) HELD: _____

TRAINING RECEIVED FROM EMPLOYER LISTED ABOVE: _____

REQUEST TO EMPLOYER LISTED ABOVE:

The person named above has applied for employment with us and has authorized release of the information requested on this form. Please complete the form below and return to us in the enclosed envelope. All information is confidential. Thank you for your assistance.

Authorizing Signature/Position Title _____

Date _____

Is the above information correct? Yes No If not, please explain: _____

Reason for leaving: _____

Would you rehire? Yes No Please explain: _____

Please rate Applicant on the following	Above Average	Average	Below Average	No Knowledge
Appearance (dress/attire).....	_____	_____	_____	_____
Attendance.....	_____	_____	_____	_____
Cooperation.....	_____	_____	_____	_____
Dependability.....	_____	_____	_____	_____
Initiative.....	_____	_____	_____	_____
Job Knowledge.....	_____	_____	_____	_____
Relationships with others.....	_____	_____	_____	_____
Quality of work.....	_____	_____	_____	_____
Quantity of work.....	_____	_____	_____	_____

COMMENTS: _____

Signature: _____

Date: _____

Position: _____

VOLUNTARY SELF-IDENTIFICATION
(Confidential: For Statistical Use Only)

Sanilac Medical Care Facility is an **equal opportunity employer** and is required by law to report periodically certain data regarding our employees and applicants. To satisfy government regulations, we must try to provide accurate data on sex/gender and race/ethnic group of all employees as well as disability and veteran status of those who have self-identified. All information is reported in statistical form only and is secure and confidential. **Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment.**

PERSONAL INFORMATION:

Sex: Male
 Female

Race: Asian/Pacific Islander
 American Indian/
Alaskan Native

Black/African/American
 Hispanic/Latino
 White

MILITARY STATUS:

Active Reserve
 Armed Forces Service Medal Veteran
 Inactive Reserve
 No Military Service
 Retired Military

Other Protected Veteran
 Service Medal and Other Veteran
 Veteran (VA Ineligible)
 Veteran of the Vietnam Era
 Vietnam and Other Protected Veteran

DISABILITY STATUS:

- Individual with a Disability** - A person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such impairment.
- Disabled Veteran** - A veteran who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans' Affairs for a disability **OR** was discharged or released from active duty because of a service-connected disability.

Please list any accommodations needed below:

FULL NAME: _____

POSITION APPLYING FOR: _____