

APPLICATION FOR EMPLOYMENT



Today's Date: _____

POSITION APPLIED FOR

Have you ever filed an application with us before? Yes _____ No _____

If yes, when _____

WERE YOU REFERRED TO US BY AN EMPLOYEE YES NO

IF YES, PLEASE LIST THE NAME OF EMPLOYEE _____

Name	(Last)	(First)	(Middle)
Address:	(Street)	(City)	(State) (Zip Code)
Telephone No. () -	Social Security Number / /	Email Address:	
Specify any days or times you are not available for work:			
What shift(s) are you willing to work?			
Salary Expectation: \$ Per	What shift(s) are you willing to work?	Employment Status Desired Full Time <input type="checkbox"/> Part Time <input type="checkbox"/>	
Have you ever been employed by the Oceana County Medical Care Facility? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes: Date Started: _____ Date Left: _____			
In What Department: _____ In what position: _____			
Reason for leaving: _____			
Are you a U.S. Citizen? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If you are not a U.S. Citizen, do you have a legal right to remain permanently in the United States? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If employed, can you submit verification of your legal right to remain in the U.S.? Yes <input type="checkbox"/> No <input type="checkbox"/>			
What prompted your application?			
Do you have a telephone at your residence? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Do you have a reliable form of transportation available to you to go to and from work? Yes <input type="checkbox"/> No <input type="checkbox"/>			

MILITARY SERVICE

Service	Branch	Date of Service
		From: To:
Were you honorably discharged? Yes <input type="checkbox"/> No <input type="checkbox"/>		Reserve Status:

Describe any specialized training and duties:

EMPLOYMENT HISTORY- List your last four employers, or all employers for the last ten years, whichever is greater. Attach additional signed sheets if necessary. Also list and explain any period(s) of unemployment. Please answer all inquiries. "See Resume" is not acceptable.

Employer's Name	Dates Worked (month and year) From / To /	
Address (Street, City, State and Zip Code)	Telephone ()	
Supervisor (Name & Title)	Your Title	Your Salary
Duties & Responsibilities		
Reason for leaving		

Employer's Name	Dates Worked (month and year) From / To /	
Address (Street, City, State and Zip Code)	Telephone ()	
Supervisor (Name & Title)	Your Title	Your Salary
Duties & Responsibilities		
Reason for leaving		

Employer's Name	Dates Worked (month and year) From / To /	
Address (Street, City, State and Zip Code)	Telephone ()	
Supervisor (Name & Title)	Your Title	Your Salary
Duties & Responsibilities		
Reason for leaving		

Employer's Name	Dates Worked (month and year) From / To /	
Address (Street, City, State and Zip Code)	Telephone ()	
Supervisor (Name & Title)	Your Title	Your Salary
Duties & Responsibilities		

Reason for leaving

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

Have you ever been disciplined (other than discharged by an employer)? Yes No

If you answered yes to either of the two previous questions, explain all such incidents, giving facts, dates, describing any action you took and any resolution, on an attached signed sheet.

How much time have you missed from work in the past twelve months? _____

Do you have a valid driver’s license? Yes No

EDUCATION

SCHOOL	LOCATION	DEGREES
High School		
Business School		
College/University		
Trade/Vocational School		

Extracurricular activities & 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. 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 above questions, explain in detail on an attached signed statement.

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 proceeding questions, explain by giving the date, nature of the offense and circumstances in 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? Yes No

References: Give the name, address and telephone numbers of three references who are not related to you:

NAME	ADDRESS	TELEPHONE NO.
1.		
2.		
3.		

CERTIFICATION

I understand that I may be required to submit to a physical examination, which may include 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, law enforcement agencies and current and previous employers to release any requested information to the Facility. I also specifically waive written notice from any and all former employers regarding their disclosure to the Facility of any prior disciplinary action and waive any claim against the Facility and current or former employers arising from such investigation of disclosure. I understand that any misrepresentation of the information I have supplied or failed to supply can result in a rejection of this application or, if I have been hired, an immediate dismissal at the sole discretion of the Facility.

I understand and agree that in the absence of an express written contract or agreement to the contrary, signed by an authorized representative of the 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 the 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 the 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 representative of the Facility has any authority to enter into an agreement with me contrary to the provisions of this paragraph and that any such agreement must be in writing and signed by such authorized representative or it shall not be effective.

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

(Signature of Applicant)

(Date)

Applicant to fill in shaded areas only (black box)

Applicant Release

Name of Supervisor: _____

Company/Facility: _____ Phone: _____

Address:

_____ City/Town _____ State _____ Zip _____

Applicant: _____
Last First M. Other name used

Position Held: _____

Social Security No. _____ Dates Employed From _____ to _____

I authorize my former employer _____ to furnish Oceana County Medical Care Facility any and all information concerning my previous employment and pertinent information they may have, personal or otherwise, and release all parties from all liability for any damage that may result from furnishing same to you.

Applicant's Signature Date

DO NOT WRITE BELOW THIS LINE

To be Completed by Previous Employer or Oceana County Medical Care Facility Representative

The individual named above is applying for a position as _____ and has given you as a reference. As we place great importance on the thorough screening of all our applicants, we would appreciate a prompt and thoughtful response.

Thank you in advance _____
Name of Oceana County Medical Care Facility Representative

Does the above information correspond with your records? ___ Yes ___ No

If no, please state correct information _____

Is applicant eligible for rehire? ___ Yes ___ No If no, why not? _____

Please comment on the applicant's attributes using the following rating scale:

4 = EXCELLENT 3 = GOOD 2 = FAIR 1 = POOR N/A = NOT APPLICABLE

Acceptance of supervision ___ Professional Appearance ___ Cooperation ___

Reliability and Attendance ___ Use of Safety measures ___ Quality of Work ___

Knowledge of Medications ___ Ability to relate to staff ___

Ability to relate to residents ___

Additional Comments:

(Attach additional sheets if necessary)

Evaluator's Signature (Printed name if per phone)	Title	Date
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Reference given by phone. Requester's Signature: _____

PLEASE SEAL WITH TAPE

From: _____

AFFIX
FIRST
CLASS
POSTAGE

To:

701 East Main St.
Hart, MI 49420
(231) 873-6600

Oceana County MCF
701 East Main St.
Hart, MI 49420

AFFIX
FIRST
CLASS
POSTAGE

To: _____

PLEASE SEAL WITH TAPE



LONG TERM CARE WORKFORCE BACKGROUND CHECK CONSENT AND DISCLOSURE

MCL 333.20173a, MCL 330.1134a, and MCL 440.734b require that a health facility/agency that is a:

- psychiatric facility
- ICF/MR
- nursing home
- county medical care facility
- adult foster care facility (AFC)
- 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 or AFC until the health facility/agency or AFC 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 or AFC 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 or AFC to conduct a criminal history check, including a state and Federal Bureau of Investigation (FBI) fingerprint-based 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.
- Clinical privileges do not apply to adult foster care facilities.

Health Facility or Agency

Licensee Name: _____ **Date:** _____

Employment Applicant Name: _____

Facility Name/License Number: _____

The health facility/agency or AFC:

- a. May not knowingly employ a worker, having direct access to patients or residents, who has been convicted of a disqualifying 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 decide 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.

* This does not include a finding of abuse, neglect, or misappropriation (financial exploitation) substantiated under the Michigan Mental Health Code or Adult Protective Services Act.

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 or AFC 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 Licensing and Regulatory Affairs, Human Services, and State Police.
- b. I further understand the Michigan State Police (MSP) and the Federal Bureau of Investigation (FBI) may also retain the submitted information and fingerprints as permitted by the Federal Privacy Act of 1974 (5 USC § 552a(b)) for routine uses beyond the principal purpose listed above. Routine uses include, but are not limited to, disclosures to: governmental authorities responsible for civil or criminal law enforcement, counterintelligence, national security, or public safety.
- c. I hereby authorize the release of any relevant information to the health facility/agency or AFC to be used to conduct the background check as required under MCL 333.20173a, MCL 330.1134a, and MCL 440.734b.
- d. I understand, except for a knowing or intentional release of false information, the health facility/agency or AFC has no liability in connection with a background check conducted under MCL 333.20173a, MCL 330.1134a, and MCL 440.734b or the release of criminal history record information for the purposes of making an employment decision.
- e. I understand that the health facility/agency or AFC will make the final employment determination. I also understand that the health facility/agency or AFC may terminate the background check or decide not to hire me at any stage of the process.
- f. I understand that the health facility/agency or AFC, 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.
- g. 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 a long-term care facility/agency or AFC. “Conviction” includes any plea of guilty or nolo contendere (no contest), including cases that resulted in a deferred sentence or delayed sentence.

- a. **Relevant Crime Described under 42 USC 1320a-7** – The crimes include patient abuse, health care fraud, and 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. **A substantiated finding of patient or resident neglect, abuse, or misappropriation of property resulting from an investigation conducted in accordance with 42 USC 1395i or 1396r***

Listed below are all offenses that I have been convicted of, including all terms and conditions of sentencing, parole and probation, and/or a substantiated finding of patient or resident neglect, abuse, or misappropriation of property. Listed below are also all PENDING FELONY charges currently alleged against me.

Offense	Date of Conviction/Finding/ Charge (if pending)	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 or AFC 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 reveals disqualifying information 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. I understand that as a condition of continued employment, I am required to report in writing to the health facility/agency or AFC immediately upon being arraigned on a felony charge or convicted of one or more of the criminal offenses as described in MCL 333.20173a, MCL 330.1134a, and MCL 440.734b, 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 or AFC 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 Licensing and Regulatory Affairs and/or Department of Human Services.

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 or AFC provides to the applicant.