APPLICATION FOR EMPLOYMENT

(Please Print Clearly)

Confidential

Personal Information

Date of Application _____ Date Available _____

Name _____ (Last / First / Middle) Social Security Number _____

Present Address _____ (Street / City / State / Zip Code) Phone Number _____

Permanent Address (if Different than Present Address) _____ (Street / City / State / Zip Code) Phone Number _____

If you cannot be reached at above phone number, where may we contact you? Name of Person _____ Phone _____

Employment Desired

Type of Work Desired	Shift	Salary
First Choice		
Second Choice		
Third Choice		

Will You Accept Employment of: ❑ Full Time? ❑ Part Time? ❑ Temporary?

Are You 18 Yrs. of Age or Older? ❑ Yes ❑ No

Are You Employed Now? ❑ Yes ❑ No

May We Contact Your Present Employer? ❑ Yes ❑ No

How Did You Learn Of This Opening? _____

Education

Circle Highest Grade Completed: 8 9 10 11 12 13 14 15 16

Scholastic Honors Received _____

	Name of School	Location (City, State)	Courses Taken	Completed	Type of Degree or Certificate Received
Grammar or Grade School				❑ No ❑ Yes	
High School				❑ No ❑ Yes	
College				❑ No ❑ Yes; ___/___/___ Date	
Vocational or Business				❑ No ❑ Yes; ___/___/___ Date	
Professional Education				❑ No ❑ Yes; ___/___/___ Date	
Laboratory or X-Ray Training				❑ No ❑ Yes; ___/___/___ Date	

Extracurricular Activities While in School _____

Member of Professional Organizations _____

Honors Received, Volunteer or Community Service or Other Qualifications You Have Which You Feel Are Related to the Position for Which You Are Applying: _____

Were you in the U.S. Armed Forces? ❑ Yes ❑ No If yes, what branch? _____

Dates of Duty: From ___/___/___ (Month / Day / Year) To ___/___/___ (Month / Day / Year) Rank at Discharge _____

Professional Licenses and/or Certifications

Type	Organization or State Issued	Date Issued	Number	Verif.
Type	Organization or State Issued	Date Issued	Number	
Type	Organization or State Issued	Date Issued	Number	
Type	Organization or State Issued	Date Issued	Number	

Form 3294R BRIGGS, Des Moines, IA 50306 (800) 247-2343
PRINTED IN U.S.A.

Rev. 4/92

Employment Record (list last or present position first)

Present and Former Employers	Dates Employed	Salary Range	Position & Duties
Name ____ Address ____ City/State/Zip ____ Supervisor ____ Phone ____	From ____ To ____	Starting ____ Ending ____	
Name ____ Address ____ City/State/Zip ____ Supervisor ____ Phone ____	From ____ To ____	Starting ____ Ending ____	
Name ____ Address ____ City/State/Zip ____ Supervisor ____ Phone ____	From ____ To ____	Starting ____ Ending ____	
Name ____ Address ____ City/State/Zip ____ Supervisor ____ Phone ____	From ____ To ____	Starting ____ Ending ____	
Name ____ Address ____ City/State/Zip ____ Supervisor ____ Phone ____	From ____ To ____	Starting ____ Ending ____	
Name ____ Address ____ City/State/Zip ____ Supervisor ____ Phone ____	From ____ To ____	Starting ____ Ending ____	

If your former employment references, education or military service are under a name other than indicated on front of application, please indicate below.

____

Last First Middle Initial

Have you ever been convicted of a crime? ☐ Yes ☐ No If Yes, for what, when and where? ____

Conviction of a criminal offense will not necessarily preclude your employment.

Use this space to give us further information which will assist us in placing you, including at least two personal references not related to you, whom you have known at least one year.

____

____

____

____

Do Not Answer Questions In This Area - To Be Completed After Employed

Date of Birth ____ Marital Status ____ Sex ____ Nationality ____ Number and Ages of Children ____

Notify In Case of Emergency:

____

Name Relationship

____

Street City State Zip Code Telephone

What Language(s) (Other than English) Do You Speak? ____

Employment Understanding (Please Read and Sign)

This institution does not discriminate in hiring or any other decision on the basis of race, color, sex, citizenship, national origin, ancestry, Vietnam era veteran status, or on the basis of age or physical or mental disability unrelated to ability to perform the work required. No question on this application is intended to secure information to be used for such discrimination.

I voluntarily give this institution the right to make a thorough investigation of my past employment and activities, agree to cooperate in such investigation and release from all liability or responsibility all persons, companies or corporations supplying such information. I consent to take the physical examination, and such future physical examinations as may be required by this institution at such times and places as the institution shall designate. I understand that an offer of employment may be contingent on passing the physical examination which relates to the essential duties I would be required to perform.

I understand that my employment is at will, and that either party is free to terminate the employment relationship at any time without cause. I also understand that my employment may be terminated for any misstatement or omission of fact appearing on this application form.

If employed, I will be required to complete an Employment Verification Form (I-9), and within three days show satisfactory evidence of identity and eligibility for employment.

Applicant's Signature _____ Date _____

Please Indicate Days and Hours You Are Available For Work (Be Specific)

Day	From	To
Sunday	A.M.	A.M.
	P.M.	P.M.
Monday	A.M.	A.M.
	P.M.	P.M.
Tuesday	A.M.	A.M.
	P.M.	P.M.
Wednesday	A.M.	A.M.
	P.M.	P.M.
Thursday	A.M.	A.M.
	P.M.	P.M.
Friday	A.M.	A.M.
	P.M.	P.M.
Saturday	A.M.	A.M.
	P.M.	P.M.

Availability Record

Primary position desired _____

Will you accept another position? ❑ Yes ❑ No

If so, what? _____

Are you available to work:
Weekends? ❑ Yes ❑ No
Holidays? ❑ Yes ❑ No
Rotating Shifts? ❑ Yes ❑ No

Do you limit your annual earnings due to Social Security or other reasons?

❑ Yes ❑ No

If yes, please state what is the maximum amount you wish to earn _____

If your availability changes, it is your responsibility to fill in an "Availability Card" indicating the changes. Such changes will be effective, then, for any future employment.

I understand that emergency conditions may require me to temporarily work shifts other than the one for which I am applying and agree to such scheduling change as directed by my department head or administrator of this institution.

Applicant's Signature _____ Date _____

This Page For Institution and Interviewers' Use Only

Interviewers Comments		
Interviewer	**Date**	**Comments**

Reference and Prior Employment Check		
Individual Contacted	**Name of Firm**	**Results of Check**

For Personnel Office Use

Hired _____ For what department _____ Position _____

Salary _____ per Year / Month / Hour Starting Date _____

NOTICE

The Iosco County Medical Care Facility is a DRUG FREE WORKPLACE.

It is the policy of the Iosco County Medical Care Facility to perform DRUG SCREENING on all candidates for employment. Failure to submit for drug screening will prevent you from being considered for employment.

All costs associated with drug screening will be taken care of by the Iosco County Medical Care Facility.

The Iosco County Medical Care Facility utilizes the services of the Harbor Health Clinic for drug screening. Once we have reviewed your application for employment and made the decision to offer you employment we will schedule you for drug screening. Failure on your part to submit for drug screening on your scheduled date and time will eliminate you from being considered for employment.

Results of drug screening are kept confidential and are only shared with those facility personnel responsible for hiring you. If you're taking a prescription drug at the time you are being considered for employment it is your responsibility to keep us informed. You will not be penalized for taking prescription drugs that are legally obtained.

You will be asked to sign a declaration of consent giving the Iosco County Medical Care Facility permission to conduct the drug screening. Failure to give us permission to conduct drug screening will eliminate you from being considered for employment.

ATTENTION: Applicant for Employment

The section of your employment application that asks if you have ever been convicted of a crime includes misdemeanors. Please answer this section truthfully. The Medical Care Facility performs criminal background checks on all applicants for employment.

POLICY

The Iosco County Medical Care Facility will not employ those individuals who make false and/or misleading statements on their employment application.

Thomas D. Meyer
For the Board of Directors

6/15/04
Date

St. Joseph Health System
110 Beech #A P.O. Box 489
Tawas City, MI 48764-0489
Ph # 989-362-9406 Fax 989-362-9494

AUTHORIZATION FOR TREATMENT & BILLING

Applicant or Employee: _____
Last Name First Name

Employer Iosco County Medical Care Facility

Employer Address 1201 Harris Ave. Tawas City, MI 48763
Street City/State Zip Code

Phone Number (989) 362-4424

You have been authorized to be seen for:

- ☐ Work Related Injury / Illness (suspected)
- ☐ Pre-Placement Examination
- ☐ Determination of work-relatedness (Employer will pay for this examination)
- ☐ DOT Exam: ☐ New Hire ☐ Re-Certification
- ☐ Impairment Examination (Physical Exam)
- ☐ Return to work exam (for personal medical reason)
- ☐ Return to work (from lay-off)
- ☐ Biological Monitoring Exam (Exposure Cases, i.e. Lead, Asbestos, Pesticides, Heavy Metals)
- Workers Compensation Disability Evaluation
- Other _____

Photo ID required for all drug screens.

- X Pre-placement drug screen
- ☐ DOT drug screen
- ☐ Post Accident/Probable Cause DOT
- ☐ Post Accident./Probable Cause Non-DOT
- ☐ Random Drug Screen
  - ☐ DOT ☐ Non-DOT
- ☐ MRO
- ☐ Drug screen collection only
  - ☐ DOT ☐ Non-DOT
- ☐ Breath Alcohol Test
- ☐ Blood Alcohol

- ☐ Bill Employer
- ☐ Bill WC carrier
- ☐ Self Pay - Employee

Employer Authorization: Thomas D. Meyer Thomas D Meyer Administrator _____
Name (printed) Signature/Title DATE

If the patient is a "no call/no show" for a scheduled appointment, the employer will be assessed a fee of $25.00.

X _____

PATIENT CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize St. Joseph Health System Occupational Health Department for treatment and examination. I also authorize St. Joseph Health System to release any information pertaining to this specific injury or physical examination to my employer, prospective employer, or employer's insurer.

X _____

Applicant or Employee Signature Date

AGREEMENT TO NOTIFY EMPLOYER

Iosco County Medical Care Facility

Employee Name: _____

I agree, that as a condition of employment, privileges or contract, I will immediately report any **arrest, arraignment or conviction** for one or more of the criminal offenses listed below:

1. Any felony or misdemeanor that could result in my permanent exclusion from participation in Medicare and State health care programs under 42 U.S.C. 1320a-7.
2. Felony – Any felony or an attempt or conspiracy to commit any felony.
3. Misdemeanor – Any misdemeanor listed below.
   a. A misdemeanor involving abuse or neglect.
   b. A misdemeanor involving cruelty or torture.
   c. A misdemeanor involving criminal sexual conduct.
   d. A misdemeanor that involves a crime against a vulnerable adult under chapter 28A of the Michigan Penal Code, 1931 PA 328, MCL 750.145m to 750.145r.
   e. A misdemeanor that 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.
   f. A misdemeanor involving home invasion.
   g. A misdemeanor involving embezzlement.
   h. A misdemeanor involving negligent homicide.
   i. A misdemeanor involving larceny.
   j. A misdemeanor involving retail fraud in the second degree.
   k. Any other misdemeanor involving assault, fraud, theft, or the possession or delivery of a controlled substance.
   l. A misdemeanor for assault even if there was no use of a firearm or dangerous weapon and no intent to commit murder or inflict great bodily injury.
   m. A misdemeanor of retail fraud in the third degree.
   n. A misdemeanor under part 74 of the public health code, 1978 PA 368, MCL 333.7401 to 333.7461 relating to controlled substances and the possession or distribution thereof.

I also hereby consent to and authorize the Facility to conduct a background check that includes a search of state and federal abuse and neglect registries and databases, in addition to a search of state and federal criminal history records that include a fingerprint-based check, for the purposes of confirming that the reporting requirements contained in this agreement are satisfied.

I also agree to immediately report whether I become the subject of an order or disposition finding of not guilty by reason of insanity.

I further agree to immediately report being the subject of a substantiated findind of neglect, abuse, or misappropriation of property by state or federal agency pursuant to an investigation conducted in relation to a licensed nursing facility.

I understand that I must report the above events to the Administrator / Designee before reporting for my next scheduled shift or within twenty-four (24) hours, whichever is sooner.

In addition, if I have not already done so, I agree to provide the Michigan State Police with an electric set of my fingerprints as soon as possible, to be included in the automated fingerprint identification system database.

I understand that the failure to report any of the findings described above or to provide a set of my fingerprints is cause for immediate termination.

_____

PRINT NAME

_____ _____

SIGNATURE DATE

LONG TERM CARE WORKFORCE BACKGROUND CHECK APPLICATION FORM

Michigan Public Acts 27, 28 and 29 of 2006 requires that a health facility or agency that is a:

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

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 or adult foster care facility/agency until the health facility or agency conducts a criminal history check. *Hereafter, note that "clinical privileges" does not apply to adult foster care facility (AFC).*

An individual who applies for employment either as an employee or as an independent contractor or for clinical privileges with a health or adult foster 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 or adult foster 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.

Health Facility or Agency

Date: _____

Name: IOSCO COUNTY MEDICAL CARE FACILITY

License Number: 414350

The health or AFC 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. May, after completion of all relevant registry and database checks, determine that it is necessary to conditionally employ or conditionally grant clinical privileges pending the results of the state and federal fingerprint criminal history record check.
d. Must ensure that any background check information provided will only be used for the purpose of determining an individual's suitability of employment in a long-term care setting.
e. Must retain verification of compliance with background check requirements.
f. Will make the final employment decision, and will notify the applicant.

FACILITY LICENSE NUMBER 414350

Part 1 – Consent

Name of Applicant: _____

Application for:

Check One		Name of Position Type
	Employment	
	Independent Contractor	
	Clinical Privileges *(does not apply to AFC)*	

As a condition of being considered for employment or hiring:

a. I hereby consent to and authorize the health or AFC 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 search of state and federal criminal history records that include a fingerprint-based check. 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 or AFC facility/agency to be used to conduct the background check as required under Michigan Public Acts 27, 28 and 29 of 2006.

c. I hereby provide the following information necessary to conduct a criminal background check:

Drivers License or State/Canadian ID Number	Place of Birth	Date of Birth
	STATE	

Race	Height	Weight	Eye Color	Hair Color

d. I understand that the health or AFC facility/agency will make the final employment determination. I also understand that the health or AFC facility/agency may terminate the background check or determine not to hire at any stage of the process.

e. I understand that the health or AFC 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.

_____ _____

Signature of Applicant Date

FACILITY LICENSE NUMBER 414350

Part 2 – Disclosure

a. I hereby certify that I have not been convicted of a crime or offense that prohibits my employment, hire, or granting of clinical privileges in a long-term care setting as required by P.A. 27, 28 and 29 of 2006, within the applicable time period prescribed by each crime. (Request health or AFC facility/agency to provide the "legal guide" for review purposes.)

Signature of Applicant _____ Date _____

b. I hereby certify that I have not been the subject of an order or disposition under the Code of Criminal Procedure dealing with findings of "not guilty by reason of insanity" for any crime.

Signature of Applicant _____ Date _____

c. I hereby certify that I have not been the subject of a state or federal agency substantiated finding of patient or resident neglect, abuse, or misappropriation of property.

Signature of Applicant _____ Date _____

d. I hereby disclose, by listing below, all offenses for which I have been convicted, including all terms and conditions of sentencing, parole and probation therefore, 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

e. I hereby certify that I have read the "legal guide" that lists the prohibited offenses as defined in P.A. 27, 28 and 29, and that the above list of my convictions and/or substantiated findings of patient or resident neglect, abuse, or misappropriation of property (if any) is true, correct, and complete to the best of my knowledge.

Signature of Applicant _____ Date _____

FACILITY LICENSE NUMBER 414350

Part 3 – Conditional Employment

If the health or AFC facility/agency determines it necessary to employ or grant clinical privileges 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 or clinical privileges 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. Further, I understand that pursuant to Michigan Public Acts 27, 28 and 29 of 2006, I agree that as a condition of continued employment, either as an employee, independent contractor, or as an individual granted clinical privileges, I shall report in writing to the health or AFC facility/agency immediately upon being arraigned or convicted of one or more of the criminal offenses as described in the "legal guide", 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 4 – Applicant Rights

a. I understand that upon my request, the health or AFC facility/agency must 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 record information found on any relevant registry or database is inaccurate, that it is my responsibility to correct the record information by directly contacting the appropriate registry/database owner.
c. I understand that if I believe the results of the criminal history fingerprint record is 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 to the appropriate state licensing or regulatory department.

Signature of Applicant _____ Date _____

Part 5 – Disclaimer

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