

# EMPLOYMENT APPLICATION

We are an Equal Opportunity Employer and do not discriminate on the basis of race, color, religion, sex, national origin, age, disability, genetic information, veteran status, or any other protected status under applicable law.

## APPLICATION INSTRUCTIONS

- Please complete all required fields marked with (\*). Incomplete applications may not be considered.
- You may attach a resume; however, completion of the employment history is required.
- See attached documents: *Ineligible Persons (OMCF Form 9-37)*, *Pre-Employment Drug Screen Consent (OMCF Form 9-38)*, and *Michigan Workforce Background Check Consent & Disclosure*. Complete both consent form and submit with your application.
- Applications are considered valid for 90 days from date of applicant's signature.
- If you need assistance or accommodation to complete this application, please contact: Diane Swider, Human Resources Manager, at [dswider@oakviewmcf.com](mailto:dswider@oakviewmcf.com) or 231.845.5185 x239.

POSITION INFORMATION	
Position(s) Applied For:*	
Department:	
Employment Type:	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Pool
Shift Preference:	<input type="checkbox"/> Days <input type="checkbox"/> Evenings <input type="checkbox"/> Nights <input type="checkbox"/> Rotating
Days Available:	<input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun
Can you work overtime, including weekends?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
Available Start Date:*	
Desired Hourly Rate:	
APPLICANT INFORMATION	
Full Name:*	
Phone Number:*	
Email Address:*	
Address:*	
City/State/Zip of Residence:*	
How long have you lived at the above address?*	
REFERRAL SOURCE & RELATIONSHIP DISCLOSURES	
How did you hear about this position?	<input type="checkbox"/> Advertisement <input type="checkbox"/> Website <input type="checkbox"/> Referring Employee:
Do you know anyone who works at Oakview?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, provide names and relationship:	
Are you related to anyone who currently works at Oakview?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, provide names and relationship:	
WORK AUTHORIZATION	
Are you legally authorized to work in the United States?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, provide document title and number:	
EMPLOYMENT ELIGIBILITY	
Are you at least 18 years of age?*	<input type="checkbox"/> Yes <input type="checkbox"/> No

HEALTHCARE COMPLIANCE SCREENING			
Have you ever been convicted of a felony offense?*			<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been excluded from participation in Medicare, Medicaid, or any federal/state healthcare program?*			<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a finding of abuse, neglect, or misappropriation of resident property?*			<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you listed on any state or federal exclusion registry (e.g., OIG, SAM)?*			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes to any of the above, please explain. Include dates and locations of all felony convictions:			
EDUCATION			
School Name	Location	Diploma/Degree/Certification	Completed?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
LICENSES & CERTIFICATIONS (if applicable)			
License/Certification	State	License Number	Expiration Date
SKILLS & QUALIFICATIONS			
<b>Check all that apply:</b>		<b>Other relevant skills:</b>	
<input type="checkbox"/> Electronic Medical Records (EMR) Experience <input type="checkbox"/> Medication Administration (licensed staff) <input type="checkbox"/> Dementia Care Experience <input type="checkbox"/> CPR Certification <input type="checkbox"/> Infection Control Practices <input type="checkbox"/> Lifting/Transferring Assistance Experience			
ESSENTIAL JOB FUNCTIONS (ADA Statement)			
Can you perform the essential functions of the position for which you are applying, with or without reasonable accommodation?*			<input type="checkbox"/> Yes <input type="checkbox"/> No
EMPLOYMENT HISTORY			
Are you currently employed?*			<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you previously worked at Oakview?*			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, provide dates and supervisor:			
Have you ever been terminated or asked to resign by an employer?*			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, provide company names and contacts:			

# EMPLOYMENT APPLICATION

<b>EMPLOYMENT HISTORY (continued)</b>				
<i>List your last 3 positions or last 10 years of employment history chronologically starting with most recent:</i>				
<b>Current or Most Recent Employer</b>				
Employer Name:*				
Job Title:*				
Dates Employed:*	From:		To:	
Salary History:	Starting:		Ending:	
Supervisor Name & Title				
Employer Phone:				
May we contact this employer?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Primary Duties (brief description):				
Reason for Leaving:				
<b>Previous Employer</b>				
Employer Name:*				
Job Title:*				
Dates Employed:*	From:		To:	
Salary History:	Starting:		Ending:	
Supervisor Name & Title				
Employer Phone:				
May we contact this employer?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Primary Duties (brief description):				
Reason for Leaving:				
<b>Previous Employer</b>				
Employer Name:*				
Job Title:*				
Dates Employed:*	From:		To:	
Salary History:	Starting:		Ending:	
Supervisor Name & Title				
Employer Phone:				
May we contact this employer?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Primary Duties (brief description):				
Reason for Leaving:				

# EMPLOYMENT APPLICATION

REFERENCES				
Name	Relationship	Phone	Email	Years Known

DRIVING POSITIONS ONLY	
Do you have a valid driver's license?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Driver's License Number:	
License Class:	
Has your driver's license been suspended or revoked in the last 3 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain:	

APPLICANT CERTIFICATION & ACKNOWLEDGEMENT	
<p>I certify that the information provided in this application is true and complete to the best of my knowledge. I understand that any falsification, omission, or misrepresentation of information may result in disqualification from employment or termination if discovered after hire.</p> <p>I authorize the employer to verify my employment history, education, and credentials. I understand that an offer of employment may be contingent upon successful completion of background screening, reference checks, and other pre-employment requirements in accordance with applicable laws.</p> <p>I understand that this application does not constitute a contract of employment. If hired, my employment will be <b>at-will</b>, meaning that either I or the employer may terminate employment at any time, with or without cause or notice, unless otherwise required by law.</p>	
Applicant Signature:*	Date:*

**Ineligible Person.** An individual is prohibited from working at a long-term health care facility such as Oakview Medical Care Facility or other nursing home if the individual is:

- (1) Currently excluded, suspended, debarred, or otherwise ineligible to participate in Federally funded healthcare programs, or;
- (2) Has been convicted of a criminal offense that falls within the scope of 42 USC 1320a-7(a) but has not yet been excluded, debarred, suspended or otherwise declared ineligible.

**Disqualifications.** Under Michigan Public Health Code Act 368, MCL 333.20173, the convictions and findings listed below may disqualify an individual. However, if a specified period has passed since the person completed all terms of the sentence, parole, and probation before applying for employment or clinical privileges, or before entering into an independent contract, the person may no longer be barred from working in a covered long-term care setting. The required waiting period depends on the nature of the offense, as described below.

Minimum Disqualification Time Period	Types of Conviction
<b>Lifetime Ban</b>	<ul style="list-style-type: none"> <li>• Felonies related to manufacture, distribution, prescription or dispensing a controlled substance after August 21, 1996</li> <li>• Felony or misdemeanor patient abuse</li> <li>• Felony health care fraud</li> <li>• Ever found not guilty by reason of insanity</li> <li>• Ever had a finding of abuse, neglect, or misappropriation of property in a nursing facility (non- criminal finding)</li> </ul>
<b>15 Years</b> after Completion of Parole or Probation	<ul style="list-style-type: none"> <li>• Felonies resulting or intended to result in death or serious injury, e.g. assault with intent to do great bodily injury</li> <li>• Felonies involving:               <ul style="list-style-type: none"> <li>○ Use or threat of violence, e.g. felonious assault</li> <li>○ Cruelty or torture</li> <li>○ Abuse of vulnerable adults, e.g. elder abuse</li> <li>○ Criminal sexual conduct (1st, 2nd or 3rd degree)</li> <li>○ Abuse or neglect, e.g. child abuse</li> <li>○ Use of firearm or dangerous weapon, e.g. armed robbery</li> <li>○ Diversion or adulteration of medication, e.g. forging drug prescriptions</li> </ul> </li> </ul>
<b>10 Years</b> after Completion of Parole or Probation	<ul style="list-style-type: none"> <li>• Any other felony</li> </ul>
<b>10 Years</b> From Date of Conviction	<ul style="list-style-type: none"> <li>• Misdemeanors involving:               <ul style="list-style-type: none"> <li>○ Use or threat of violence</li> <li>○ Use of firearm or dangerous weapon</li> <li>○ Abuse of vulnerable adults, e.g. misdemeanor elder abuse</li> <li>○ Criminal sexual conduct (4th degree)</li> <li>○ Cruelty or torture</li> </ul> </li> <li>• Abuse or neglect</li> </ul>
<b>5 Years</b> from Date of Conviction	<ul style="list-style-type: none"> <li>• Misdemeanors:               <ul style="list-style-type: none"> <li>○ Involving cruelty if committed by an individual under age of 16</li> <li>○ Home invasion, e.g. breaking and entering</li> <li>○ Embezzlement</li> <li>○ Negligent homicide</li> <li>○ Most theft offenses</li> <li>○ 2<sup>nd</sup> degree retail fraud (shoplifting)</li> <li>○ Certain controlled substance offenses</li> </ul> </li> <li>• Most involving fraud</li> </ul>
<b>3 Years</b> from Date of Conviction	<ul style="list-style-type: none"> <li>• Misdemeanor assaults</li> <li>• 3<sup>rd</sup> degree retail fraud (shoplifting)</li> <li>• Most misdemeanors involving creation, deliver, possession or use of a controlled substance</li> </ul>
<b>1 Year</b> from Date of Conviction	<ul style="list-style-type: none"> <li>• Most misdemeanor controlled substance offenses if conviction occurred before age of 18</li> <li>• Misdemeanor larceny or retail fraud in 2<sup>nd</sup> and 3<sup>rd</sup> degree if conviction occurred before age of 16</li> </ul>





## MICHIGAN WORKFORCE BACKGROUND CHECK CONSENT AND DISCLOSURE

MCL 333.20173a, MCL 330.1134a, and MCL 400.734b require that a health facility/agency that is a:

- Nursing Home
- Hospice
- Home for the Aged
- Adult Foster Care Facility (AFC)
- County Medical Care Facility
- Hospital that provides Swing Bed Services
- Home Health Agency
- Psychiatric Hospital/Inpatient Unit

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 covered health care facility/agency or AFC.
- 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 and State Police.
- b. 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 400.734b.
- c. 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 400.734b or the release of criminal history record information for the purposes of making an employment decision.
- d. 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.
- e. 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.
- f. I agree to provide the information necessary to conduct a criminal background check.
- g. Privacy Act Statement:
  - a. Authority: Acquisition, preservation, and exchange of fingerprints and associated information by the Federal Bureau of Investigation (FBI) is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.
  - b. Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

c. Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine Uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

h. Procedure to Obtain a Change, Correction or Update of Identification Records:

If, after reviewing his/her identification record, the subject thereof believes that it is incorrect or incomplete in any respect and wishes changes, corrections, or updating of the alleged deficiency; he/she should make application directly to the agency which contributed the questioned information. The subject of a record may also direct his/her challenge as to the accuracy or completeness of any entry on his/her record to the FBI, Criminal Justice Information Services (CJIS) Division, ATTN: SCU, Mod. D2, 1000 Custer Hollow Road, Clarksburg, WV 26306. The FBI will then forward the challenge to the agency which submitted the data requesting that agency to verify or correct the challenged entry. Upon the receipt of an official communication directly from the agency which contributed the original information, the FBI CJIS Division will make any changes necessary in accordance with the information supplied by that agency. (28 CFR § 16.34)

i. Consent:

I understand that my personal information and biometric data being submitted by Live Scan, will be used to search against identification records from both the Michigan State Police (MSP) and the FBI for the purpose listed above. I hereby authorize the release of my personal information for such purposes and release of any records found to the authorized requesting agency listed above.

\_\_\_\_\_  
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: \_\_\_\_\_

(Please use back of form or attach additional sheets if needed to report all other/alias names used)

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
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

**ADDRESS**

Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Driver’s License or State/Canadian ID Number: \_\_\_\_\_  
State/Prov. License/ID Number

**RESIDENCY**

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

Job Title: \_\_\_\_\_ Conditional Hire Date: \_\_\_\_\_

**PROFESSIONAL LICENSE(S)/CERTIFICATION(S)**

- 1. License/Certification Number: \_\_\_\_\_
- 2. License/Certification Number: \_\_\_\_\_
- 3. License/Certification Number: \_\_\_\_\_

**Part 3 – Employment Applicant Disclosure Statements**

MCL 333.20173a, MCL 330.1134a, and MCL 400.734b, subsections (1)(a) through (g) describe crimes for which a conviction during the applicable time period will disqualify a person from being employed by, independently contracting with, or being granted clinical privileges in a covered health care facility/agency or AFC.

The above laws define “conviction” as, “... a final conviction, the payment of a fine, a plea of guilty or nolo contendere (no contest) if accepted by the court, or a finding of guilt for a criminal law violation or a juvenile adjudication or disposition by the juvenile division of probate court or family division of circuit court for a violation that if committed by an adult would be a crime.” For relevant crimes described under 42-USC 1320a-7(a), convicted means that term as defined in 42-USC 1320a-7. These definitions may include cases that resulted in an alternative sentencing agreement, including deferred or delayed sentences, and for relevant crimes under 42-USC 1320a-(7)(a), convictions which may have been expunged or set aside.

I hereby certify that:

- a. I have not been convicted of 1 or more of the crimes described in subsection (1)(a) through (g) of MCL 333.20173a, MCL 330.1134a, or MCL 400.734b within the applicable time period described in each subdivision. Initial \_\_\_\_\_ Date \_\_\_\_\_
- b. I have never been found Not Guilty by Reason of Insanity. Initial \_\_\_\_\_ Date \_\_\_\_\_
- c. I have never been the subject of a substantiated finding of neglect, abuse, or misappropriation of property resulting from an investigation conducted in accordance with 42 USC 1395i or 1396r. Initial \_\_\_\_\_ Date \_\_\_\_\_

If you are not able to certify a, b, or c above, please explain below:

Offense/Finding	Date	City, State	Sentence	Discharge Date

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 of more of the criminal offenses as described in MCL 333.20173a, MCL 330.1134a, and MCL 400.734b, 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 of 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.

\_\_\_\_\_  
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.

**THIS FORM MUST BE MAINTAINED IN THE APPLICANT FILE AND SHALL BE MADE AVAILABLE TO THE DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS UPON REQUEST.**

If you are concerned about maintaining personal information in the file, you may only black out the following information as all additional information is required by Michigan State Police:

**Social Security Number**  
**Address**  
**Driver's License Number**

**Telephone Number**  
**Email Address**  
**Professional License/Certification Number(s)**