520 Main Street, Manistique MI 49854
Phone: 906-341-6921 Fax: 906-341-6213

Applicant Information

Name: ______________________________ Preferred Name: ______________

Present Address: ______________________________ Phone Number: ______________

Permanent Address if different: ______________________________

Education/Training

School	Name of School	Courses Taken	Graduated?	Certificate Received?
High School				
College				
Other				

Other Classes/Trainings: ______________________________

Honors Received, Volunteer or Community Service Activities: ______________________________

____

Desired Position

Type of Work Desired	Shift	Salary

How did you learn of this position? ______________________ Date Available______________

Will you accept another position? ☐ Yes ☐ No If so, what? ______________________

Type of Employment Preferred: _______ Full Time _______ Part Time _______ Temporary

Please indicate if there are any Days or Hours that you are not able to work (Be Specific – certain times on certain days, already pre-scheduled vacations, any upcoming events you will need off): ______________

____

____

Are you available to work:

Weekends ☐ Yes ☐ No Holidays ☐ Yes ☐ No

Rotating Shifts ☐ Yes ☐ No On Call ☐ Yes ☐ No

Employment History

List Current (or most recent) employer first.

Company Name	
Dates Employed (From – To)	
Full Address, City, State	
Phone Number	
Position Title	
Responsibilities	
Supervisor Name	
May we contact for a reference?	

Company Name	
Dates Employed (From – To)	
Full Address, City, State	
Phone Number	
Position Title	
Responsibilities	
Supervisor Name	
May we contact for a reference?	

Company Name	
Dates Employed (From – To)	
Full Address, City, State	
Phone Number	
Position Title	
Responsibilities	
Supervisor Name	
May we contact for a reference?	

Company Name	
Dates Employed (From – To)	
Full Address, City, State	
Phone Number	
Position Title	
Responsibilities	
Supervisor Name	
May we contact for a reference?	

Have you ever been convicted of a crime? If so, for what, when and where? ______________________

____

Under Michigan Law, some convictions may limit eligibility to work in a skilled nursing facility. If any conviction is listed above, please provide any additional information. ______________________

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Professional License and/or Certifications

Type	Issued By	Date Issued	Number

Military Record

Military Branch	Rank	Separation Date	Specialty

Specialized Training, Service Awards, Commendations: ______________________

____

References

Please list 3 References – please include a Professional Reference

Name/Relationship	Title	Company Name	Phone Number

I understand that certain 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. If my availability status changes, it is my responsibility to notify my department head or the administrator. Such changes will be effective for any continuing or future employment. I consent to Schoolcraft Medical Care Facility investigating my past employment and activities, and I agree to cooperate in such investigations. I further release from all liability or responsibility all persons, companies or corporations supplying such information. I understand that employment with Schoolcraft Medical Care Facility requires a background investigation which may include but not be limited to past employment, activities, education, criminal investigation, and finger-printing as required by state or federal law. I consent to take a physical examination which relates solely to my ability to perform the essential functions of my position. This consent includes drug screening or future physical examinations as may be required by Schoolcraft Medical Care Facility at such times and places as the institution shall designate. I understand that any offer of employment may be contingent on passing a required physical examination and drug screening. I 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 (1-9), and within three days show satisfactory evidence of identity and eligibility for employment.

Applicant Signature: ______________________ Date: ______________

State of Michigan
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
DEPARTMENT OF HUMAN SERVICES

Long Term Care Workforce Background Check Consent and Disclosure

MCL 333.20173a, MCL330.1134a, and MCL 440.734b require that a health facility/agency that is a:

- Physchiatric Facility
- ICF/MR
- Nursing Home
- County Medical Care Facility
- Adult Foster Care Facility (ACF)
- Hospital providing swing bed services
- Home for 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: Schoolcraft Medical Care Facility (MCF) License: SCMCF 107000326

Employment Applicant Name: ______________________________ Date: ____________________

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.

Consent to Conduct Background and Criminal Record Check

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

The Michigan Department of Licensing & Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. You may make your needs known to this Agency under the Americans with Disabilities Act if you need assistance with reading, writing, hearing, etc.

Information for Background Check Process – Please fill out completely.

Employee Personal Information

First Name	
Middle Name	
Last Name	

Other Name (s) Used (Maiden Name, Alias)

First Name	
Middle Name	
Last Name	

Suffix	

Place of Birth (City):	State:
Height:	Weight:
Hair Color:	Eye Color:
Gender: ☐ Female ☐ Male	Race:
Social Security Number:	DOB:

Address

Street Address:	City:
State:	Zip:
Phone:	Conditional Hire Date:
Drivers License State:	Drivers License Number:

Professional License (s) /Certification (s)

License/Certification Number:	
License/Certification Number:	
License/Certification Number:	

Employment Application 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.

A. Felony – Any felony, or an attempt or conspiracy to commit any felony.
B. Misdemeanor - Any state or federal crime that is substantially similar to the misdemeanors described:
   a. 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.
   b. 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.
   c. Any misdemeanor involving criminal sexual conduct.
   d. Any misdemeanor involving abuse or neglect, torture, or cruelty.
   e. Any misdemeanor involving home invasion.
   f. Any misdemeanor involving embezzlement, larceny, fraud, theft or second or third degree retail fraud.
   g. Any misdemeanor involving negligent homicide.
   h. Any misdemeanor involving the possession, use or delivery of a controlled substance.
   i. Any misdemeanor involving the creation, delivery, or possession with intent to manufacture or deliver a controlled substance.

C. Any finding of Not Guilty by Reason of Insanity
D. 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 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 all PENDING FELONY charges currently alleged against me.

Offense	Date of Conviction	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 ____________________

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

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

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.

Fillable Records Release

520 Main Street, Manistique MI 49854
Phone: 906-341-6921 Fax: 906-341-6213

INFORMATION/RECORDS RELEASE

hereby certify that I give permission for disclosure of information affecting my past employment and any and all law enforcement records which pertain to my honesty, drug use, abuse and neglect of an individual and abuse or neglect of an employment position or title.

It is my understanding that any information obtained by the Schoolcraft County Medical Care Facility will be held in the strictest of confidence and in compliance with state and federal law.

This release includes permission to retrieve all vaccination records from Michigan Care Improvement Registry (MCIR), the Veterans' Administration, or any other state or federal agency which gathers vaccination information and records.

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Printed Name:

____

Signature of Applicant:

____

Date: