

MAPLE MANOR REHAB CENTER
3999 VENOY ROAD WAYNE, MI 48184
734-727-0440

MAPLE MANOR REHAB CENTER
31215 NOVI ROAD, NOVI MI 48377
(248) 626-1114

APPLICATION FOR EMPLOYMENT

Equal Opportunity Employer - This facility does not discriminate on the basis of race, color, religion, national origin or ancestry, handicap or disability, sex, marital status, obligation to serve in the armed forces of the United States, or citizenship in admission or access to or treatment or employment in its programs and activities. This facility will coordinate efforts to comply with all agencies enforced by EEOC.

What MAPLE MANOR facility are you applying for? NOVI _____ WAYNE _____ HOWELL _____

Today's Date: _____ Date of Birth: _____

Name: _____ Social Security No. _____
Last _____ First _____ Middle _____

Address _____ Tel. No. () _____

City _____ State _____ Zip Code _____ Email: _____

Position(s) applied for: _____ Salary desired: _____

Are you applying for: Full-time Part-time Contingent Contract Labor Summer Employment

If seeking part-time work, specify the number of days per week _____

How soon will you be available for employment? _____

Shift preference (check one)	If preferred shift is unavailable, will you work?	If required, will you work?
Day _____	Day Yes _____ No _____	Saturdays Yes _____ No _____
Evening _____	Evening Yes _____ No _____	Sundays Yes _____ No _____
Night _____	Night Yes _____ No _____	Holidays Yes _____ No _____
		Rotating Shifts Yes _____ No _____

Are you either a US citizen or an Alien who has the legal right to work in the job(s) for which you are applying?

Yes _____ No _____

Are you 18 or older? Yes _____ No _____

Have you ever been convicted of any felony other than a minor traffic violation? Yes _____ No _____

To help us evaluate your application, please describe the nature of felony and your subsequent rehabilitation.

Have you ever been disciplined for resident abuse? Yes _____ No _____

Have you ever been disciplined for child abuse? Yes _____ No _____

Do you have relatives or friends employed at this company? Yes _____ No _____ Have you ever been employed by this company? Yes _____ No _____

If yes, dates, position and department employed. _____

Have you ever applied at this company or affiliate before? Yes _____

Are you interested in: _____ Skilled/Rehab _____ Therapy _____ Assisted Living _____ Home Health Care _____
Dietary _____ Housekeeping/Laundry _____ Maintenance _____ Admin _____ Other _____

Are you or a friend interested in our school Avanti Career Institute which has a 12 day course to be a certified nurse's assistant? Yes _____ No _____

Are you or a friend interested in working for our company Avanti Home Health Care where you can earn extra income by following your patients home? Yes _____ No _____

How were you referred? Newspaper Ad _____ Friends/Relative _____ Job Fair _____ Employee _____ Other _____

Beginning with your current or last employer, list the last four positions or employment held by date.

Name of Employer			Telephone Number
Address	City	State	Zip Code
When may this employer be contacted? Now _____ After offer of employment		Name and Title of Supervisor	
Dates From _____ To _____	Hours / Week	Position held	
Starting Salary	Ending Salary	Reason for Leaving	
Duties			

Name of Employer			Telephone Number
Address	City	State	Zip Code
When may this employer be contacted? Now _____ After offer of employment		Name and Title of Supervisor	
Dates From _____ To _____	Hours / Week	Position held	
Starting Salary	Ending Salary	Reason for Leaving	
Duties			

Name of Employer			Telephone Number
Address	City	State	Zip Code
When may this employer be contacted? Now _____ After offer of employment		Name and Title of Supervisor	
Dates From _____ To _____	Hours / Week	Position held	
Starting Salary	Ending Salary	Reason for Leaving	
Duties			

Name of Employer			Telephone Number
Address	City	State	Zip Code
When may this employer be contacted? Now _____ After offer of employment		Name and Title of Supervisor	
Dates From _____ To _____	Hours / Week	Position held	
Starting Salary	Ending Salary	Reason for Leaving	
Duties			

RECORD OF EDUCATION

School	Name and Address	Course of Study	Circle Last Year Completed	List Diploma, Degree(s) Obtained
High School			1 2 3 4	
College(s)			1 2 3 4 5 6 7 8	
Other				

LANGUAGE SKILLS: (Other Than English)

Please identify other languages that you Speak _____ Write _____ Read _____
 Computer software skills _____ Typing approximate WPM _____
 Other Special Skills _____

PROFESSIONAL LICENSES AND / OR CERTIFICATIONS

Currently Registered No. _____ Licensed No. _____ Certified No. _____

IF LICENSED, REGISTERED, OR CERTIFIED

Type	No.	State Issued	Date Issued	Expiration

REFERENCES

Professional References Only. (References should not be friends, relatives, or clergy.)

Name	Address	Telephone	Relationship

Can you provide any Letters of Recommendation? Yes _____ No _____

QUESTION (Response Required) Why Should We Hire You? What Can You Contribute to the Company? _____

REFERENCE VERIFICATION / RECORD INFORMATION RELEASE

<input type="checkbox"/> Phone <input type="checkbox"/> Mail	Date Mailed / Called	By Whom
--	----------------------	---------

To Whom It May Concern:

I have applied to **MAPLE MANOR REHAB CENTER** for employment. To enable **MAPLE MANOR REHAB CENTER** to properly evaluate my qualifications, I request and authorize you to release and furnish to **MAPLE MANOR REHAB CENTER** any and all information in your record or files, or within your knowledge, concerning my present and/or past employment with you. I authorize all persons, schools, current employer, previous employers, and/ or organizations named in this application or provided by me to the facility, to provide this facility with any relevant information that may be requested by the facility. I also hereby indemnify, waive, discharge and release all parties seeking and providing information from any and all claims, liability, damage or loss whatsoever that may result from this information's release, disclosure, maintenance, or use.

Signature of Applicant

Date

Printed Name of Applicant

Other Name(s) while employed

Social Security Number

COMPANY NAME: **MAPLE MANOR REHAB CENTER**

In consideration of my employment I agree to conform to all of the rules, and regulations and employee handbook of this facility and I agree that my employment and compensation can be terminated, with or without cause, and with or without notice, at any time, for any reason, at the option of either this facility or myself. I also understand and agree that the company rules, handbook terms and conditions of my employment may be changed, with or without cause, and with or without notice, at any time by this facility. I understand that no employee, owner or representative of this facility, has any authority to enter into any agreement for employment for any specified period of time, unless the agreement is signed in writing by the owner. I certify that I have read and understand the foregoing paragraphs. I further certify that all the information submitted by me on the application is true and complete to the best of my knowledge, and I understand that any false information, omissions, or misrepresentations of facts called for on this application may be cause for the denial of my application or, if I am employed, may cause my discharge at any time. As a condition of my employment, and continued employment, I agree not to file any action or suit relating to any employment. For any and all claims, grievances or disputes, I understand that my sole and exclusive recourse is to resign and seek employment elsewhere since I am an employee at will, since I have the ability to leave at anytime, and since I have no vested rights, interests, or entitlements. I indemnify, release, waive, discharge and hold my Employer harmless for any past, present or future claims. I warrant and represent I have no right to sue or file any kind of complaint, claim or charge for any reason whatsoever with any court or government agency. To the extent any claim may be filed, I further understand that such claim must be filed within thirty days after the event actually occurs and I hereby waive any state or federal statute of limitation to the contrary and I also waive the possibility of extending such the thirty day statute of limitation period under the continuing violation doctrine. As a condition of employment, I hereby consent to testing for drug and alcohol use, as determined to be appropriate by management, either before being hired or at any time during my employment with this facility.

Date _____ Signature _____

TO BE COMPLETED BY EMPLOYEE

Date of Birth	Maiden Name (if applicable)				
Person to notify in case of emergency			Relationship		
Address	City	State	Zip Code	Area Code	Telephone Number



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:

- 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.
- May terminate the background check or decide not to hire the individual at any stage of the process.
- 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.
- Must retain verification of compliance with background check requirements.
- 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 Unknown

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 or 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

1. 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.
2. 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.
3. 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.
4. As an applicant who is the subject of a national fingerprint-based criminal history record check for a noncriminal justice purpose (such as an application for employment or a license, an immigration or naturalization matter, security clearance, or adoption), you have certain rights which are discussed below. All notices must be provided to you in writing. These obligations are pursuant to the Privacy Act of 1974, Title 5, United States Code (U.S.C.) Section 552a, and Title 28 Code of Federal Regulations (CFR), 50.12, among other authorities.
 - You must be provided an adequate written FBI Privacy Act Statement (dated 2013 or later) when you submit your fingerprints and associated personal information. This Privacy Act Statement must explain the authority for collecting your fingerprints and associated information and whether your fingerprints and associated information will be searched, shared, or retained.
 - You must be advised in writing of the procedures for obtaining a change, correction, or update of your FBI criminal history record as set forth at 28 CFR 16.34.
 - You must be provided the opportunity to complete or challenge the accuracy of the information in your FBI criminal history record (if you have such a record).
 - If you have a criminal history record, you should be afforded a reasonable amount of time to correct or complete the record (or decline to do so) before the officials deny you the employment, license, or other benefit based on information in the FBI criminal history record.

- If agency policy permits, the officials may provide you with a copy of your FBI criminal history record for review and possible challenge. If agency policy does not permit it to provide you a copy of the record, you may obtain a copy of the record by submitting fingerprints and a fee to the FBI. Information regarding this process may be obtained at <https://www.fbi.gov/services/cjis/identity-history-summary-checks> and <https://www.edo.cjis.gov>.
- If you decide to challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI by submitting a request via <https://www.edo.cjis.gov>. The FBI will then forward your challenge to the agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency. (See 28 CFR 16.30 through 16.34.)
- You have the right to expect that officials receiving the results of the criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.

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

Telephone Number

Address

Email Address

Driver's License Number

Professional License/Certification Number(s)

MAPLE MANOR REHAB CENTER - EMPLOYMENT VERIFICATION

To Be Filled Out By Applicant:

As a condition of being considered for employment, I acknowledge that representatives of Maple Manor will contact the references/previous employers to inquire about my employment history, character and qualifications.

Applicant Name: _____ **Position Applying for:** _____

I hereby authorize the following information to be released for all previous employers listed. I release you and all persons and organizations from all claims and liabilities of any nature from any information given.

Applicant's Signature: _____ **Date:** _____

To Be Filled Out By Applicant:

We would like to verify employment for this individual who applied for a job with our company. In order for us to process this application, we would like you to complete this form. Above is the applicant's authorization to release information.

Name of Previous Employer: _____

Please complete the following:

Currently Employed	YES / NO	Employee was dependable?	YES / NO
Eligible for Rehire	YES / NO	Employee was cooperative?	YES / NO
Dates of Employment		Employee met satisfactory work requirements?	YES / NO
Position Held		Reason for separation?	

Verification Obtained From: _____ Title: _____

How long was the applicant employed? From: _____ To: _____

What was the reason for separation? _____

Please rate the candidate based on the following areas:

	Excellent	Good	Fair	Poor	Comments
Attendance					
Productivity					
Co-worker Relationships					
Quality of Work					
Initiative					
Follows Instructions					

Please fax back to: (248) 624-8810, ATTN: Human Resources. Thank you!