GRANDVUE MEDICAL CARE FACILITY
1728 South Peninsula Road
East Jordan, MI 49727
p: (231) 536-2286
f: (231) 536-2476

APPLICATION FOR EMPLOYMENT

PERSONAL INFORMATION

Name:				
Present Address:	City:	State:	ZIP:	How many years?
Previous Address:	City:	State:	ZIP:	How many years?
Phone Number:	Email:			

Are you 18 years of age or older?	◯ Yes	◯ No
Are you legally authorized to work in the United States?	◯ Yes	◯ No
Have you ever been convicted or are you presently charged with a felony? If so, where and when, and explain circumstances:	◯ Yes	◯ No

MILITARY SERVICE

U.S. Military Service:	Branch:	Dates of Service:

Were you honorably discharged?	◯ Yes	◯ No
Reserve Status:		
Specialized training and duties:		

EMPLOYMENT DESIRED

Position:	Part Time ☐ Full Time ☐	Date you can start:
Specify any days or times you are not available for work:		

Are you currently employed?	◯ Yes	◯ No
If so, may we contact your present employer?	◯ Yes	◯ No
Have you ever been employed by Grandvue?	◯ Yes	◯ No
If so, when?		
Do you have any relatives employed by Grandvue?	◯ Yes	◯ No
If so, please provide name(s):		

EMPLOYMENT HISTORY

How much time did you miss from work in the past year?		
Have you ever been discharged by an employer or resigned in lieu of discharge?	◯ Yes	◯ No
Have you ever been disciplined (other than discharge) by an employer?	◯ Yes	◯ No
If you answered yes, to any of the previous questions, explain all such incidents, giving facts, dates, describing any action you took and any resolution:		

EMPLOYMENT HISTORY *(cont.) – List your last four employers, beginning with present*

EMPLOYER'S NAME:				Dates (month and year) From	To
Street Address:	City:	State:	ZIP	Telephone:	
Supervisor (name and title)		Your Title		Wages	
Duties and Responsibilities:					
Reason for Leaving:					

EMPLOYER'S NAME:				Dates (month and year) From	To
Street Address:	City:	State:	ZIP	Telephone:	
Supervisor (name and title)		Your Title		Wages	
Duties and Responsibilities:					
Reason for Leaving:					

EMPLOYER'S NAME:				Dates (month and year) From	To
Street Address:	City:	State:	ZIP	Telephone:	
Supervisor (name and title)		Your Title		Wages	
Duties and Responsibilities:					
Reason for Leaving:					

EMPLOYER'S NAME:				Dates (month and year) From	To
Street Address:	City:	State:	ZIP	Telephone:	
Supervisor (name and title)		Your Title		Wages	
Duties and Responsibilities:					
Reason for Leaving:					

EDUCATION

Highest grade completed: _____ Grade School (1 - 8) _____ High School (9 - 12) _____ College (1 - 4)

Name of last school attended:

Vocational or trade training:

Do you hold any licenses or certificates? If so, please list:

Have you ever had any license or certification placed under investigation, disciplinary action, suspended, revoked or put on probation? ○ Yes ○ No

Have you ever been denied a license or certification? ○ Yes ○ No

If you answered yes to either of the above questions, explain in detail:

REFERENCES - *Give the names of three persons, not related to you, whom you have known at least one year.*

Name:	Business:	Years Acquainted:
Address:	Phone Number:	
Name:	Business:	Years Acquainted:
Address:	Phone Number:	
Name:	Business:	Years Acquainted:
Address:	Phone Number:	

EMERGENCY CONTACT

Name:	Relationship:
Address:	Phone Number:

VERIFICATION

I understand that I may be required to submit to a physical examination, which may include a drug test, as part of the application process and that I must satisfactorily pass such an examination before I can start to work.

I have read and fully understand the questions on this application for employment and have completely, truthfully, and accurately answered each question to the best of my knowledge. I understand that discovery of misrepresentation or omission of facts will be cause for immediate dismissal.

I authorize and request licensing boards, references, educational institutions and my former employers, to provide Grandvue Medical Care Facility with any information requested pursuant to its investigation and employment decision. I also authorize and request federal, state and local governmental agencies to release to Grandvue Medical Care Facility any information concerning any criminal convictions on my record or medical information pertinent to my potential employment.

I further understand and agree that if I am hired, unless I am covered by a union contract or other written agreement to the contrary, signed by me or on my behalf as a bargaining unit member, that my employment is at will and that it may be terminated, either by me or by Grandvue Medical Care Facility, at any time, with or without notice or cause. It is with this full understanding of Grandvue Medical Care Facility's exclusive right to make such discharge decisions, that I will accept employment offered to me.

Please sign application and consent forms and return to:

Grandvue Medical Care Facility fax: (231) 536-2476 email: jkorthase@grandvue.org
1728 S. Peninsula Road
East Jordan, MI 49727
Attn: HR

Signature of Applicant **Date**

Interviewed by **Date**

Consent to Obtain of Personally Immunization Information from the Michigan Care Improvement Registry

I understand and acknowledge that Grandvue Medical Care Facility (GMCF) is required to comply with certain regulations promulgated by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Community and Health Systems, including certain Infection Prevention and Control rules (the "Michigan Regulations"). I further understand and acknowledge that the Michigan Regulations require GMCF to adopt policies and procedures addressing a process to evaluate my vaccination status regarding certain vaccine preventable diseases, including, but not limited to, COVID-19, Hepatitis B, Influenza, MMR, Varicella, Tetanus, diphtheria, pertussis, and Meningitis. I acknowledge and understand that I must provide GMCF with information related to my vaccination status regarding those certain vaccine preventable diseases for GMCF to remain in compliance with the Michigan Regulations, and I understand that my failure to comply with this requirement may result in termination of my employment or loss of consideration of my application for employment with GMCF. I understand that GMCF, as a healthcare provider, has access to the Michigan Care Improvement Registry ("MCIR"). In lieu of providing GMCF with my vaccination status, I hereby authorize GMCF to access MCIR for the purpose of verifying my vaccination status to comply with the Michigan Regulations. I acknowledge and understand that my immunization record GMCF obtains from MCIR may contain additional information not contemplated in the Michigan Regulations. GMCF will keep all information obtained from MCIR confidential in accordance with federal, state, and local laws, rules, and regulations.

I understand that I may withdraw this consent for GMCF to access MCIR to obtain my vaccination status. If I withdraw this consent, however, I understand that I am still required to provide GMCF with my vaccination status so that GMCF can remain in compliance with the Michigan Regulations.

I hereby authorize GMCF to access my immunization record and personally identifiable information from MCIR. I understand this information will be accessed only to comply with the Michigan Regulations requiring Medicare that require GMCF to evaluate my vaccination status.

AGREED TO:

_____

Applicant Name (printed)

_____

Applicant Signature

_____

Date

PUBLIC ACT 28
Passed April 1, 2006

Public Act 28 of 2006 states that a health facility or agency that is a nursing home or county medical 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 health facilities or agencies if the individual satisfies one or more of the following:

1. He or she had been convicted of certain felonies, or an attempt or conspiracy to commit certain felonies, unless 15 years had elapsed since the individual completed all of the terms and conditions of sentencing, parole, or probation prior to application for employment or clinical privileges or the date of execution of the independent contract. Felonies prohibited within 15 years would include the following:

- A felony involving the intent to cause death or serious impairment of body function, that results in death or serious impairment of a body function, that involves the use of force or violence, or that involves the threat or the use of force or violence;
- A felony involving cruelty or torture;
- A felony against a vulnerable adult;
- A felony involving criminal sexual conduct;
- A felony involving the use of a firearm or dangerous weapon; or
- A felony involving the diversion or adulteration of a prescription drug or other medications.

2. He or she had been convicted of other felonies not listed as 15 year prohibitions, or an attempt or conspiracy to commit other felonies not listed as 15 year prohibitions felonies, unless 10 years had elapsed since the individual completed all of the terms and conditions of sentencing, parole, or probation prior to application for employment or clinical privileges or the date of execution of the independent contract.

3. He or she had been convicted of a misdemeanor that involved abuse, neglect, assault, battery, criminal sexual conduct, fraud, or theft, or a similar state or federal misdemeanor, within the 10 years immediately preceding the date of application. Misdemeanor offenses with 10 year bans would include the following:

- A 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 the use of force or violence or the threat of the use of force or violence;
- A misdemeanor against a vulnerable adult;
- A misdemeanor involving criminal sexual conduct;
- A misdemeanor involving cruelty or torture, unless less than 16 years of age at the time of conviction; or
- A misdemeanor involving abuse or neglect.

4. He or she had been convicted of the following misdemeanors or relevant federal health care fraud and abuse crime, within the 5 years immediately preceding application. Misdemeanor offenses with 5 year bans would include the following:

- A misdemeanor involving cruelty if committed before age 16 at the time of conviction;
- A misdemeanor involving home invasion;
- A misdemeanor involving embezzlement
- A misdemeanor involving negligent homicide;
- A misdemeanor involving larceny;
- A misdemeanor involving retail fraud in the second degree, unless less than 16 years of age at the time of conviction, or
- A misdemeanor involving assault, fraud, or theft, or possession or distribution of a controlled substance that is not otherwise identified by another section of the statute.

5. He or she had been convicted of the following misdemeanors within 3 years immediately preceding the date of application. Other misdemeanor offenses would include the following:

- A misdemeanor for assault if there was not use of a firearm or dangerous weapon and no intent to commit murder or inflict great bodily injury;
- A misdemeanor of retail fraud in the third degree, unless less than 16 years of age at the time of conviction; or
- Misdemeanor drug violations under the Public Health Code, unless less than 18 years of age at the time of conviction.

6. He or she had been convicted of one of the following misdemeanors within 1 year immediately preceding the date of application:

- Any misdemeanor drug violations under the Public Health Code if under the age of 18 at the time of conviction; or
- A misdemeanor for larceny or retail fraud in the second or third degree if under the age of 16 at the time of conviction.

7. He or she is the subject of an order declaring not guilty by reason of insanity under the Code of Criminal Procedure.

8. He or she had been the subject of a substantiated finding of neglect, abuse, or misappropriation of property by a state or federal agency under federal health care law.

9. He or she has ever been convicted of federal health care fraud or abuse felonies.

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

MICHIGAN WORKFORCE BACKGROUND CHECK CONSENT AND DISCLOSURE

MCL 333.20173a, MCL 330.1134a, and MCL 400.734b require that a heath 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 **Telephone Number**
Address **Email Address**
Driver's License Number **Professional License/Certification Number(s)**