

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

MAPLE MANOR REHAB CENTER
31215 NOVI ROAD, NOVI MI 48377
(248) 624-8800

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 facility are you applying for? _____ MAPLE MANOR (WAYNE) _____ MAPLE MANOR (NOVI)

Date: _____

Name: _____ Social Security No. _____
Last First Middle

Address _____ Tel. No. () _____ AM

City _____ State _____ Zip Code _____ Tel. No. () _____ PM

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 _____

PLEASE MAIL OR FAX YOUR COMPLETED APPLICATION TO:

Maple Manor Rehab Center Wayne FAX TO: # 734-727-0441 or Novi #248-624-8810 or email info@maplemanorrehab.com

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	
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Address	City	State	Zip Code
When may this employer be contacted? Now _____ After offer of employment _____		Name and Title of Supervisor	
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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			

Granting and continued employment is conditioned upon receipt of favorable references.

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
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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 or 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 AFTER EMPLOYMENT

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



LONG TERM CARE WORKFORCE BACKGROUND CHECK CONSENT AND DISCLOSURE

MCL 333.20173a, MCL 330.1134a, and MCL 440.734b require that a health facility/agency that is a:

- psychiatric facility
- ICF/MR
- nursing home
- county medical care facility
- adult foster care facility (AFC)
- hospital that provides swing bed services
- home for the 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: _____ 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 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.

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, 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

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:
Date of Birth: 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

Social Security Number:

ADDRESS

Street Address:
City: State: Zip Code: County:

Phone Number:

Job Title: Conditional Hire Date:

RESIDENCY

Driver's License or State/Canadian ID Number:
State/Prov. License/ID Number

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

PROFESSIONAL LICENSE(S)/CERTIFICATION(S)

1. License/Certification Number:
2. License/Certification Number:
3. License/Certification Number:

Part 3 – Employment Applicant 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.
- b. **Felony** – Any felony, or an attempt or conspiracy to commit any felony.
- c. **Misdemeanor** - Any state or federal crime that is substantially similar to the misdemeanors described below:
 - 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.
 - 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.
 - Any misdemeanor involving criminal sexual conduct.
 - Any misdemeanor involving abuse or neglect, torture, or cruelty.
 - Any misdemeanor involving home invasion.
 - Any misdemeanor involving embezzlement, larceny, fraud, theft or second or third degree retail fraud.
 - Any misdemeanor involving negligent homicide.
 - Any misdemeanor involving the possession, use or delivery of a controlled substance.
 - Any misdemeanor involving the creation, delivery, or possession with intent to manufacture or deliver a controlled substance.
- d. **Any finding of Not Guilty by Reason of Insanity**
- e. **A substantiated finding of patient or resident neglect, abuse, or misappropriation of property resulting from an investigation conducted in accordance with 42 USC 1395j or 1396r***

Listed below are all 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 also all PENDING FELONY charges currently alleged against me.

Offense	Date of Conviction/Finding/ Charge (if pending)	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

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 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

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 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

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.

PHYSICAL EXAM REQUIREMENT



INSTRUCTIONS:

Please call Livonia Diagnostic Center to schedule
your pre-employment physical.

Address:

Livonia Diagnostic Center
10475 Farmington Rd
Livonia, MI 48150

Phone:

(734) 427-9440

Thankyou for your prompt cooperation!