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

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.

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** ☐ **Temporary** ☐ **Regular** ☐ **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 a US citizen or Alien with the legal right to work in the job 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 _____
A felony conviction will not necessarily be a bar to employment. 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 ____No ____When? _____
Are you interested in working 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 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_____
What Facility are you applying for? _____ Maple Manor (Wayne) _____Maple Manor (Novi)

PLEASE MAIL, FAX OR EMAIL COMPLETED APPLICATION TO:
Maple Manor Rehab Center, Attn: Human Resources, 3999 Venoy Road, Wayne, MI 48184
Fax (734) 727-0441 Email: Andrea@maplemanorrehab.com

Revised 8/5/2010

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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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			

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_____, **Including sign language**_____

Area of specialization or major interest_____, **Typing approximate WPM**_____

Shorthand: Approx. WPM_____ **Word Processing:** ☐ **Yes** ☐ **No** **What word processing equipment**

are you familiar with? _____

List business, hospital, or industrial equipment operated _____

PROFESSIONAL LICENSES AND / OR CERTIFICATIONS

ARE YOU:

Currently ☐ **Registered No.** _____ ☐ **Licensed No.**_____ ☐ **Certified No.** _____

Eligible ☐ **Registration** ☐ **Licensure** ☐ **Ce**rtification

IF LICENSED, REGISTERED, OR CERTIFIED				
Type	**No.**	**State Issued**	**Date Issued**	**Expiration**

REFERENCES

(Please complete if only one or no employment references are listed. References should include persons in academic institutions, volunteer organizations, etc. not friends, relatives, or clergy.)

Name	Address	Telephone	Relationship

REFERENCE VERIFICATION

☐ Phone ☐ Mail	Date Mailed / Called	By Whom

RECORD INFORMATION RELEASE

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 release all parties seeking and providing information from any and all liability or claims for damages 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 my 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. Although I warrant and represent I have no right to sue or file any kind of complaint for any reason whatsoever, to the extent any statute of limitations may apply, I further understand that more than one hundred and eighty calendar days after the event actually occurs and I waive any state or federal statute of limitation to the contrary except those requiring shorter periods. I understand and agree that the one hundred and eighty day period or applicable shorter period will not be extended for continuing violations doctrine. Filing a charge with any administrative agency, or internally with employer, does not toll the one hundred and eighty day period for filing an action or suit. 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**

Employment Application Fee and Other Charges

Applicant acknowledges and agrees to pay for an employment application fee of **$175**, physical examination fee of **$50,** and finger print fee of **$60**. Employee authorizes these charges to be automatically deducted from his/her earned wages on the employee's last paycheck.

Maple Manor Rehab Center, Maple Manor of Wayne, and Avanti Rehab Group, and Avanti Home Health Care ("Employer") agrees to ***waive*** the application fee and physical examination fee ***if*** the Applicant is hired and remains employed and is in good standing with Employer for more than 30 days.

Employee also authorizes the following charges to be automatically deducted from his/her earned wages on the employee's paycheck if the following items are stolen, lost or damaged during the course of employment or not immediately returned upon termination: Name Tag = $**10**, Gait Belt = $**25**.

_____ _____

Applicant Name Date Employer Date

REVISED 10/1/2007

Michigan Department of Community Health
MDCH
Jennifer M. Granholm, Governor
Janet Olszewski, Director

DEPARTMENT OF HUMAN SERVICES

LONG TERM CARE WORKFORCE BACKGROUND CHECK APPLICATION FORM

Michigan Public Acts 27, 28 and 29 of 2006 requires that a health facility or agency that is a:

- psychiatric facility
- ICF/MR
- nursing home
- county medical care facility
- hospice
- hospital that provides swing bed services
- home for the aged
- home health agency
- adult foster 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 the health or adult foster care facility/agency until the health facility or agency conducts a criminal history check. *Hereafter, note that "clinical privileges" does not apply to adult foster care facility (AFC).*

An individual who applies for employment either as an employee or as an independent contractor or for clinical privileges with a health or adult foster care facility/agency 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 or adult foster care facility/agency to conduct a criminal history check, and shall give a written statement disclosing that he or she has not been convicted of a crime that would prohibit employment.

Health Facility or Agency

Date: _____

Name: _____

License Number: _____

The health or AFC facility/agency:

a. May not knowingly employ a worker, having direct access to patients or residents, who has been convicted of a relevant 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 may determine not to hire the individual at any stage of the process.
c. May, after completion of all relevant registry and database checks, determine that it is necessary to conditionally employ or conditionally grant clinical privileges pending the results of the state and federal fingerprint criminal history record check.
d. Must ensure that any background check information provided will only be used for the purpose of determining an individual's suitability of employment in a long-term care setting.
e. Must retain verification of compliance with background check requirements.
f. Will make the final employment decision, and will notify the applicant.

FACILITY LICENSE NUMBER _____

Part 1 – Consent

Name of Applicant: _____

Application for:	Check One		Name of Position Type
		Employment	
		Independent Contractor	
		Clinical Privileges *(does not apply to AFC)*	

As a condition of being considered for employment or hiring:

a. I hereby consent to and authorize the health or AFC facility/agency to conduct a background check that includes a search of state and federal abuse and neglect registries and databases, in addition to a search of state and federal criminal history records that include a fingerprint-based check. I understand that this consent extends to the release and sharing of such information with the Michigan Departments of Community Health, Human Services, Corrections, and State Police.
b. I hereby authorize the release of any relevant information to the health or AFC facility/agency to be used to conduct the background check as required under Michigan Public Acts 27, 28 and 29 of 2006.
c. I hereby provide the following information necessary to conduct a criminal background check:

Drivers License or State/Canadian ID Number	**Place of Birth**	**Date of Birth**

Race	**Height**	**Weight**	**Eye Color**	**Hair Color**

d. I understand that the health or AFC facility/agency will make the final employment determination. I also understand that the health or AFC facility/agency may terminate the background check or determine not to hire at any stage of the process.
e. I understand that the health or AFC facility/agency, 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.

_____ _____

Signature of Applicant Date

FACILITY LICENSE NUMBER _____

Part 2 – Disclosure

a. I hereby certify that I have not been convicted of a crime or offense that prohibits my employment, hire, or granting of clinical privileges in a long-term care setting as required by P.A. 27, 28 and 29 of 2006, within the applicable time period prescribed by each crime. (Request health or AFC facility/agency to provide the "legal guide" for review purposes.)

_____ _____
Signature of Applicant Date

b. I hereby certify that I have not been the subject of an order or disposition under the Code of Criminal Procedure dealing with findings of "not guilty by reason of insanity" for any crime.

_____ _____
Signature of Applicant Date

c. I hereby certify that I have not been the subject of a state or federal agency substantiated finding of patient or resident neglect, abuse, or misappropriation of property.

_____ _____
Signature of Applicant Date

d. I hereby disclose, by listing below, all offenses for which I have been convicted, including all terms and conditions of sentencing, parole and probation therefore, and/or any substantiated finding of patient or resident neglect, abuse, or misappropriation of property.

Offense	Date of Conviction/Finding	City	State	Sentence	Date of Discharge

e. I hereby certify that I have read the "legal guide" that lists the prohibited offenses as defined in P.A. 27, 28 and 29, and that the above list of my convictions and/or substantiated findings of patient or resident neglect, abuse, or misappropriation of property (if any) is true, correct, and complete to the best of my knowledge.

_____ _____
Signature of Applicant Date

FACILITY LICENSE NUMBER _____

Part 3 – Conditional Employment

If the health or AFC facility/agency determines it necessary to employ or grant clinical privileges pending the results of the state and federal criminal history background check, I understand the following:

a. If the background check does not confirm my disclosure statement made above, my employment or clinical privileges 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. Further, I understand that pursuant to Michigan Public Acts 27, 28 and 29 of 2006, I agree that as a condition of continued employment, either as an employee, independent contractor, or as an individual granted clinical privileges, I shall report in writing to the health or AFC facility/agency immediately upon being arraigned or convicted of one or more of the criminal offenses as described in the "legal guide", 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 4 – Applicant Rights

a. I understand that upon my request, the health or AFC facility/agency must 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 record information found on any relevant registry or database is inaccurate, that it is my responsibility to correct the record information by directly contacting the appropriate registry/database owner.
c. I understand that if I believe the results of the criminal history fingerprint record is 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 to the appropriate state licensing or regulatory department.

_____ _____
Signature of Applicant Date

Part 5 – Disclaimer

The State of Michigan is not responsible for any additional information, requirements, or use of any substitute forms that the above named health or AFC facility/agency 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

Thank you for your prompt cooperation!