Pleasant View
Shiawassee County Medical Care Facility

Application of Employment

Equal Employment Opportunity has been, and will continue to be, a fundamental principle at Shiawassee County Medical Care Facility ("SCMCF"), where employment decisions are based upon experience and qualifications without discrimination because of race, color, religion, gender, national origin, age, genetic information, disability, military status, weight, height, family status, marital status, or any other basis protected by state, federal or other applicable law. **Initial _____**

Nothing contained in the application or in granting an interview constitutes an employment contract. If employment is granted, I agree my employment can be terminated with or without cause and with or without notice, at any time, at the option of either SCMCF or myself, unless otherwise confirmed, in writing, in a collective bargaining agreement or in a signed writing, signed by myself and the Administrator. **Initial _____**

I authorize SCMCF to verify and investigate all statements made in this application, and in connection with this application, including a criminal background check in accordance with Michigan law, regarding my previous employment, education, qualifications, or any information required to determine my qualifications for the position for which I am applying. I request that my previous employers and references contacted by SCMCF in connection with this application fully respond to all inquiries concerning my previous employment. If hired, I specifically waive prior written notice of disclosure of my personnel record information including salary information, disciplinary reports, and job performance. This authorization also serves as a waiver of my right to be notified of any disclosure of any information which may be contained in my personnel records from any previous employment under the Bullard Plawecki Employee Right to Know Act. I hereby release from any liability SCMCF, its board of trustees, employees, and agents, as well as all persons, employers, companies/corporations, or schools, for supplying any information in connection with my employment. If applicable, I authorize SCMCF to verify and confirm my qualifications and eligibility with the State Nurse Aide Registry or other licensing authority. **Initial _____**

I agree to a pre-employment physical examination and urine drug screening to be performed by a physician or clinic of SCMCF's choosing. I understand that my employment is conditional upon successfully passing the physical exam and a negative drug test.

I agree that any action or lawsuit against SCMCF and/or its predecessors, successors, assigns, subsidiaries, affiliates, and all past and present officers, directors, employees and agents in their individual and representative capacities of the foregoing entities arising out of my application, employment or termination, including but not limited to claims arising under state or federal civil rights statues, must be brought within one hundred eighty (180) days of the event giving rise to the claim(s) or within the limitations period contained in the statue I am suing under, whichever is shorter, I understand and agree that any action or lawsuit filed outside this limitation period is barred forever. I waive any limitation period to the contrary. **Initial _____**

employment or termination, including but not limited to claims arising under state or federal civil rights statues, must be brought within one hundred eighty (180) days of the event giving rise to the claim(s) or within the limitations period contained in the statue I am suing under, whichever is shorter, I understand and agree that any action or lawsuit filed outside this limitation period is barred forever. I waive any limitation period to the contrary. **Initial _____**

I agree to notify SCMCF, in writing, of the need for an accommodation within 182 days after I know or reasonably should have known that an accommodation was needed. I understand that under Michigan law, a person with a disability may allege a violation against an employer regarding a failure to accommodate his or her disability only if the person with a disability notifies his or her employer within 182 days after the date an employee knew or should have known that an accommodation is needed. **Initial _____**

I certify that all statements on the employment application are made completely and truthfully. Any false or misleading or incomplete or omitted information in the application, or connection with the application, shall be considered sufficient cause to deny employment or discharge an employee if employment is obtained. **Initial _____**

I have read, understand, and agree to the above statement and conditions of employment.

_____ _____

Applicant's Signature Date

Please print clearly*:*

1. Name _____
   Last First Initial

   Previous/Maiden names/Aliases _____

2. Address _____
   Number Street City State Zip Code

3. Telephone Number _____E-mail address_____

4. Are you a relative of a current or former employee of Pleasant View? _____ If yes, name of relative_____

5. Age: Are you 18 years old or older? _____

6. Are you on a lay-off or subject to recall? (circle one) Yes No

7. What position are you applying for? _____

8. Shift:_____

9. Are you able to work overtime (mandatory overtime may be required as an essential job function)? (circle one) Yes No

10. Are you able to work holidays and weekends (weekend and holiday work may be required as an essential job function)? (circle one) Yes No

11. Are you an authorized to work in the United States (proof will be required if hired)? ____

12. Have you worked for us before? _____If yes, when? _____

13. Have you ever been convicted of a crime or are there any felony charges pending against you?___ _____ If yes, please describe the nature and date of the crime and your present status (i.e. probation). _____

    A conviction does not necessarily bar you from employment. The conviction will be considered with all other information to determine whether you will be hired, including but not limited to the nature of the crime, the time elapsed since the conviction, the duties you may be assigned, and any statutory exclusion.

14. Are you currently certified/licensed by the State of Michigan in a health care related occupation?

    (circle one) Yes No If yes, please indicate the type of certification/license and its effective date.

    _____

15. Have you ever been certified/licensed by any other state in a health care related occupation?

    (circle one) Yes No

16. Have you successfully completed a CNA State approved training program? (circle one) Yes No

    If yes, complete the following:

    Complete Name of Training Program/Facility _____

    Address _____

    City_____State_____Zip Code_____County _____

    Name of Trainer: _____

    Date of Completion:____/____/____Training Programs Phone Number (____) _____

    If No, have you been State-approved for exemption from training? (Circle one) Yes No

17. Have you taken the Clinical Skills of Knowledge Test before? (Circle one) Yes No

18. Have you previously registered in Michigan or any other state? (Circle one) Yes No

    If yes, has your name changed since last registered? (Circle one) Yes No

Educational Background

Type of School	Name and Address	Years	Did you graduate?	Degree or Diploma
High School				
College				
Business/Trade				
Other				

Prior Work History: (List all positions held including part-time and self-employment, in order, beginning with your present or most recent employment. You may use a separate sheet of paper to list previous positions held. Writing "see resume" is not appropriate.

Dates From To	Name and Address of Employer	Rate of Pay Start Finish	Supervisor's Name and Title	Reason For Leaving
Describe in detail the work you did:				

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Describe in detail the work you did:				

Prior Work History Continued:

Dates From To	Name and Address of Employer	Rate of Pay Start Finish	Supervisor's Name and Title	Reason For Leaving
Describe in detail the work you did:				

May we contact the employers listed above?_____ If not, indicate below which one(s) you do not wish us to contact.

Military Record:

Branch of Service	Number of Years Served	Type of discharge, discharge date and rank at discharge:

References: Please do not use relatives

Name and Occupation of Personal Reference	Complete Address/Email Address	Phone Number
1.		
2.		
3.		
4.		