

Please print clearly  
 Complete both sides  
 All information is confidential



2960 Stanton Street  
 Springfield, IL 62703  
 P: 217-529-1611

## Application For Employment:

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_  
 Last, First and Middle

Social Security Number: \_\_\_\_\_

Current Address: \_\_\_\_\_  
 Street City, State and ZIP

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Date Available: \_\_\_\_\_

## Employment Desired:

Please circle the appropriate answer:

Pick:	Type of Work Desired:	Shift	Salary
First Choice:			
Second Choice:			
Third Choice:			

Are you 18 years of age or older? **YES / NO**

What type of employment are you looking for?  
**FULL TIME / PART TIME / TEMPORARY**

Are you employed now? **YES / NO**

May we contact your present employer? **YES / NO**

How did you hear about us?  
 \_\_\_\_\_

## Education Information:

Grade:	Name of School:	Location:	Course of Study, Diploma, Degree or Certificate:	Dates:
High School:				
College:				
Vocational, Certificates or Training:				

Have you received any honors, scholastic achievements, or community services which you feel are related to the position you are applying for?  
 \_\_\_\_\_

Have you ever been convicted of a crime? **YES / NO** If yes, for what, when and where?  
*Conviction of a criminal offense will not necessarily preclude you for employment.*

## Professional Licenses and/or Certifications:

Type:	Organization or State Issued:	Date Issued:	Expiration Date:	Number:	Verification (Office Use)

## Current and Former Employment:

Please list current to oldest

<b>Name:</b>	<b>Dates of Employment:</b>		<b>Position(s) &amp; Duties:</b>
<b>Address:</b>	<b>Start:</b>	<b>End:</b>	
<b>City/State/ZIP:</b>	<b>Salary Range:</b>		
<b>Phone</b>	<b>Start:</b>	<b>End:</b>	
<b>Supervisor:</b>	<b>Reason for leaving:</b>		
<b>Name:</b>	<b>Dates of Employment:</b>		<b>Position(s) &amp; Duties:</b>
<b>Address:</b>	<b>Start:</b>	<b>End:</b>	
<b>City/State/ZIP:</b>	<b>Salary Range:</b>		
<b>Phone</b>	<b>Start:</b>	<b>End:</b>	
<b>Supervisor:</b>	<b>Reason for leaving:</b>		
<b>Name:</b>	<b>Dates of Employment:</b>		<b>Position(s) &amp; Duties:</b>
<b>Address:</b>	<b>Start:</b>	<b>End:</b>	
<b>City/State/ZIP:</b>	<b>Salary Range:</b>		
<b>Phone</b>	<b>Start:</b>	<b>End:</b>	
<b>Supervisor:</b>	<b>Reason for leaving:</b>		

## Availability and Scheduling:

Please circle the appropriate answer:

Can you work weekends? **YES / NO** Holidays? **YES / NO**

I understand if my availability changes, it is my responsibility to notify Mary Bryant Home of such changes. Any changes will be effective then, and for any future employment.

I understand that emergency conditions may require me to temporarily work shifts other than the one for which I am applying and agree to such scheduling change as directed by my supervisor.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Day:	Start:	End:
Sunday	AM PM	AM PM
Monday	AM PM	AM PM
Tuesday	AM PM	AM PM
Wednesday	AM PM	AM PM
Thursday	AM PM	AM PM
Friday	AM PM	AM PM
Saturday	AM PM	AM PM

This institution does not discriminate in hiring or any other decision on the basis of race, color, sex, citizenship, national origin, ancestry, Vietnam era veteran status, or on the basis of age or physical or mental disability unrelated to ability to perform the work required. No question on this application is intended to secure information to be used for such discrimination.

I understand that my employment is at will, and that either party is free to terminate the employment relationship at any time without cause. I also understand that my employment may be terminated for any misstatement or omission of fact appearing on this application form.

I authorize Mary Bryant Home to access the health care worker registry, if applicable, to view my personal background and full Illinois State Police background check report.

I certify that my answers are true and complete to the best of my knowledge.

Applicant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_



# Health Care Worker Background Check

## Authorization and Disclosure for Criminal History Records Information (CHRI) Check

I hereby authorize the Illinois Department of Public Health (the Department), the Department's designee, educational entities that train and/or test health care workers, staffing agencies, my current or potential employer, or a health care facility where I want to volunteer to initiate/request a CHRI check on me. I further authorize the Illinois State Police (ISP) and/or the Federal Bureau of Investigation (FBI) to release information and photographs relative to the existence or nonexistence of any criminal record, which it might have concerning me, to any initiator/requestor solely to determine my suitability for training or testing in a health care training program, employment, continued employment, or to work as a volunteer. I further authorize any entity that maintains criminal records and photographs relating to me, including but not limited to a local unit of government in any State, to release those records and photographs to the ISP, FBI, or the Department. I authorize the Department to provide any health care facility, training program or staffing agency, to which I have provided this authorization and disclosure form, a copy of my ISP CHRI and a determination of eligibility of the FBI CHRI. I certify that the ISP, FBI, any entity that maintains criminal records and photographs, the Department, and any of their employees or officers who furnish this information shall be held harmless from all liability, which may be incurred as a result of releasing such information. I further acknowledge that an educational entity or a health care employer shall not be liable for the failure to hire or retain me as an applicant, student, employee, or volunteer if I have been convicted of committing or attempting to commit one or more of the offenses stated in the Health Care Worker Background Check Act (225 ILCS 46/25).

I understand that any false statements or deliberate omissions on this document may be grounds for disqualification from employment, training, or volunteering, if discovered after employment, training, or volunteering begins, and can result in discipline up to and including my termination of employment, being a volunteer, or a student.

I understand that the information requested below regarding gender, race, height, eye color, hair color, weight, place of birth and date of birth is for the sole purpose of identification and the accurate gathering of the criminal history record information, and that it will not be used to discriminate against me in violation of the law. I understand that the provision of my Social Security number is required by law. A facsimile or photographic copy of this authorization will be as valid as the original.

First Name \_\_\_\_\_ Full Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_

Mailing Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

Other Names Used \_\_\_\_\_ Telephone \_\_\_\_\_ - \_\_\_\_\_

States Where You Have Lived? \_\_\_\_\_

Male  Female Race \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

(Enter a letter from below)

Hair Color \_\_\_\_\_ Eye Color \_\_\_\_\_ Place of Birth \_\_\_\_\_

- Race
- A** Chinese, Japanese, Filipino, Korean, Polynesian, Indian, Indonesian, Asian Indian, Samoan, or any other Pacific Islander.
  - B** Black or African American (Not Hispanic or Latino)
  - H** Hispanic or Latino (Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin)
  - I** American Indian, Eskimo, or Alaskan native, or a person having origins in any of the 48 contiguous states of the United States or Alaska who maintains cultural identification through tribal affiliation or community recognition.
  - U** Of undeterminable race. Of Untold mixture.
  - W** Caucasian (not Hispanic or Latino)

Have you ever had an administrative finding of Abuse, Neglect or Theft?  Yes  No If "Yes," give full details and state. Continue on back if more space is needed.

Have you ever been convicted of a criminal offense other than a minor traffic violation (do not include convictions that have been expunged, sealed or adjudicated delinquent)?  Yes  No If "Yes," give full details of each offense and the state in which convicted. Continue on back if more space is needed.

I certify that the above is true and correct and give my consent for my name to appear on Department's Health Care Worker Registry with the results of my criminal history records check.

\_\_\_\_\_  
(Signature) (Date)

As the parent or guardian of the above named individual, who is younger than the age of 17, I give my consent for this named individual to have a criminal history records check.

\_\_\_\_\_  
(Signature of Parent or Guardian when applicable) (Date)

**Health Care Worker Registry, 525 W. Jefferson St., Springfield, IL 62761 Phone: 217-785-5133**

**\*\*\* ALL FIELDS MUST BE COMPLETED OR APPLICATION WILL NOT BE PROCESSED\*\*\***