APPLICATION FOR EMPLOYMENT

NAME/Last, First, Middle_____ Position_____ Date_____

PERSONAL INFORMATION

Name _____ (Last) _____ (First) _____ (Middle)

Present Address _____ (Street) _____ (City) _____ (State) _____ (Zip Code) Phone Number _____ ○ Hon ○ Cell

Permanent Address _____ (Street) _____ (City) _____ (State) _____ (Zip Code) Phone Number _____ ○ Hon ○ Cell

If you cannot be reached at above phone number, where may we contact you? Phone _____ ○ Home ○ Cell Name of Person _____

EMPLOYMENT DESIRED

Type of Work Desired	Shift	Salary
First Choice		
Second Choice		

How Did You Learn Of This Opening? _____

Will You Accept Employment of: ○ Full time ○ Part time ○ Temporary

Date Available _____ If Under 18 Yrs. of Age, Do You Have a Work Permit? ○ No ○ Y

EDUCATION/TRAINING

School	Name and Address of School	Courses Taken	Did You Graduate?	Diploma, Degree, or Certificate Received
High School			○ No ○ Yes	
College			○ No ○ Yes If Yes, Date _____	
Lab or X-Ray Training			○ No ○ Yes If Yes, Date _____	

Other Classes/Training

Extracurricular Activities While in School _____

Area of Specialization or Major Interest _____

Professional Organization Membership, Honors Received, Volunteer or Community Service or Other Qualifications You Have Which You Feel are Related to the Position for Which You are Applying:

PROFESSIONAL LICENSES AND/OR CERTIFICATIONS

Type	Organization or State Issued	Date Issued	Number	Verified
Type	Organization or State Issued	Date Issued	Number	
Type	Organization or State Issued	Date Issued	Number	

MILITARY RECORD

Military Branch	Entry Rank	Separation Rank	Separation Date(s)	Military Occupational Specialty

Specialized Training: _____

List Service Awards, Commendations: _____

EMPLOYMENT HISTORY

List current (or most recent) employer first and all others in reverse chronological order.

Company Name	Dates Employed From Month | Year	To Month | Year
Address (Street, City, State, Zip Code)	Phone	
Position Title	Immediate Supervisor's Name and Title	
Job Description & Responsibilities:		
May we contact for reference? ○ No ○ Yes		

Company Name	Dates Employed From Month | Year	To Month | Year
Address (Street, City, State, Zip Code)	Phone	
Position Title	Immediate Supervisor's Name and Title	
Job Description & Responsibilities:		
May we contact for reference? ○ No ○ Yes		

Company Name	Dates Employed From Month | Year	To Month | Year
Address (Street, City, State, Zip Code)	Phone	
Position Title	Immediate Supervisor's Name and Title	
Job Description & Responsibilities:		
May we contact for reference? ○ No ○ Yes		

Company Name	Dates Employed From Month | Year	To Month | Year
Address (Street, City, State, Zip Code)	Phone	
Position Title	Immediate Supervisor's Name and Title	
Job Description & Responsibilities:		
May we contact for reference? ○ No ○ Yes		

Company Name	Dates Employed From Month | Year	To Month | Year
Address (Street, City, State, Zip Code)	Phone	
Position Title	Immediate Supervisor's Name and Title	
Job Description & Responsibilities:		
May we contact for reference? ○ No ○ Yes		

Use this space to give us further information which may assist us in placing you. _____

REFERENCES LIST THREE REFERENCES WHO ARE NOT RELATIVES OR FORMER EMPLOYERS

Name And Relationship	Title	Company Name & Address	Telephone
			○ Home ○ Cell
			○ Home ○ Cell
			○ Home ○ Cell

AVAILABILITY INFORMATION

Please Indicate Days and Hours You Are Available For Work (Be Specific)

Day	From	To
Sunday	A.M.	A.M.
	P.M.	P.M.
Monday	A.M.	A.M.
	P.M.	P.M.
Tuesday	A.M.	A.M.
	P.M.	P.M.
Wednesday	A.M.	A.M.
	P.M.	P.M.
Thursday	A.M.	A.M.
	P.M.	P.M.
Friday	A.M.	A.M.
	P.M.	P.M.
Saturday	A.M.	A.M.
	P.M.	P.M.

Primary position desired _____

Will you accept another position? ○ No ○ Yes

If so, what? _____

Are you available to work:

Weekends ○ No ○ Yes Holidays ○ No ○ Yes

Rotating Shifts ○ No ○ Yes On Call ○ No ○ Yes

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 department head or the Administrator of this institution.

_____ _____

Applicant's Signature Date

If your availability status changes, it is your responsibility to notify your department head or the Administrator. Such changes will be effective, then, for any future employment.

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 voluntarily give this institution the right to make a thorough investigation of my past employment and activities, agree to cooperate in such investigation and release from all liability or responsibility all persons, companies or corporations supplying such information. I consent to take the physical examination, and such future physical examinations as may be required by this institution at such times and places as the institution shall designate. I understand that an offer of employment may be contingent on passing the physical examination which relates to the essential duties I would be required to perform.

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.

If employed, I will be required to complete an Employment Verification Form (I-9), and within three days show satisfactory evidence of identity and eligibility for employment.

_____ _____

Applicant's Signature Date

St Luke's Nursing Center, Inc.

1220 E. Fairview
Carthage, Missouri 64836

417-358-9084

Skilled and Assisted Living Facility

Not-For-Profit Corporation

Dear Applicant:

In an effort to make St Luke's a drug-free workplace, prior to being offered a position, you will be asked to take a drug screening test, as part of our onboarding process.

It is also the policy of St. Luke's to conduct a criminal background check on all prospective employees as in accordance with the State of Missouri measures 660.317, 660.317.5, 660317.6 and 660317.8

A complete copy of St. Luke's Substance Abuse Policy is available in the business office. A copy of the State of Missouri is enclosed with this application packet.

Thank you for your interest in becoming a member of our team

Sincerely,

Dee Shaffer

Adminstrator

REQUEST FOR CRIMINAL RECORD CHECK

Reference No. _____
(Office use only)

PLEASE PRINT CLEARLY OR TYPE

Name (Last, First, M.I.) _____

(Maiden/Alias) _____ Date of Birth _____

Social Security No. _____ Sex ☐ Male ☐ Female

Address _____

I authorize the release of any criminal history record information to the requestor.

Signature: _____

It is the responsibility of the requestor to inform the Central Repository of the records that are desired and to provide the information necessary to conduct the appropriate search.

PURPOSE

EMPLOYMENT: Child Care ☐ Nursing Home ☑ Home Health Care ☐ Other Employment ☐

Licensing: Other (specify): _____

SEND REPLY TO:
(Must be completely filled out)

Facility: St. Luke's Nursing Center

Street Address: 1220 East Fairview

City, State and Zip Code: Carthage, MO 64836

Telephone Number (including area code): 417-358-9084

I verify that the above named Person has received a copy of "A Summary of Your Rights Under the Fair Credit Reporting Act."

Signed: Stacy Baker

Print: Stacy Baker, Personnel

The criminal record check can not be processed without this signature, a name, date of birth, and a social security number. If any of these components are missing or are not legible, there may be a delay in processing.

REQUEST FOR EMPLOYEE DISQUALIFICATION CHECK

(PUSUANT TO 660.317, RSMO)

The undersigned which is a provider, licensed pursuant to Chapter198 RSMo, does herby request of the Missouri Department of Social Services a report from the employee disqualification list described in 660.315 RSMo whether the following person is or has ever been listed:

X_____
Name of Applicant

X_____-_____-_____
Social Security #

X_____/_____/_____
Date of Birth

St. Luke's Nursing Center
1220 East Fairview
Carthage, MO 64836
417-358-9084

X_____
Authorizing Signature

X_____/_____/_____
Date

_____Employer Use (Below line) _____

Confirmation Number_____

(573) 522-6510 Automated EDL Line

License Verification

CNA/CMT _____ (573) 526-5686
(Information & Date)

LPN/RN _____ (573) 751-0681
(Information & Date)

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
FAMILY CARE SAFETY REGISTRY

WORKER REGISTRATION

FCSR USE ONLY

Register online at www.health.mo.gov/safety/fcsr OR mail this form, copy of Social Security card, and payment to Missouri Dept. of Health and Senior Services, Fee Receipts, PO Box 570, Jefferson City, MO 65102.

REGISTRATION TYPE (Check all that apply. Complete column on right only if Long Term Care/Personal Care selected from left.)

- ☐ Adoptive Parent
  - Agency Name: _____
- ☐ Child Care
- ☐ Foster Parent/Family Member of Foster Parent
  - County Office: _____
- ☐ Hospital
- ☑ Long Term Care/Personal Care (Please choose subcategory at right ▸.)
- ☐ Mental Health/Psychiatric Hospital
- ☐ Voluntary *(Select voluntary if no other registration type applies.)*

A one-time registration fee of $14.00 applies to all categories except Foster Parents. Foster Parents must list the Children's Division county office.

Register only once. If you believe you have already registered, check our website at www.health.mo.gov/safety/fcsr or call, toll free, 866-422-6872.

Long Term Care / Personal Care Subcategories (Complete if LTC/PC selected at left.)

- ☐ Adult Day Care
- ☑ Assisted Living Facility
- ☐ Hospice
- ☐ Hospital LTAC/Swing Bed
- ☐ Mental Health – Residential Facility/ICF
- ☑ Nursing Facility/Skilled Nursing
- ☐ Personal Care – Home Health
- ☐ Personal Care – In-Home Services
- ☐ Personal Care – Consumer Directed Services/Center for Independent Living
- ☐ Personal Care – HCY/PDW/DDD/Other

SOCIAL SECURITY NUMBER (Mail copy of card with form.)

– –

PERSONAL INFORMATION (Provide all names you have used, starting with most recent. Include legal names and nicknames.)

LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX (JR., SR., II, III)

MAIDEN NAME (IF APPLICABLE)	PRIOR NAMES USED (IF APPLICABLE, LIST FIRST AND LAST NAMES.)	DATE OF BIRTH (MM-DD-YYYY)	GENDER
			☐ M ☐ F

CONTACT INFORMATION

MAILING ADDRESS (ENTER YOUR STREET ADDRESS OR POST OFFICE BOX. THIS ADDRESS MUST BE DIFFERENT FROM EMPLOYER ADDRESS.)

CITY	STATE	ZIP CODE	COUNTY

TELEPHONE	EMAIL ADDRESS (REQUIRED)	COUNTRY (COMPLETE ONLY IF OUTSIDE U.S.)

EMPLOYER ASSOCIATED WITH THIS REGISTRATION (Complete either left or right column, not both.)

☐ My current/potential child care, long term care or mental health care employer is:

EMPLOYER NAME: St. Luke's Nursing Center, Inc.

EMPLOYER ADDRESS: 1220 East Fairview

EMPLOYER CITY	STATE	ZIP
Carthage	MO	64836

EMPLOYER TELEPHONE	EMPLOYER CONTACT NAME	EMPLOYER CONTACT TITLE
(417) 358-9084	Stacy Baker	Personnel

☐ No Employer, because I am a(n):

- ☐ Adoptive Parent
- ☐ Foster Parent/Family Member
- ☐ Home Child Care Provider
- ☐ Private Pay/Private Duty
- ☐ Student
- ☐ Volunteer
- ☐ Other (Explain:)

REGISTRATION AGREEMENT

The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant my permission for the Missouri Department of Health and Senior Services (DHSS) to obtain any and all background information authorized by law to process this request. Furthermore, I authorize the DHSS to release the fact that I am a registrant in the Family Care Safety Registry (FCSR) and any related background information to the requester of the FCSR for employment purposes only, as provided in §210.921, subsection 1, subdivisions (1) and (2), RSMo. For purposes of the FCSR, "employment purposes" includes direct employer/employee relationships, prospective employer/employee relationships, and screening and interviewing of persons or facilities by those persons contemplating the placement of an individual in a child care, elder care or personal care setting. I understand that if I dispute the information contained in the FCSR I have the right to appeal the accuracy of the transfer of information to the FCSR within thirty (30) days of receiving the results of the background screening.

NOTICE: The FCSR may choose to deposit the check enclosed electronically as an ACH debit entry to my designated bank account. I understand that my signature below authorizes my financial institution to deduct this payment from my account. In the event that DHSS or its subcontractor is unable to secure funds from my account or I provide insufficient or inaccurate information regarding my account, my obligation to the DHSS will remain unpaid and further collection action may be taken by the DHSS or its subcontractor, including, but not limited to, returned check fees.

SIGNATURE OF APPLICANT	DATE OF SIGNATURE (MUST BE WITHIN SIX MONTHS OF SUBMISSION.)

WHAT IS THE FAMILY CARE SAFETY REGISTRY?

The Family Care Safety Registry (FCSR), administered by the Missouri Department of Health and Senior Services (DHSS), provides families and employers with a method to obtain background screening information. The Registry, through various state agencies, offers several resources to screen child care, long term care and mental health workers:

- State criminal history and sex offender registry records maintained by the Missouri State Highway Patrol
- Child abuse/neglect records maintained by the Missouri Department of Social Services
- The Employee Disqualification List maintained by the Missouri Department of Health and Senior Services
- The Employee Disqualification Registry maintained by the Missouri Department of Mental Health
- Child care facility licensing records maintained by the Missouri Department of Health and Senior Services
- Foster parent records maintained by the Missouri Department of Social Services

WHO HAS TO REGISTER?

Any person hired on or after January 1, 2001, as a child care worker or elder care worker, hired on or after January 1, 2002, as a personal care worker, or hired on or after January 1, 2009, as a mental health worker, as provided in §210.906, RSMo, is required to make application for registration in the Family Care Safety Registry within fifteen (15) days of the beginning of employment. Such person who fails to submit a completed registration form to the DHSS without good cause, as determined by the department, is guilty of a class B misdemeanor. Employees and volunteers from non-state and/or federally regulated entities are NOT REQUIRED to register with the FCSR.

HOW DO I COMPLETE THE REGISTRATION FORM?

Registration Type – Check at least one box from the left column for type of registration that best describes your worker category. If no other type applies, select "Voluntary." (A "voluntary registrant" is a person who is not mandated to register with the Family Care Safety Registry pursuant to §210.900 et seq., RSMo.) If you checked Long Term Care / Personal Care, please also make one or more selections from the column on the right for subcategory.

Social Security Number – You must provide your Social Security number pursuant to 19CSR 30-80.030(1). This identifying information, including Social Security number, will be used for internal identification purposes and to conduct background screenings for the resource information listed in paragraph one above.

Personal Information – List your current Last Name, First Name, Middle Name, and any suffix associated with your last name. List any other names by which you may have been known, including maiden names, past married names, and nicknames (attach additional sheets if needed). For identification purposes, list your gender and date of birth.

Contact Information – List your address, city, state, ZIP code, and county. Include your telephone number and email address. We will use this information to notify you of registration results and any background screenings conducted. Email notifications will be encrypted for improved security. To reduce postage costs, the Registry may contact you to request a personal email address if one is not provided.

Employer Associated with this Registration - If you are currently employed by or are seeking employment with a child care or long term care provider, please list the facility name, address, telephone number, and contact person. If registration is not for employment purposes, make a selection from column on right. The employer entered in this section will not receive a copy of the registration notification. Employers eligible to use the Registry for caregiver screenings must make a separate request for your background information.

Registration Agreement – Sign and date the registration form. Your signature will authorize the Family Care Safety Registry to conduct the background screening outlined in §210.903.2, RSMo and to provide the information to requesters for employment purposes, as provided in §210.921.1, RSMo.

WHERE DO I SEND MY REGISTRATION FORM?

Send your completed registration form and photocopy of Social Security card and required fee to the Missouri Department of Health and Senior Services, ATTN: Fee Receipts, P.O. Box 570, Jefferson City, MO 65102. If you have questions, please call the Registry using the toll-free telephone number, 866-422-6872.

WHEN WILL I KNOW THE RESULTS OF MY BACKGROUND SCREENING?

After the background screening has been completed, you will be notified in writing of the results that will be recorded in the Family Care Safety Registry. You will also be notified in writing each time background screening information is provided. The notification will contain the name and address of the person who made the request and the background information disclosed. The person making the request will be informed that information will be released for employment purposes only, pursuant to §210.921.1, RSMo. Any person using Registry information for any other purpose is guilty of a class B misdemeanor. In addition, state agencies can request information for licensure or regulatory purposes. Prior to disclosing information, the Registry obtains the name and address of the requester, and determines that the request is for employment or regulatory purposes. To ensure you receive these notifications, it will be important for you to notify the Family Care Safety Registry when you have a change in your contact information. Notify the Family Care Safety Registry of changes in personal or contact information using the toll-free telephone number, 866-422-6872, by email to fcsr@health.mo.gov, or by mail to FCSR, PO Box 570, Jefferson City, MO 65102.

WHAT IF I DON'T AGREE WITH THE RESULTS OF MY BACKGROUND SCREENING?

As provided in §210.912, RSMo, you have the right to appeal the information transferred to the Family Care Safety Registry. Your right to appeal is limited to the accuracy of the transfer of information from the state agency that maintains the background information and does not include a right to appeal the accuracy of the substance of the information transferred. An appeal must be filed in writing to the Office of the Director, Missouri Department of Health and Senior Services, P.O. Box 570, Jefferson City, MO, 65102, within 30 days of receiving the results of the background screening determination. An administrative appeal shall be set within 30 days of the filing of the appeal and a decision shall be made within 60 days. This right to appeal is in addition to any other appeal rights granted by state law.

WHAT INFORMATION WILL BE DISCLOSED BY THE FAMILY CARE SAFETY REGISTRY?

Disclosure of background information on a person registered in the Family Care Safety Registry will be limited. If the person is registered, the Registry worker will disclose whether the person's name is listed in any of the background checks pursuant to §210.903, subsection 2, RSMo, and if so, which one(s). Specific information will be disclosed by the Registry pursuant to §210.921, subsection 1, subdivision (2).