Grayson Nursing & Rehabilitation
Application for Employment
Equal Opportunity Employer

Please answer all questions carefully, accurately, and completely. Any falsification on this application will be grounds for the facility to deny employment or grounds for the dismissal of employment.

Conviction records, as mandated by House Bill 528, will be checked and continuation of employment is based on the result of these findings.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security #: _____ Phone #: (___) _____

Position applied for: _____ Shift preference: _____

Have you ever worked at Grayson Nursing & Rehab? _____

If so, when? _____Who was your supervisor? _____

Do you have any family employed here? _____

If so, who? _____What dept.? _____

Special training, education, and experience in type of work for which you have applied:

_____

_____

_____

Have you ever been convicted of a felony? _____

_____

If applying for nurse aide position, have you ever taken the Medicaid Nurse Aide Test and passed the competency test? _____

If yes, State where registered _____ Date registered _____

Important-----Please List All Previous Work Experience

Previous Employer: _____ Supervisor _____
Phone # ( ) _____ Dates of employment _____
Duties: _____
Reason for leaving: _____

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Phone # ( ) _____ Dates of employment _____
Duties: _____
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Phone # ( ) _____ Dates of employment _____
Duties: _____
Reason for leaving: _____

May we contact your present/previous employer for references? _____

When would you be available for employment? _____

Please give the names and phone numbers of three persons whom we may contact for references: (**DO NOT LIST RELATIVES**)

1.) _____
2.) _____
3.) _____

I understand that Grayson Nursing & Rehab operates on a 24 hour continuous basis. I, as an employee, am not guaranteed any particular shift and have not been told I will get holidays or weekends off. I acknowledge by signing below that my physical condition is good and I am free of communicable diseases. I understand that if hired I will be subject to a drug test. I acknowledge that I will receive information about the Hepatitis B Vaccine so as to determine my risk and contraindications, realizing that the Hepatitis B Vaccine is recommended for health care providers. The decision is mine and any questions regarding my decision to receive or refuse the vaccine will be directed to my own physician.

I also certify that I am physically and mentally capable of performing the duties specified within my job description for which I am applying, to include the unassisted lifting and moving of 50-100 pounds.

I understand that Grayson Nursing & Rehab utilizes electronic deposit and I will be required to have an open checking or savings account upon my first day of employment and will turn in a deposit slip to the business office staff before I will be able to clock in to work

SIGNATURE _____ DATE _____

Applicant Self-Disclosure Form

(Please Type or Print Clearly)

The Applicant must complete this form before an application can be processed in the Kentucky Applicant Registry and Employment Screening (KARES) Program

The Applicant Self-Disclosure Form and the Kentucky Applicant Registry and Employment Screening Program web portal collects information as required by the National Background Check Program to help employers as define by 906 KAR 1:190 section 1 to make employment decisions. Complete and return the entire form and attach explanations as specified by the requesting employer.

You may view the current Background Check Regulation at http://www.lrc.ky.gov/kar/906/001/190.htm

This information will be used to obtain relevant data as required by the provisions set forth by the National Background Check Program. Providing your social security number is necessary to prevent incorrect matches in the criminal background check and certain registry checks. For example, the Department of Justice uses social security numbers, names, gender, race, and date of birth to prevent incorrect matches of persons with criminal convictions. The US Department of Health Services' Caregiver Misconduct Registry uses social security numbers as one identifier to prevent incorrect matches of persons with findings of abuse or neglect of a client or misappropriation of a client's property.

Name of Facility or Employer: Grayson Nursing & Rehabilitation			
Address of Employer: 505 William Thomason Byway, Leitchfield, KY 42754			
Applicant's Last Name:		Applicants First and Middle Names:	
Maiden Name:	Social Security Number:	Date of Birth:	Male or Female:
Government Issued ID (Include No. & Type):		State or Agency of Issue:	
Phone Number:	Phone Number Type:	Email Address:	
Current Physical Address Line One:		Current Physical Address Line Two:	
City:	State:	Zip Code:	County:
Current Mailing Address (if different):		City:	State:
Zip Code:	County:	Alt Phone Number:	Alt Phone Number Type:

List all residences you have lived at during the past seven years: (Use additional sheets if needed)

List all cities and states where you have worked during the past seven years: (Use additional sheets if needed)

List aliases and other names you have ever used: (Use additional sheets if needed)

Have you ever been convicted of a crime? ☐Yes ☐No

- If you answered "YES" to the question above, please provide an explanation in this box for each conviction. Please provide the following: (1) offense(s) for which you were convicted; (2) the date of the conviction(s); (3) the state or territory where the conviction(s) occurred; (4) the court; and (5) any action(s) taken by the court against you, including any sentence, or probation imposed. (Use additional sheets if needed)

Do you have any charges (pending) against you for a crime? ☐Yes ☐No

- If you answered "YES" to the question above, please provide an explanation in this box for each charge. Please provide the following: (1) offense(s) for which you were charged; (2) the date of the conviction(s); (3) the state or territory where the conviction(s) occurred; (4) the court; and (5) any action(s) taken by the court against you, including any sentence, or probation imposed. (Use additional sheets if needed)

Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client? ☐Yes ☐No

- If you answered "YES" to the question above, please provide an explanation in this box, including when and where it happened.

Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client? ☐Yes ☐ No

- If you answered "YES" to the question above, please provide an explanation in this box, including when and where it happened.

Has any government agency (other than the police) ever found that you abused an elderly person? ☐Yes ☐No

- If you answered "YES" to the question above, please provide an explanation in this box, including when and where it happened.

Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients? ☐Yes ☐No

- If yes, explain, including credential name, laminations or restrictions and time period.

Answering "NO" to all questions does not guarantee employment.

SIGNATURE, CERTIFICATION AND RELEASE OF INFORMATION

YOU MUST SIGN THIS FORM. Please read the following acknowledgements carefully before you sign.

I understand that information requested regarding gender, race, height, eye color, hair color, weight, place of birth, citizenship 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 a false statement on any part of this form is grounds for either not hiring me, or firing me after I begin work. I consent to the release of information regarding a criminal history on me by the Kentucky State Police, Federal Bureau of Investigation (FBI), and any of its authorized agents. I certify that, to the best of my knowledge and belief, all of my statements are true, correct and complete.

Applicant's Signature:	Signature of Parent or Guardian if Under Age 18:	
Signature of Authorized Personnel at Hiring Facility:	Title:	Today's Date:

CABINET FOR HEALTH AND FAMILY SERVICES

OFFICE OF INSPECTOR GENERAL
Kentucky Applicant Registry and Employment Screening (KARES) Program
275 East Main Street, 5EA (502) 564-2159 (Phone)
Frankfort, Kentucky 40621 (502) 564-6546 (Fax)
Web site: http://chfs.ky.gov.os/oig/KARES
Helpdesk email: KARES.Helpdesk@ky.gov

CONSENT AND RELEASE FORM

STATE AND NATIONAL BACKGROUND CHECK

A SIGNED COPY OF THIS FORM
MUST BE KEPT IN THE HUMAN RESOURCES FILE OF THE EMPLOYER

PURSUANT TO 906 KAR 1:190 SECTIONS 4 AND 6 CLEARANCE FOR EMPLOYMENT WITH A LONG-TERM CARE FACILITY OR EMPLOYER PARTICIPATING IN THE KARES PROGRAM CANNOT BE ISSUED WITHOUT THE COMPLETION OF THIS FORM.

PERSONAL INFORMATION REGARDING THE INDIVIDUAL SUBMITTING TO A STATE AND NATIONAL BACKGROUND CHECK, PLEASE TYPE OR PRINT CLEARLY:

Applicant's Last Name:		Applicants First and Middle Names:	
Maiden Name:	Social Security Number:	Date of Birth:	Male or Female:
Current Mailing Address Line One:		Current Mailing Address Line Two:	
City:	State:	Zip Code:	

Prior to employment with a long-term care facility or employer participating in the KARES Program, a prospective employee shall consent to a State and National background check, which shall consist of a: (1) check of required abuse registries; (2) check of licensing board data, if applicable, to validate licensure status; and (3) fingerprint-supported State and FBI criminal background check.

1. If cleared upon a check of required abuse registries and licensing board data, a prospective employee shall submit to a fingerprint-supported criminal history check and may be offered provisional employment upon submitting to the fingerprint scan.
2. Fingerprint images of the prospective employee will be used to determine if the individual has any criminal history information on file with the Federal Bureau of Investigation (FBI) and Kentucky's Criminal History Repository(s).
3. All information provided to the KARES Program, Office of Inspector General (OIG), Cabinet for Health and Family Services, shall be kept confidential and will comply with applicable laws and regulations.
4. The OIG will submit a request to the appropriate court system for any missing criminal charge disposition related to a disqualifying offense. If a response is not provided to the OIG's request for final disposition within 60 days of fingerprint submission, the applicant shall not be eligible to hire.

OIG 1:190-C, edition February 2014

Further, the applicant will be responsible for securing his or her final disposition information if the OIG's attempts to secure the information are not successful.

I hereby consent to a State and National background check pursuant to KRS 17.185 and 42 U.S.C. 1320a-7l. I understand that the Kentucky State Police (KSP) will provide the OIG with any record I may have for a felony, misdemeanor, or violation conviction found in the files of the Kentucky Central Repository. I understand and know that KSP will forward my fingerprint submission to the FBI to conduct a National criminal history check, and that the results of the check will be provided to the OIG.

I authorize the KSP and FBI to release criminal history information to KARES staff in the OIG to determine the eligibility of my employment with a long-term care facility or other employer participating in KARES pursuant to 906 KAR 1:190.

I understand I have the right to inspect my criminal history record and to request correction of any inaccurate information. If I do not exercise that right, I agree to hold harmless the KSP and its employees from any claim for damages arising from the dissemination of inaccurate information. I also release the OIG and its employees from any liability or damages resulting from its determination of my eligibility for employment with a long-term care facility or employer participating in the KARES program.

I authorize the OIG to recheck the required abuse registries; licensing board data, if applicable, to validate licensure status; and fingerprint-supported or name-based State and FBI criminal background check pursuant to 906 KAR 1:190 annually.

My signature acknowledges that I have read, understand and accept the terms and conditions outlined in this form.

<table>
<tr><td>Agency or Facility Name:
Grayson Nursing & Rehabilitation</td><td colspan="2">Address of Agency or Facility:
505 William Thomason Byway
Leitchfield, KY 42754</td></tr>
<tr><td colspan="2">Applicant's Signature:</td><td>Date:</td></tr>
<tr><td>Witness Signature:</td><td>Title:</td><td>Date:</td></tr>
</table>

Cliick here to send the completed email to us via email.