

**BARTELS LUTHERAN RETIREMENT COMMUNITY
APPLICATION FOR EMPLOYMENT**

THIS APPLICATION IS GOOD FOR 60 DAYS.

EQUAL ACCESS TO PROGRAMS, SERVICES AND EMPLOYMENT IS AVAILABLE TO ALL PERSONS. THOSE APPLICANTS REQUIRING REASONABLE ACCOMMODATION TO THE APPLICATION AND/OR INTERVIEW PROCESS SHOULD NOTIFY A REPRESENTATIVE OF THE HUMAN RESOURCES DEPARTMENT.

THIS FACILITY CONDUCTS POST-OFFER DRUG TESTING OF ALL PROSPECTIVE EMPLOYEES CONDITIONALLY OFFERED EMPLOYMENT WITH THIS FACILITY. A COPY OF THE FACILITY'S DRUG-FREE WORKPLACE POLICY IS AVAILABLE FOR YOUR REVIEW AND INSPECTION AT ANY TIME DURING NORMAL BUSINESS OFFICE HOURS (i.e. , 8:00 A.M – 5:00 P.M., MONDAY THROUGH FRIDAY). A CONDITIONAL JOB OFFER WILL BE WITHDRAWN IN THE EVENT OF A CONFIRMED POSITIVE TESTS RESULT FOR PROHIBITED DRUGS AND/OR A REFUSAL TO TEST.

Applicants are considered for all positions, and employees are treated during employment, without regard to race, color, religion, sex, national origin, age, disability or any other prohibited basis of discrimination, as provided under applicable state and federal law.

PLEASE PRINT Date of Application _____ Position(s) Applied For: _____

Referral Source: Advertisement _____ Friend _____ Relative _____ Walk-In _____ Employment Agency _____ Other _____

Name _____

Address _____

Telephone _____

Number _____ Street _____ City _____ State _____ Zip Code _____

Social Security Number _____ / _____ / _____ E-Mail Address _____

Have you filed an application here before? Yes No If yes, give date _____

Have you ever been employed here before? Yes No If yes, give date _____

Are you employed now? Yes No May we contact your present employer? Yes No

Are you legally eligible for employment in this country? Yes No

If hired, you will be required to submit documents sufficient to establish employment authorization and identity in compliance with the Immigration Reform and Control Act of 1986. While you need not provide this proof of citizenship or immigration status at the time you are interviewed, please be prepared to assure us that you can do so immediately upon being hired.

On what date would you be available for work? _____ Expected salary: _____

Are you available to work: Full-Time Part-Time Temporary What days? S M T W T F S

Are you on lay-off and subject to recall? Yes No Shift? _____

Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime, in this state or any other state? Yes No

If yes, please explain _____

Veteran of the U.S. Military Service? Yes No If Yes, Branch _____

List professional, trade, business or civic activities and offices held. (You may exclude those which indicate race, color, religion, sex or national origin): _____

Give name, address and telephone number of three references who are not related to you and are not previous employers.

EDUCATION

Please list education or specialized experience which relates to the position(s) for which you are applying. Exclude names or terms which indicate, for example, race, color, religion, sex, disability or national origin.

School Name	High School	College/University	Graduate/Professional
Years Completed (Circle)	9 10 11 12	1 2 3 4	1 2 3 4
Diploma/Degree			
Describe Course of Study:			
Describe Specialized Training, Apprenticeship, Skills, and Extra-Curricular Activities			

Honors received: _____

Special Skills and Qualifications, including those acquired from employment or other experience: _____

EMPLOYMENT EXPERIENCE

Start with your present or last job. Include military service assignments and volunteer activities. Exclude organization names which indicate, for example, race, color, religion, sex, disability or national origin.

Employer ()	Telephone ()	Dates Employed		Work Performed
Address		From	To	
Job Title		Hourly Rate/Salary		
		Starting	Final	
Supervisor				
Reason for Leaving				

Employer ()	Telephone ()	Dates Employed		Work Performed
Address		From	To	
Job Title		Hourly Rate/Salary		
		Starting	Final	
Supervisor				
Reason for Leaving				

Employer ()	Telephone ()	Dates Employed		Work Performed
Address		From	To	
Job Title		Hourly Rate/Salary		
		Starting	Final	
Supervisor				
Reason for Leaving				

If you need additional space, please continue on a separate sheet of paper.

 State any additional information you feel may be helpful to us in considering your application. _____

APPLICANT'S STATEMENT

“These answers are true and complete to the best of my knowledge. The Company may investigate all statements contained in this application, and I understand that any false or misleading information provided during the application or interview process will result in withdrawal from consideration for employment or my immediate discharge if I am hired, regardless of when discovered.”

“I understand that this application is not a contract of employment. I also understand that if hired, regardless of any oral representations to the contrary, the employment relationship between myself and the company is terminable-at-will so that both the company and I remain free to choose to end our work relationship at any time for any or no reason. Any changes in this employment relationship must be made in writing.”

“I also understand that any offer of employment may be conditioned upon a health evaluation by a doctor selected by the Company, to determine whether I can perform the job duties. In addition, I understand a drug or alcohol test may be required depending upon Company policy. I authorize the Company to make a thorough investigation of my past employment, education and job-related activities and I release from all liability all persons, companies, and corporations supplying such information. I also indemnify this Company against any liability which might result from making such investigation.”

“Additionally, I authorize the Company to supply my employment record, in its sole discretion, in whole or in part, to any prospective employer, government agency, or other party, with an interest that the Company deems appropriate.”

“The applicant understands that prior to employing any individual in this facility, state law requires facilities licensed under 135C of the Iowa code to conduct criminal record and dependent adult abuse record checks through the Department of Criminal Investigation. The applicant hereby consents to the facility conducting the required record checks and agrees to cooperate in any evaluation which may be required by the Department of Human Services.”

 Signature of Applicant

 Date

Authorization To Release Information

To: _____

As an applicant for a position with Bartels Lutheran Retirement Community, I have been asked to furnish information for use in reviewing my background and qualifications. In this connection, I hereby authorize _____ to investigate my past and present work, character, education, military and police records to ascertain any and all information which may be pertinent to my employment qualifications. I agree to cooperate in such investigation, and release from all liability or responsibility all persons and corporations requesting or supplying such information.

This authorization shall be valid for three months from the date of my signature below. You may retain this copy of my release for your files. Thank you for your assistance.

Signature _____ Date _____

Social Security No. _____

Other Names Used _____

The applicant named above is being considered for employment as _____

_____ with our Home. We would appreciate your recording below your experience with the applicant and returning this form to us in the enclosed self-addressed stamped envelope. The applicant has signed the above waiver authorizing you to release this information to us.

Position _____ Dates of Employment: From _____ to _____

Reason for termination _____

Would you re-employ? _____ If not, why? _____

What is your estimate of the applicant on the following:

Quality of work _____ Quantity of work _____

Cooperation _____ Dependability _____

Attendance _____

If there is any other information concerning this applicant which would assist us in our employment evaluation:

Date _____ Signature _____

Title _____

**IOWA HEALTH CARE FACILITY (135C) RECORD CHECK
Form C**

ACCOUNT NUMBER _____

**TO: Iowa Division of Criminal Investigation
Bureau of Identification
Wallace State Office Building
Des Moines, Iowa 50319
(515) 281-5138
(515) 242-6876 (fax)**

FROM: _____

Phone # _____
Fax # _____

I am requesting an Iowa Criminal History Check on:

(TYPE/PRINT LEGIBLY)

REQUEST

Last Name
(mandatory)

First Name
(mandatory)

Middle Name
(recommended)

____/____/_____
Date of Birth
(mandatory)

Sex
(mandatory)

____/____/_____
Social Security Number
(mandatory)

Signature of Requester

There is a separate Form "C" required for each last name submitted.

(DCI Use Only)

RESULTS

As of _____, a Name and date of birth check revealed:

CCH record Attached

No CCH Record

DCI initials _____

WAIVER

I hereby give permission for the above requesting official to conduct an Iowa criminal history check with the Division of Criminal Investigation.

Signature

Date

Iowa Department of Human Services

REQUEST FOR DEPENDENT ADULT ABUSE REGISTRY INFORMATION

To request information about dependent adult abuse, complete this form and mail it to:

Central Abuse Registry, Iowa Department of Human Services, 1305 E. Walnut, Des Moines, Iowa 50319-0114.

Note: Information will be released only to people who have access to it under Iowa Code section 235B.6.

Criminal Penalties (235B.12)

1. Any person who willfully requests, or seeks to obtain dependent adult abuse information under false pretenses, or who willfully communicates or seeks to communicate dependent adult abuse information to any agency or person except in accordance with section 235B.6 and 235B.8, or any person connected with any research authorized pursuant to section 235B.6 who willfully falsifies dependent adult abuse information or any records relating thereto, is guilty of a serious misdemeanor. Any person who knowingly, but without criminal purposes, communicates or seeks to communicate dependent adult abuse information except in accordance with section 235B.6 and 235B.8 shall be guilty of a simple misdemeanor.
2. Any responsible grounds for belief that a person has violated any provision of this chapter shall be grounds for the immediate withdrawal of any authorized access such person might otherwise have to dependent adult abuse information.

Redissemination of Dependent Adult Abuse Information (235B.8)

1. A recipient of dependent adult abuse information authorized to receive the information shall not redisseminate the information, except that redissemination shall be permitted when all of the following conditions apply:
 - a. The redissemination is for official purposes in connection with prescribed duties or, in the case of a health practitioner, pursuant to professional responsibilities.
 - b. The person to whom such information would be redisseminated would have independent access to the same information under section 235B.6.
 - c. A written record is made of the redissemination, including the name of the recipient and the date and purpose of the redissemination.
 - d. The written record is forwarded to the registry within thirty days of the redissemination.

Name of person making request:		Office phone:	
		Fax:	
Office address:			
Position and basis for authorization (Code 235B.6):			
Information requested concerning (name—first, middle, last):		Social Security Number:	Birthdate:
Maiden name or alias (if applicable):	Address:		
What information is requested: Dependent Adult Abuse check			
Date:		Signature:	
To be completed by Registry personnel			Date:
<input type="checkbox"/> Request approved by:			
<input type="checkbox"/> Request denied because:			
Information released:			

ACKNOWLEDGEMENT & CONSENT FORM

I hereby acknowledge that I have been advised by Bartels Lutheran Retirement Community that it conducts post-offer drug testing of all prospective employees conditionally offered employment. I further acknowledge that I have been advised that the facility's Drug-Free Workplace Policy is available for my review and inspection at any time during normal business office hours (i.e., 8:00 a.m. – 5 p.m., Monday through Friday). Finally, I acknowledge that I have been advised that my conditional job offer will be withdrawn in the event I receive a confirmed positive test result for prohibited drugs and/or a refusal to test.

I have been advised that the drugs for which I will be tested include: Cannabinoids, (ex: Marijuana, Hashish etc.) Opiates (ex: Heroin, Codeine, Morphine etc.), Cocaine (ex: Crack, Coke, etc.) Amphetamines, Methamphetamines, Phencyclidine (ex: PCP etc.) Barbiturates (ex: Phenobarbital, Seconal, Amytal, Nembutol, etc.) Benzodiazepine (ex: Valium, Librium, Restoril, Tranxene, Dalmane, etc.) Methaqualone, Methadone, Propoxyphene (ex: Darvon, etc.) I have also been advised that at the time the test is conducted, I may provide any information which I feel may be relevant to the test, including identification of prescription or nonprescription drugs, currently or recently used, or any other relevant medical information.

I hereby consent and agree to submit to such drug testing under the terms and conditions outlined in Bartels Lutheran Retirement Community's Drug-Free Workplace Policy.”

Date _____

Signed _____

THIS APPLICATION FOR EMPLOYMENT WILL REMAIN ACTIVE FOR A PERIOD OF TIME NOT TO EXCEED 60 DAYS.

(REVISED 06-06-03)