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 A CONDITIONAL JOB OFFER WILL BE WITHDRAWN IN THE EVENT OF A CONFIRMED POSITIVE TESTS RESULT FOR PROHIBITED DRUGS AND/OR A REFUSAL TO TEST.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____
Last First Middle

Address____
Number Street City State Zip Code

Telephone________________ 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____

(6/15/85, 6/9/97)

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**

Form No. 595-1490 (10/99)

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 f 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:
☐ Request approved by:	
☐ Request denied because:	
Information released:	

470-0612 (Rev. 1/01)

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)

Iowa Department of Human Services

Request for Child and Dependent Adult Abuse Information

Persons or agencies with authorized access to child or dependent adult abuse information must use this form to request information about a child or dependent adult abuse report. **Complete a separate form for each family or individual** and email to dhsabuseregistry@dhs.state.ia.us, or fax to (515) 564-4112, or mail to the Iowa Department of Human Services, Central Abuse Registry, P.O. Box 4826, Des Moines, IA 50305.

Please specify your type of request by checking the appropriate box below:

☐ Child abuse request ☐ Dependent adult abuse request ☐ Both

Please specify your preferred **method of response** by checking a box and completing the information in Section 1.

☐ Address ☐ Fax ☐ Email

Section 1: ***To be completed by the person or agency requesting the information.***

Requester: Last	First	Agency Name	Telephone Number ( )
Address			Fax Number ( )
City	State	Zip Code	Email
Relationship to the persons listed in Section 2 or 3:			
Purpose for request:			
State the Iowa Code section that allows access to the child **or** dependent adult abuse information requested:			

I have read and understand the legal provisions for handling child or dependent adult abuse information which is printed on the second page of this form. I understand that this request will not be approved unless I have authorized access.

Signature of Requester	Date

Complete Section 2 if the purpose of this record check is employment, licensing or registration, or payment approval.

Section 2: ***List the name and address of the person whose record is being checked.***

Last	First	Middle	Birth Date	Social Security Number	
Address	City		County	State	Zip Code
List maiden name, any previous married names, and any alias:					

Complete Section 3 if the request is for a copy of the written summary of the abuse investigation or assessment.

Section 3: ***List the name of the persons for whom you are requesting information. Attach pages for additional family members.***

Last	First	Middle	County	Birth Date	Social Security #
Address			City	State	Zip Code
List maiden name, any previous married names, and any alias:					

Section 4: ***Registry or designee decision.***

☐ This request for information is approved.

☐ This request for information is denied because:

Signature of Registry or Designee	Date

470-0643 (Rev. 2/16) Copy 1: Central Registry or Designee Copy 2: County Office

LEGAL PROVISIONS FOR HANDLING CHILD AND DEPENDENT ADULT ABUSE INFORMATION

Redissemination of Child and Dependent Adult Abuse Information (Iowa Code sections 235A.17 and 235B.8)

A person, agency, or other recipient of child or dependent adult abuse information shall not redisseminate (release) this information, except that redissemination is permitted when **ALL** of the following conditions apply:

- The redissemination is for official purposes in connection with prescribed duties or, in the case of a health practitioner, pursuant to professional responsibilities.
- The person to whom such information would be redisseminated would have independent access to the same information under Iowa Code sections 235A.15 or 235B.6.
- A written record is made of the redissemination, including the name of the recipient and the date and purpose of the redissemination.
- The written record is forwarded to the Central Abuse Registry within 30 days of the redissemination.

Criminal Penalties (Iowa Code sections 235A.21 and 235B.12)

A person is guilty of a criminal offense when the person:

- Willfully requests, obtains, or seeks to obtain child or dependent adult abuse information under false pretenses, or
- Willfully communicates or seeks to communicate child or dependent adult abuse information to any agency or person except in accordance with Iowa Code sections 235A.15, 235A.17, 235B.6, and 235B.8, or
- Is connected with any research authorized pursuant to Iowa Code sections 235A.15 and 235B.6 and willfully falsifies child or dependent adult abuse information or any records relating to child or dependent adult abuse.

Upon conviction for each offense, the person is guilty of a serious misdemeanor punishable by a fine or imprisonment.

Any person who knowingly, but without criminal purposes, communicates or seeks to communicate child or dependent adult abuse information except in accordance with Iowa Code sections 235A.15, 235A.17, 235B.6, and 235B.8 is guilty of a simple misdemeanor punishable, upon conviction for each offense, by a fine or imprisonment.

Any reasonable grounds for belief that a person has violated any provision of Iowa Code Chapters 235A or 235B shall be grounds for the immediate withdrawal of any authorized access that person might otherwise have to child or dependent adult abuse information.

REQUESTS FOR CORRECTION OR EXPUNGEMENT OF A CHILD OR DEPENDENT ADULT ABUSE REPORT

To request an administrative appeal hearing of a child or dependent adult abuse report, please submit a request in writing to: Department of Human Services, Appeals Section, 5th Fl, 1305 E Walnut St, Des Moines, Iowa 50319-0114. You will be notified in writing acknowledging receipt of your request; time, date, and place of your hearing; and any decisions regarding your request. If you disagree with this decision, the written notice will explain how you may request an administrative hearing about the report and its conclusions per Iowa Code sections 235A.19 or 235B.10.