



BACKGROUND SCREENING Application for Exemption

AUTHORITY: In accordance with section 435.07, Florida Statutes, persons disqualified from employment *may be* granted an exemption from disqualification. The granting of an exemption does not change an individual's criminal history. It only provides eligibility for employment in a health care setting.

An individual seeking an exemption must demonstrate by clear and convincing evidence that an exemption from disqualification should be granted. The application will be reviewed and a decision made once all relevant documentation listed below has been received.

Persons with disqualifying felonies committed within the previous 3 years of the date of this application will not be considered for an exemption.

APPLICATION CHECKLIST:

The following items **must** be included with this Application for Exemption from Disqualification:

- A **criminal history report** dated within the previous six months of this application. Please indicate one of the following:
 - A current criminal history report is attached to this application.
 - A current criminal history report was requested by my employer with the Agency for Health Care Administration's Background Screening Unit.
 - I request the Agency's Background Screening Unit complete a criminal history screening. I have completed and attached "Request for Level 1 Screening" AHCA Form #3110-0002, July 2005. A copy of this form may be found on the Agency's website at: ahca.myflorida.com/MCHQ/Long_Term_Care/Background_Screening/Level_1_Criminal_History_Request_form.pdf. A check or money order for **\$24.00** is enclosed to cover the cost of the screening. Please make checks or money orders payable to *Agency for Health Care Administration*. Some health care positions require a Level 2 fingerprint screening. Please check with the health care provider where you are seeking employment to verify if a Level 2 screening has been conducted.
- Arrest reports** for each offense listed on the criminal history report. The arrest report is a detailed narrative that explains the reason for your arrest. Arrest reports may be obtained from the law enforcement (police department, sheriff's office, etc) agency that made the arrest.
- Court dispositions** for each offense listed on the criminal history report. Court dispositions may be obtained from the clerk of the court in the county in which you were arrested. The disposition is the court document that states what you were actually sentenced for and the conditions of your sentence.
- If you were given **probation or parole**, you will need a letter from the probation department with the following information **required for each offense**: the date you started probation or parole; the date you are scheduled to terminate probation or parole; if you are eligible for early termination of probation or parole; if you have violated probation or parole; and if so, what was the violation.
- Provide **3-5 letters of reference**. One reference letter must be from a current or most recent employer on the employer's letterhead. Other letters must be from individuals you have known for **at least two years** through contact at the workplace, community activities, education or training centers. Individuals providing a letter of recommendation should include their name, address and telephone number for verification or possible interview.
- Documentation of rehabilitation**. Rehabilitation includes successful completion of a court-ordered treatment or counseling program, educational or training certificates, proof of participation in community activities, special recognition or awards received.



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AHCA Use Only	
Date Received:	_____
Date 1 st Reviewed:	_____
Date Omissions Sent:	_____
Date Appl. Complete:	_____
Hearing? Y N	_____
Decision Date:	_____

AUTHORITY: In accordance with section 435.07, Florida Statutes, this application is submitted for an Exemption from Disqualification to seek employment in a health care setting for which employment was denied due to a disqualifying criminal history offense. Disclosure of your social security number is voluntary. The Agency for Health Care Administration shall use such information for purposes of internal identification.

1. PERSONAL INFORMATION

Please complete the following:

YES NO I am submitting this application because I am **currently** employed by a health care provider and have a criminal offense on my record that will be disqualifying after October 1, 2009, pursuant to section 408.809, Florida Statutes.

YES NO I am submitting this application because I **applied** for employment with a health care provider and must obtain an exemption before I can work.

Last Name:	First Name:	Middle Name:	Maiden Name:
Mailing Address:		Phone Number: <i>Please include Area Code</i>	
City:	State:	Zip:	
Social Security Number:	Date of Birth: <i>mm/dd/yyyy</i>	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
List All Prior Names, Aliases, AKAs:	Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Indian <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other: (INDICATE HISPANIC AS BLACK OR WHITE BASED ON SKIN COLOR)		

2. EMPLOYMENT INFORMATION

Name of Provider where you are employed or seeking employment:		
Street Address:		Phone Number: <i>Please include Area Code</i>
City:	State:	Zip:

Please select the type of health care provider for which you work or were denied employment due to your criminal history:

- | | | |
|--|--|--|
| <input type="checkbox"/> Adult Day Care Center | <input type="checkbox"/> Home Health Agency | <input type="checkbox"/> Nursing Home |
| <input type="checkbox"/> Adult Family Care Home | <input type="checkbox"/> Home Medical Equipment | <input type="checkbox"/> Prescribed Pediatric Extended Care |
| <input type="checkbox"/> Assisted Living Facility | <input type="checkbox"/> Homemaker/Companion Service | <input type="checkbox"/> Residential Treatment Facility/Center |
| <input type="checkbox"/> Community Mental Health | <input type="checkbox"/> Hospice | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Crisis Stabilization Unit | <input type="checkbox"/> ICF/DD | |
| <input type="checkbox"/> Health Care Services Pool | <input type="checkbox"/> Nurse Registry | |

Please select the type of position you are seeking an exemption. **NOTE:** Nurses, Certified Nursing Assistants and other professions licensed or certified through the Department of Health (DOH) must apply for an exemption through the appropriate licensing board at DOH.

- | | |
|--|--|
| <input type="checkbox"/> Administrator | <input type="checkbox"/> Homemaker/Companion Sitter |
| <input type="checkbox"/> Chief Financial Officer | <input type="checkbox"/> Maintenance |
| <input type="checkbox"/> Dietary | <input type="checkbox"/> Nursing Assistant (non-certified)/Patient Aid |
| <input type="checkbox"/> Home Health Aide | <input type="checkbox"/> Relief Person |
| <input type="checkbox"/> Owner / Operator w/ 5% or more interest | <input type="checkbox"/> Employee / Staff Person |
| <input type="checkbox"/> Mental Health Personnel | <input type="checkbox"/> Risk Manager |

3. EMPLOYMENT HISTORY

Identify the name and address of each employer, supervisor, address, telephone number, dates of employment and your job responsibilities for the last 5 years. **Please explain any breaks in employment that exceed 3 months.** Attach additional sheets if necessary.

Most Recent Employer:		Supervisor's Name:	
Address:		Telephone Number: (include area code)	
Job Title:	Employment Dates:		
Job Responsibilities:			
Employer:		Supervisor's Name:	
Address:		Telephone Number: (include area code)	
Job Title:	Employment Dates:		
Job Responsibilities:			
Employer:		Supervisor's Name:	
Address:		Telephone Number: (include area code)	
Job Title:	Employment Dates:		
Job Responsibilities:			
Employer:		Supervisor's Name:	
Address:		Telephone Number: (include area code)	
Job Title:	Employment Dates:		
Job Responsibilities:			
Employer:		Supervisor's Name:	
Address:		Telephone Number: (include area code)	
Job Title:	Employment Dates:		
Job Responsibilities:			

4. EDUCATION / TRAINING

Please complete the following and include copies of any certificates, diplomas, licenses if applicable.

1. Are you enrolled in or have you completed a training program to obtain certification or professional licensure in a health-related occupation? Yes No

If Yes, please complete the following:

Name of School/Program	Type of Training (Home Health Aide, Nursing Assistant, etc.)	Date of Training	Training Completed?	Certificate or License Received?
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

2. Have you registered for examinations required to obtain certification or professional licensure in a health related occupation? Yes No

If yes, please complete the following:

Type of Exam	Date Applied for Exam	Date of Exam

5. CONFIRMATION TO REQUEST AN EXEMPTION REVIEW

By submitting this application I formally request an exemption review in accordance with section 435.07, Florida Statutes. The information in this application and the documents I have provided are true and correct. I understand that it is my responsibility to provide clear and convincing evidence that I will not pose a danger to the health or safety of health care patients or their property. I also understand that the decision of the Agency for Health Care Administration regarding this exemption may be contested through a hearing requested under the provisions of Chapter 120, Florida Statutes.

Signature

Date