State of Illinois
Illinois Department of Public Health

HEALTH CARE WORKER WAIVER APPLICATION
Illinois Department of Public Health

Health Care Worker Registry, 525 W. Jefferson St., Fourth Floor, Springfield, IL 62761
Phone 217-785-5133 Fax 217-524-0137 E-mail DPH.HCWR@Illinois.gov

All information requested on this application must be provided before you will be considered for a waiver. Type or print clearly in ink.

Today's Date _____

Name _____ (First, Full Middle and Last)

Address _____ (Street, Apartment #, P. O. Box)

_____ (City, State, ZIP Code)

_____
Maiden Name (or other name(s) used)

_____ _____
Telephone Social Security Number (required)

I hereby authorize the Illinois Department of Public Health, the Department's designee that trains or tests health care workers, a staffing agency, or the health care employer to request a fingerprint-based criminal history records check submitted as a fee applicant inquiry requested by the Department. I further authorize the Illinois State Police (ISP) to release information relative to the existence or nonexistence of any criminal record which it might have concerning me to the requestor solely to determine my suitability for employment or continued employment. I further authorize any agency that maintains records relating to me, including but not limited to the Federal Bureau of Investigation or a local unit of government, to provide same on request to the ISP or the Department. I certify that the ISP and any agency, including the Department, their employees or officers who furnish this information shall be held harmless from any and all liability which may be incurred as a result of releasing such information. I further acknowledge that a health care employer shall not be liable for the failure to hire or retain an applicant or employee who has been convicted of committing or attempting to commit one or more of the offenses stated in the Health Care Worker Background Check Act (225 ILCS 46/25).

I understand that the information requested below regarding sex, race, height, eye color, and date of birth is for the sole purpose of identification, the gathering of the above mentioned information and the processing of this waiver application. This information will not be used to discriminate against me in violation of the law. I understand that the provision of my Social Security number is required by law. A facsimile or photographic copy of this authorization will be as valid as the original.

☐Male ☐Female Race _____ Height _____ Eye Color _____ Date of Birth _____
(Enter a letter from below):

- **A** Chinese, Japanese, Filipino, Korean, Polynesian, Indian, Indonesian, Asian Indian, Samoan, or any other Pacific Islander
- **B** Black or African American (Not Hispanic or Latino)
- **H** Hispanic or Latino (Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin)
- **I** American Indian, Eskimo, or Alaskan native, or a person having origins in any of the 48 contiguous states of the United States or Alaska who maintains cultural identification through tribal affiliation or community recognition.
- **U** Of undetermined race or of untold mixture
- **W** Caucasian (not Hispanic or Latino)

Work History – If you have previously been employed, you must provide an entire work history or attach a complete resume. Start with your current employer. Attach addition pages if necessary.

_____ _____ _____
Employer Date Started Separation Date

_____
Employer's Address, City, State, ZIP Code

_____ _____ _____
Employer Date Started Separation Date

_____
Employer's Address, City, State, ZIP Code

Other states where you have lived or worked _____

If the use of alcohol or other drugs was involved in the offense, were you ordered to participate in a rehabilitation program as part of the judgment? ☐ Yes ☐ No If yes, you must provide proof of successful completion of the rehabilitation program.

Were you required to pay a fine in connection to a disqualifying offense? ☐ Yes ☐ No If yes, you must provide proof of having paid all fines unless you are on a payment schedule. If on a payment schedule, you must provide proof that you are up-to-date on the schedule.

If you were released on probation (or mandatory supervised release) or parole, you must provide proof of having successfully completed it.

Have you been certified as a nurse aide/assistant in another state? ☐ Yes ☐ No If yes, you must attach a copy of your certification or verification information (such as your certification number_____).

Name used when certified_____. If your current name is different, please attach a copy of the legal document(s) used to change your name (i.e. marriage certificate, divorce decree, etc.) and a copy of your driver's license or other picture identification.

Have you ever had an administrative finding of abuse, neglect or theft? ☐ Yes ☐ No

If "yes," indicate in what state this finding was issued. _____

Have you ever been convicted of a criminal offense, other than a minor traffic violation? ☐ Yes ☐ No

If "yes," provide the circumstance surrounding each offense (what happened, how many years have passed since the offense, the individuals involved, your age at the time of the offense, and any other circumstances surrounding the offense) as well as the state in which you were convicted. If you have been convicted in another state, you must provide information concerning those convictions or attach the complete results of a criminal history records check from that state. If you have a federal conviction, you must provide information concerning that conviction or attach the complete results of a criminal history records check from the Federal Bureau of Investigation. If more space is needed, please attach additional pages. Do not include convictions that have been expunged, sealed or were a juvenile adjudication.

A copy of the following items may be submitted with this application but are not required. (This material will not be returned to you)

1. A current or recent employment reference.
2. A character reference.
3. Other evidence demonstrating the ability of the applicant to perform the employment responsibilities competently and evidence that the applicant does not pose as a threat to the health or safety of residents, patients or clients.

I certify that the above is true and correct and give my consent for my name to appear on the Department's Health Care Worker Registry with the results of my criminal history records check.

_____ _____
Signature Date

As the parent or guardian of the above named individual, who is younger than the age of 17, I give my consent for this named individual to have a criminal history records check.

_____ _____
Signature Date

Mail this completed form to Illinois Department of Public Health, Health Care Worker Registry, 525 W. Jefferson St., Fourth Floor, Springfield, IL 62761. The Department will send you a Livescan Request Form by return mail. You will use the Livescan Request Form to have your fingerprints collected from one of the contracted livescan vendors.