State of Illinois
Illinois Department of Public Health

Health Care Worker Waiver Application

(Contact the Health Care Worker Registry at 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. All Fields must be completed or application will not be processed.

Name (First, Full Middle, and Last) *Today's Date*

Address (Street, Apartment #, P. 0. Box, City, State, ZIP Code)

Maiden Name (or other name(s) used) *Email Address*

Phone Number *Social Security Number* ***(REQUIRED)***

Before a waiver can be granted, there must be a record of your criminal history background check listed on the Health Care Worker Registry. If there is not one, you must be fingerprinted by a Livescan fingerprint vendor authorized by the Illinois Department of Public Health (IDPH) and undergo a fingerprint-based criminal history records check. No other background check will be accepted for purposes of a waiver. IDPH will not initiate a Livescan request for you to be fingerprinted. The Department's designee that trains or tests health care workers, a staffing agency, a health care employer, a workforce intermediary, or an organization providing pro bono legal services must initiate the Livescan request and ask you to report for fingerprints. 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, weight, 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 *(Enter a letter from below)*: ___ Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

Date of Birth: _____ Place of Birth: _____

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 *Start Date* *Separation Date*

Employer's Address (City, State, ZIP Code)

Employer *Start Date* *Separation Date*

Employer's Address (City, State, ZIP Code)

Other states where you have lived or worked: _____

Illinois Department of Public Health, Healthcare Worker Registry
525 W. Jefferson, 4th Floor, Springfield, IL 62761; Phone: 844-789-3676; Fax: 217-524-3479; Email: DPH.HCWR@illinois.gov

Printed by Authority of the State of Illinois 2/26
IOCI 26-1136

If the use of alcohol or other drugs was involved in your 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, 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, and/or Theft issued by the Illinois Department of Public Health or the Illinois Department of Human Services? ☐ 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," **YOU MUST PROVIDE A DETAILED DESCRIPTION OF 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 or sealed or that were a juvenile adjudication. Include who, what, when, where and how police got involved in each.

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 appear on the Department's Health Care Worker Registry with the results of his/her criminal history records check.

Signature: _____ Date: _____

Mail this completed form, **along with all supporting documents**, to Illinois Department of Public Health, Health Care Worker Registry, 525 W. Jefferson St., Springfield, IL 62761. Alternatively, you may **fax** this form and supporting documents to (217) 524-3479 or **scan (as a PDF document) and e-mail** this form and supporting documents to **DPH.HCWR@illinois.gov**.