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., Springfield, IL 62761
Phone: 844-789-3676 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. All Fields must be completed or application will not be processed.

Today's Date _____

Name _____ (First, Full Middle, and Last)

Address _____ (Street, Apartment #, P. 0. Box)

_____ (City, State, ZIP Code)

_____ _____
Maiden Name (or other name(s) used) E-Mail Address

_____ _____
Telephone Social Security Number (**REQUIRED**)

Before a waiver can be granted, 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 _____ Height _____ Weight _____ Date of Birth _____
(Enter a letter from below)

Hair Color _____ Eye Color _____ 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 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 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? ☐ 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.

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) 524-0137 or **scan (as a PDF document) and e-mail** this form and supporting documents to DPH.HCWR@illinois.gov.