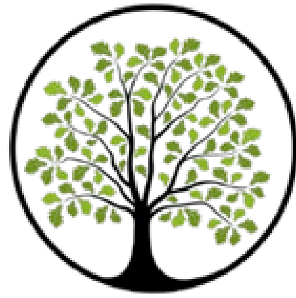

Documents Below Required Before You Can Begin Working

	Item	Where To Get The Item	How Long it's Good For
1.	TB Skin Test	Health Department or Dr.	1 year
2.	CPR & Basic First Aid	Internet: simplecpr.com Red Cross	Simplecpr.com =2 yrs Red Cross = 1 – 3 yrs
3.	CNA License	Tech School	Until Expiration Date
4.	Drivers License / Photo ID	Department of Motor Vehicles	Until Expiration Date
5.	Social Security Card	Provide Photocopy	
6.	Complete Application	Office	Must turn in before receiving first check
7.	PCA Quiz	Clinical Director	1 Year
8.	Insurance		1 Year
9.	Fingerprint	National Background Check	1 Year
10.	Drug Screening	Apple Care	1 Year
11.	Motor Vehicle Records (2-5 year)		1 Year

Application must be mailed to **1000 Corporate Pointe Suite 307 Warner Robins, GA 31088** or hand delivered to the office. Please make a copy of the completed application before mailing in case the application gets lost in the mail. Please call the office to make sure all credentials and application have been received and processed. Failure to receive all credentials and application may result in a delay receiving your first paycheck. **It is your responsibility to send and verify the receipt of your credentials and paperwork.**

Applicant Information Sheet

Please print or type all information. Make legible and clear.

Applicant Name:____

SS#:__________________________ DOB: _________________ Age: ____________

Applicant Address: ____

City:_________________ State:__________ Zip:_________ County:______________

HM Phone: ____________________ WK Phone: _____________________

Cell Phone: ___________________

Email Address: ____

Emergency Contact: ____

Phone Number: ________________ Relationship: _________________________

____

(Below Line For Office Use Only)

Representative Signature: _______________________ Date:____________________

Hire Date: ____________________

Five (5) Year Work History

List what you have been doing for the last 5 years including schooling, employment gaps, and must go back 5 years. **MOST RECENT 1ST**

Start Date:______________________ End Date: ________________________ Position Held: ________________________________

Employer: ____ Phone Number:(___)________________________________

Address: ____

____

Reason for Leaving: ____

Start Date:______________________ End Date: ________________________ Position Held: ________________________________

Employer: ____ Phone Number:(___)________________________________

Address: ____

____

Reason for Leaving: ____

Start Date:______________________ End Date: ________________________ Position Held: ________________________________

Employer: ____ Phone Number:(___)________________________________

Address: ____

____

Reason for Leaving: ____

Start Date:______________________ End Date: ________________________ Position Held: ________________________________

Employer: ____ Phone Number:(___)________________________________

Address: ____

____

Reason for Leaving: ____

Start Date:______________________ End Date: ________________________ Position Held: ________________________________

Employer: ____ Phone Number:(___)________________________________

Address: ____

____

Reason for Leaving: ____

HIPPA Privacy and Security Policy Acknowledgement Form

This notice tells all applicants how and why personal information about applicants will be collected, how it will be handled and with whom the information is shared. We respect the privacy of personal information and maintain it securely according to the privacy and security rules under HIPPA. This notice applies to information regarding all current and former applicants.

Why we collect personal information:

- To determine eligibility for health care coverage.
- To transmit premium payments to the health insurance carrier.
- To provide test results to an officer of the company, government regulatory agencies, or companies that require certain test under contract.
- For pre-employment physicals and to determine fitness for duty of the applicants job.
- To evaluate work related injuries and comply with workers' compensation laws.
- To administer leave under FMLA
- To comply with OSHA, MSHA, and similar state laws.
- For judicial or administrative proceedings.

Personal Information we collect from applicants:

We ask people seeking employment and benefits to provide certain information when they begin employment and enroll in benefit plan. This information includes but not limited to:

- Name, address, and phone number
- Social Security Number
- Birth Date
- Marital Status
- Information regarding current illness, injuries, or disabilities that may affect the ability to perform the job
- Consent to release all applicable information, including physical exams, drug screening and fitness for duty results to the company and its agents and service providers

How we protect personal information under federal law:

Applicant's personal medical information is maintained in accordance with HIPPA and other state or federal law to protect the privacy of such information. The confidentiality, integrity, and availability of any electronic protected health information (EPHI) will be ensured via appropriate safeguards as specified under HIPPAA's security rule's effective date (4/21/2006 for small health plans ; 4/21/2005 for all other covered entities).

How we protect personal information under state law:

Applicant's personal medical information is maintained in accordance with state law where such rules are more stringent than, but not contrary to HIPPAA's privacy rule are preempted by the federal requirements, which means that the federal requirements will apply. The HIPPA privacy rule provides exception to the general rule of federal preemption for contrary state laws required certain health plan reporting, provide greater privacy protections, or provide for the reporting of disease or injury, child abuse, birth, or death.

If you want more information on HIPPA as it applies to your health information, please contact a representative at Majestic Oaks Home Care Agency.

By signing this form, applicant has read and understand the policy of HIPPA.

____ ___________________________

Applicant Signature Date

HIPPA Privacy Rule Applicant Confidentiality Form

I, ____ have read and understand Majestic Oaks policies regarding the privacy of individually identifiable health information (PHI), as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the State of Georgia. In addition, I acknowledge that I have received training in Majestic Oaks policies concerning PHI use, disclosure, storage and destruction as required by HIPAA.

In consideration of my employment or compensation from Majestic Oaks Homecare Agency, I hereby agree that I will not at any time – either during my period of employment or association with Majestic Oaks or after my employment ends – use, access or disclose PHI to any person or entity, internally, or externally, except as is required and permitted in the course of my duties and responsibilities with Majestic Oaks, as set forth in Majestic Oaks privacy policy and procedures or as permitted under HIPAA. I understand that this obligation extends to and PHI that I may acquire during the course of my employment or association with Majestic Oaks, whether in oral, written or electronic form and regardless of the manner in which access was obtained.

I understand and acknowledge my responsibility to apply Majestic Oaks policies and procedures during the course of my employment or association. I also understand that unauthorized use of disclosure of PHI will result in disciplinary action, up to and including termination of employment or association with Majestic Oaks and imposition of civil penalties and criminal penalties under the applicable federal and state law, as well as professional disciplinary action as appropriate.

I understand that this obligation will survive the termination of my employment or end of my association with Majestic Oaks Homecare Agency, regardless of the reason for such termination.

By signing this form, applicant has read and understand the policy of HIPPA.

____ ___________________________

Applicant Signature Date

Applicant Non-Disclosure Agreement

FOR GOOD CONSIDERATION, and in consideration of being employed by or associated with Majestic Oaks Home Care Agency, hereby and after referred to as the company, the undersigned applicant hereby agrees and acknowledges:

1. That During the course of my employment there may be disclosed to me certain trade secrets of the company or client, patient, and/or member; said trade secrets consisting but not necessarily limited to:
    a. Technical information: Methods, processes, formulas, compositions, systems, techniques, inventions, machines, computer programs, and research projects.
    b. Business information: Customer lists, pricing data sources of supply, financial data, marketing, production or merchandising systems or plans.

2. I agree that I shall not during, or at any time after the termination of my employment or end of association with the company, use for myself or others, or disclose or divulge to other including future employers, trade secrets, confidential information, or any other proprietary data of the company in violation of this agreement.

3. That upon the termination of my employment of end of association with the company:
    a. I shall return to the company all documents a d property of the company, including but not necessarily limited to: drawings, blueprints, reports, manuals, correspondences, customer list, computer programs, and all other materials and all copies thereof relating in any way to the company's business, or in any way obtained by me during the course of employment. I further agree that I shall not retain any copies, notes or abstracts of the foregoing.
    b. The company may notify any future or prospective employer of the former employee or former associates of the existence of this agreement and shall be entitled to full injunctive relief for any breach.
    c. This agreement shall be binding upon me and my personal representatives and successor in interest, and shall insure to benefit the company, its successors and assigns.

By signing this form, applicant has read and understands the Applicant Non-Disclosure Agreement.

____ ______________________

Applicant Signature Date

Code of Ethics

Caregivers <u>CAN DO</u>	Caregivers <u>CANNOT DO</u>
Assist with Eating	Wound Care
Bathing	NG Tube Feeding
Dressing	Catheters
Personal Hygiene	Suppositories
Housekeeping	Prepare, Dispense, or assist with medication
Transfer Assistance	Bowel Programs
Hair/Dental/Skin Care	Any Form of Nursing Services
Condom Catheter Care	
Foley Catheter Care	
Activities of Daily Living	
Companion Sit	

Caregivers can NOT under any circumstances:

1. Use member's care for personal reasons.
2. Consume member's food or beverages.
3. Use member's telephone for personal calls.
4. Discuss political or religious beliefs, or personal problems with the member.
5. Accept gifts or financial gratuities (tips) from the member or member's representative.
6. Lend money or other items to the member; borrow money or other items from the member or member's representative.
7. Sell gifts, food, or other items to or for the member.
8. Purchase any item for the member unless directed in member's care plan.
9. Bring other visitors (e.g., CHILDREN, FRIENDS, RELATIVES, PETS, etc.) to the member's home AT ANY TIME.
10. Smoke in the member's home.
11. Report for duty under the influence of alcoholic beverages or illegal substance.
12. Sleep in the member's home.
13. Remain in the member's home after services have been rendered.
14. Move in with member
15. Bring children to work with them.

If you have any questions about the above information or if you need help determining approved tasks, please call the office for assistance. Our nurse can answer any questions about the approved tasks.

By signing this form, applicant has read and understands What Caregivers Can and Cannot Do.

____ ________________________

Applicant Signature Date

Member’s Rights & Responsibilities

1. The client has the right to be informed about the plan of service and to participate in the planning.
2. The client has the right to be promptly and fully informed of any changes in the plan of service.
3. The client has the right to accept or refuse service.
4. The client has the right to be fully informed of the charges for services.
5. The client has the right to be informed of the name, business telephone number, business address and how to contact the person supervising services.
6. The client has the right to be informed of the complaint procedures and the right to submit complaints without fear of discrimination or retaliation and to have complaints investigated by Majestic Oak Home Care within a reasonable period of time.
7. The client has the right to have property and residence treated with respect.
8. The client has the right of confidentiality of client records.
9. The client has the right to receive a written notice of the address and telephone number of the state licensing authority, which further explains that the department is charged with the responsibility of licensing Majestic Oaks Home Care and investigating client complaints which appears to violate licensing regulations. Call or write (404) 657-5850 Healthcare Facility Regulations Division, 2 Peachtree St. N.W. Atlanta GA, 30303.
10. The client has the right to obtain a copy of Majestic Oaks most recently completed report of licensure inspection upon request.
11. The client is advised that the client and the responsible party , if applicable, must advise Majestic Oaks of any changes in the client’s conditions or any events that affect the client’s service needs.
12. The client has the right to present, either orally or in writing, complaints about services, and to have their complaints addressed and resolved as deemed appropriate by Majestic.
13. The client is advised that the client and the responsible party, if applicable, must advise Majestic Oaks immediately if a caregiver fails to arrive as scheduled to provide care.

By signing this form, applicant has read and understands the Member’s Rights and Responsibilities.

____ __________________________

Applicant Signature Date

Member Rights and Responsibilities

Member's rights include:

1. The right of access to accurate and easy to understand information.
2. The right to be treated with respect and to maintain ones dignity and individuality.
3. The right to voice grievances and complaints regarding treatment or care that is furnished, without fear of retaliation, discrimination, coercion, or reprisal.
4. The right of choice of an approved provider.
5. The right to accept or refuse services.
6. The right to be informed of and participate in preparing the care plan and any changes in the plan .
7. The right to be advised in advanced of the providers who will furnish care and the frequency and duration of visits ordered.
8. The right to confidential treatment of all information, including information in the member record.
9. The right to receive services in accordance with the current plan of care.
10. The right to be informed of the name, business telephone number and business address of the person/agency supervising the services and how to contact that person/agency.
11. The right to have property and place of residence treated with respect.
12. The right to review member's records on request.
13. The right to receiver care and services without discrimination.

Independent Care Waiver Services

Member's Responsibilities include:

1. The responsibilities to notify case manager/service providers of any changes in care needs.
2. The responsibility to treat provider staff in a courteous and respectful manner, as well as cooperate with and respect the rights of the caregiver providing care.
3. The responsibility to be as accurate as possible when providing information on health history and personal care needs.
4. The responsibility to participate actively in decisions regarding individual health care service care plan development.
5. The responsibility to comply with agreed upon care plans.
6. The responsibility to notify the member's physical, providers, and caregiver of any changes in one's condition.
7. The responsibility to maintain a safe home environment and to inform providers of the presence of any hazard in the home.
8. The responsibility to be available to provider staff at agreed upon time services are scheduled to be rendered.

By signing this form, applicant has read and understands the member rights and responsibilities.

____ __________________________

Applicant Signature Date

Member Abuse, Neglect, Exploitation and Resolution of Complaints

Policy

All individuals with a prior conviction on charges of abuse, neglect, mistreatment, or financial exploitation are prohibited from performing direct member care duties.

Procedure

All incidents of abuse, neglect, exploitation and or complaints submitted by client, caregiver or any responsible parties either orally or in writing will be documented in the complaint log book. All actions taken to resolve incident of abuse, neglect exploitation and or complaints will be documented in complaint and resolution log book. A representative of Majestic Oaks will conduct a thorough investigation of all incidents of abuse, neglect, exploitation and or complaints submitted to Majestic Oaks in WRITING. Majestic Oaks will report to DCH/GHP within 5 days. A plan of correction will be submitted with the investigators report. A copy of the K-3 and plan of correction will be maintained in an accident and incident file for review by DCH. Majestic Oaks will take all steps to assure that no other incidents or abuse takes place while the investigation is ongoing.

Abuse, neglect of care or exploitation includes, but is not limited to:

A. Unauthorized or inappropriate touching of a member such as pushing, striking, slapping, pinching, beating, fondling, etc.
B. Use of physical or chemical restraints.
C. Withholding of food, water, or medications unless the member has requested the withholding.
D. Psychological or emotional abuse (verbal berating, harassment, intimidation, or threats of punishment or deprivation.)
E. Isolating member from member representative, family, friends or activities.
F. Sexual harassment, exploitation or rape.
G. Failure to provide basic care or seek medical care.
H. Inadequate assistance with personal care, changing bed linen laundry, etc.
I. Ostracizing the member or giving the silent treatment.
J. Leaving a member alone for long periods of time.
K. Taking a member's money or property by force, threat, or deceit.
L. Use of member's money or property against the member's wishes or without the member's knowledge.

By signing this form, applicant has read and understands the Member Abuse.

____ ______________________

Applicant Signature Date

Dress Code & Safety

Dress Code:

- Tennis Shoes – Rubber non-slip soles
- Professional Dress at all times (Scrubs or Majestic Oaks Uniform)
- Cleanliness and Good Personal Hygiene
- Fingernails trimmed short and neat at all times
- Minimal jewelry

Safety:

- Keep walking area and area around the member's bed clear and free of any trip hazards including cords.
- Use legs to lift straight up. Do not lift with back bent.
- Immediately clean any spills/fluids off floor that can cause slip or injury.
- Wear gloves at all times.

By signing this form, applicant has read and understands the Dress Code.

____ ___________________

Applicant Signature Date

Active Applicant Certificate of Agreement of Majestic Oaks Home Care's

Policy & Procedure Handbook

I ____, have been provided a copy of Majestic Oaks Home Care Policy and Procedure Handbook, I have also received the Substance Abuse and Testing Policy. I have read and understand that if my performance indicates it is necessary, or in the case of random testing, I will submit to a drug test. I also understand that failure to comply with the substance abuse test request or a positive result may lead to termination of employment or assignment and denial of unemployment benefits. I understand that failure to submit to a substance abuse test or a positive test result my affect my right to obtain workers compensation benefits. I further agree to and hereby authorize the release of the results of said test to the company. I have read and been given the opportunity to ask questions, and been given the answers to my questions about all material contained within this handbook for future reference and will advise office personnel if I should need another copy in the future. Nothing in this content form is to be construed as a contract between the parties.

____ _____________________

Applicant Signature Date

Majestic Oaks Signature Page

Responsibility to Report Known Exposure

As a part of the Majestic Oaks family, I understand that it is the applicant's responsibility and obligation to report any known exposure such as but not limited to: Tuberculosis and Hepatitis to Majestic Oaks immediately:

____ _____________________

Applicant Signature Date

Evidence of Abuse

As applicant I understand that the Georgia Department of Community Health will not allow anyone who has been shown, by credible evidence to have abused, neglected, sexually assaulted, exploited, or deprived any person or to have subjected any person to serious injury as a result of intentional or gross negligent misconduct as evidence by an oral or written statement to the effect obtained at the time of the application.

By signing this form, applicant states to have no evidence of Abuse in the applicant background.

____ _____________________

Applicant Signature Date

Acknowledgement of Initial Orientation and Receipt of Majestic Oaks Policy & Procedure Handbook

I, ____________________________________, as part of my initial orientation I have been provided a copy of Majestic Oaks Policy and Procedure Handbook. I have read and been given the opportunity to ask questions about the content and materials contained within, and have my questions answered by Office Personnel. I fully understand all of the Policies and Procedures set in place by future reference and will advise office personnel if I should require another copy in the future.

I agree and understand that the purpose of this handbook is to inform me about the company's policies and procedures and nothing contained in this handbook constitutes and employment contract between the company and me.

I agree and understand that I am PRN (as needed) and as said PRN, I am not guaranteed any hours or days of employment, and my employment may be terminated, at any time with or without cause and with or without notice at either my option or at the option of the company.

I understand and agree that the company reserves the right to modify or terminate any policies or procedures, in whole or in part, at any time, with or without notice. Since the information is subject to change, I acknowledge that revisions to the handbook may occur and it is my responsibility to view the most up to date handbook. **Upon termination of employment, employee shall turn in all equipment and uniforms within 48 hours. If property is not delivered, employees pay shall be docked to reflect to total cost of items**.

___________________________________ _____________________

Applicant Signature Date

Applicant Direct Deposit Authorization

Applicant Name: ____

SS#: _____________-_____________-______________

I hereby authorize Majestic Oaks to initiate credit entries or such adjusting entries, either credit or debit which are necessary for corrections, to my account indicated below and the depository indicated below to credit or debit the same such account.

Applicant Name as appears on Account: ____

Bank Name: ____

Depository Account #: ____

Routing #:____ Checking____ Savings______

This authority is to remain in full force and effect until Majestic Oaks has received written notification from me of its termination in such time and in such manner as to afford Majestic Oaks a reasonable opportunity to act on it. I understand that enrolling in direct deposit could take up to 2 weeks for processing and to go into effect.

*** Changes to this direct deposit will not be accepted by telephone; all changes must be put in writing, with the applicant's signature and faxed, emailed or mailed to the office. If changes are not received by Monday prior to the Friday Payroll no changes will be made until the following payroll to allow time for processing.

____ ___________________

Applicant Signature Date

Job Description

Personal support services perform personal care task such as, but not limited to, assistance with eating, bathing, dressing, personal hygiene, preparation of meals, housekeeping tasks, positioning, home management, home safety, sanitation, infectious control, taking of vital signs, proper nutrition and other activities of daily living as determined by appropriate staff. Personal support will be provided by staff that appropriate trained and/or certified.

Caregivers shall conduct the following based on care plan:

- **Assist with bathing**
- **Prepare Meals**
- **Wash dishes**
- **Clean Bathroom**
- **Clean Bedroom**
- **Change Linens**
- **Assist with dressing and undressing**
- **Housekeeping**
- **Run Errands**
- **Empty Trash**
- **Dust Furniture**
- **Transferring**

Caregiver Name:____ Start Date:_____________________

Supervisor Signature:____ Date:___________________________

By signing this statement I certify that the Supervisor/Staffing Coordinator have gone over all of my above named duties. These are descriptive duties that are required of me to perform on my job at the above mentioned client’s home.

Caregiver Signature:____ Date:_______________________

ACKNOWLEDGEMENT OF APPLICANT'S NON-CRIMINAL JUSTICE PRIVACY RIGHTS AND CONSENT TO BE INCLUDED IN THE CAREGIVER PORTAL

SECTION I – PRIVACY RIGHTS - TO BE COMPLETED BY INDIVIDUAL BEING FINGERPRINTED:

APPLICANT TYPE:
- ☐ Owner (Facility)
- ☐ Applicant for Employment/Direct Access Employee (Facility)
- ☐ Non-Employee (Facility Volunteer)
- ☐ Contractor/Direct Access (Facility)

PRINT FULL NAME ______________________ ______________________ ______________________ ______________________
Last First Middle Date of Birth (mm/dd/yyyy)

Home Address______________________ ______________________ __________ __________
Street City State Zip

______________________ ______________________
Email Address Telephone No.

____
Name of Facility

______________________ ______________________ __________ __________
Street City State Zip

I hereby authorize the Georgia Department of Community Health (DCH), Office of Inspector General, to receive any criminal history record information pertaining to me which may be in the files of any state or local criminal justice agency in Georgia. I understand a State and Federal fingerprint criminal background check will be conducted. By signing below, I am indicating that I have read and understand the terms and conditions of the attached Non-Criminal Justice Applicant's Privacy Rights and Policy Act Statements.

______________________________ ______________
Applicant Signature Date

SECTION II – CAREGIVER PORTAL - TO BE COMPLETED ONLY BY AN APPLICANT OR EMPLOYEE BEING FINGERPRINTED AS PART OF FACILITY LICENSURE. DOES NOT INCLUDE OWNERS OR FAMILY EMPLOYERS.

APPLICANT TYPE
- ☐ Applicant for Employment/Direct Access Employee (Licensed Facility)
- ☐ Non-Employee (Volunteer at Licensed Facility)
- ☐ Contractor/Direct Access Employee (Licensed Facility)

The Georgia Caregiver Portal only contains the eligibility status of applicants and employees who have successfully passed the background screening process. The Caregiver Portal does not contain the names of applicants and employees who are ineligible. Family employers can access the Caregiver Portal to view a prospective applicant or current employee's eligibility to determine their suitability for employment to provide personal care services to that employer's elderly family member or wards. All services are performed at locations not licensed by DCH. Individuals should check one of the boxes below.

☐ I **agree** to the results of my background check determination being available to family employers in the Georgia Caregiver Portal.

☐ I am seeking employment only by licensed healthcare employers. I **do not want or agree** to the results of my background check determination being available to family employers.

______________________________ ______________
Applicant Signature Date

Non-Criminal Justice Applicant's Privacy Rights

As an applicant that is the subject of a Georgia only or a Georgia and Federal Bureau of Investigation (FBI) national fingerprint/biometric-based criminal history record check for a non-criminal justice purpose (such as an application for a job or license, immigration or naturalization, security clearance, or adoption), you have certain rights which are discussed below:

- You must be provided written notification that your fingerprints/biometrics will be used to check the criminal history records maintained by the Georgia Crime Information Center (GCIC) and the FBI, when a federal record check is so authorized.
- If your fingerprints/biometrics are used to conduct a FBI national criminal history check, you are provided a copy of the Privacy Act Statement that would normally appear on the FBI fingerprint card.
- If you have a criminal history record, the agency making a determination of your suitability for the job, license, or other benefit must provide you the opportunity to complete or challenge the accuracy of the information in the record.
- The agency must advise you of the procedures for changing, correcting, or updating your criminal history record as set forth in Title 28, Code of Federal Regulations (CFR), Section 16.34.
- If you have a Georgia or FBI criminal history record, you should be afforded a reasonable amount of time to correct or complete the record (or decline to do so) before the agency denies you the job, license or other benefit based on information in the criminal history record.
- In the event an adverse employment or licensing decision is made, you must be informed of all information pertinent to that decision to include the contents of the record and the effect the record had upon the decision. Failure to provide all such information to the person subject to the adverse decision shall be a misdemeanor [O.C.G.A.§35-3-34(b) and §35-3- 35(b)].

You have the right to expect the agency receiving the results of the criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of state and/or federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.

If the employment/licensing agency policy permits, the agency may provide you with a copy of your Georgia or FBI criminal history record for review and possible challenge. If agency policy does not permit it to provide you a copy of the record, information regarding how to obtain a copy of your Georgia, FBI or other state criminal history may be obtained at the GBI website (http://gbi.georgia.gov/obtaining-criminal-history-record-information).

If you decide to challenge the accuracy or completeness of your Georgia or FBI criminal history record, you should send your challenge to the agency that contributed the questioned information. Alternatively, you may send your challenge directly to GCIC provided the disputed arrest occurred in Georgia. Instructions to dispute the accuracy of your criminal history can be obtained at the GBI website (http://gbi.georgia.gov/obtaining-criminal-history-record-information).

Privacy Act Statement

Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.