Employment Application in PDF instructions:
1) Complete and save application; 2) E-mail as an attachment; OR 3) Print and fax or mail completed application.

EMPLOYMENT APPLICATION

HAWAII HEALTH SYSTEMS CORPORATION

CORPORATE OFFICE
3675 Kilauea Avenue, Honolulu 96816

OAHU REGION
Maluhia (Kalihi, Palama, Kapalama)
Leahi Hospital (Kaimuki, Waialae, Kahala)

MAUI REGION
Maui Memorial Medical Center (Wailuku)
Kula Hospital
Lana'i Community Hospital

KAUAI REGION
Samuel Mahelona Memorial Hospital (Kapaa)
Kauai Veterans Memorial Hospital (Waimea)

EAST HAWAII REGION
Hilo Medical Center
Hale Ho'ola Hamakua (Honokaa)
Kau Hospital

WEST HAWAII REGION
Kona Community Hospital
Kohala Hospital

The information you provide will be used to determine whether you meet public employment requirements and the minimum qualification requirements specified in the vacancy announcement. **It is Hawaii Health Systems Corporation's policy to provide equal opportunity in all areas of the employment practices and to assure that there is no discrimination against its employees or applicants** on the basis of race, sex (including pregnancy), sexual orientation, age, religion, color, ancestry, national origin, disability, marital status, U.S. veteran status, national guard participation, arrest and court record (except as permitted by law) or other protected status.

Please type or print legibly in ink

1. Title Of Job Applying For:	**2. Recruitment Number:**
3. Name (last, first, middle):	**4. Phone Number(s):** Home:
5. Mailing Address:	Work:
Number, Street	Cell:
	E-mail:
City / State / Zip Code	

Previously employed with HHSC? ☐ No ☐ Yes If yes, Facility Name: _____ Position Title _____

I will accept job which is: A. ☐ Permanent, Full-Time B. ☐ Permanent, Part-Time C. ☐ Temporary, Full-Time D. ☐ Temporary, Part-Time

How did you hear about this position? ☐ HHSC Website ☐ Family/Friends ☐ Newspaper specify: _____

☐ Other, specify ☐ Journal/Magazine, specify ☐ Internet, specify

7. EDUCATION: Please submit proof or evidence of having completed the course(s) of study.

Name and location of last grade attended:(elementary, intermediate or high school)		Highest Grade Completed:	

In-Service Training, Business, Trade, Armed Forces, College or University, Graduate or Professional Schools

Name & Address	From Mo. Yr.	To Mo. Yr.	Course Or Major Field Of Study	Number Of Credits Or Hours Completed Sem'tr	Quarter	Kind Of Degree, Diploma Or Certificate Received

8. OTHER QUALIFICATIONS:

LICENSE OR CERTIFICATE: Please indicate the kind, registration number, and the State or other licensing authority.
If proof or evidence is required as indicated in the vacancy announcement, please submit a copy or present for verification.

1) PROFESSIONAL LICENSE:		2) OTHER (DRIVER'S LICENSE, etc.):
Identification Number:		
Expiration Date:		
Type:		

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9. EXPERIENCE. **Please begin with your present or last employment and work backward showing all of your employment for the past 20 years**. In addition, describe all training, including military service and volunteer work, which you have received. To receive full credit for your experiences, use separate blocks if your duties and responsibilities changed while working for the same employer describing in detail the tasks you were assigned. If you supervised others, explain your duties as a supervisor and indicate the number and types of employees you supervised. If more space is needed use a blank sheet and attach it to this form. Your answers may be verified with former employers. **NOTE**: If you do **not** have any work experience, please indicate "No work experience" or "No employment history" in this section. Your employment application may be disqualified, if you fail to complete this section thoroughly. ***Please complete even if attaching a resume***.

PRESENT OR LAST POSITION

DO NOT WRITE IN THIS SPACE

Employer		From (mm/yy):		To (mm/yy):			
Employer's Address		Phone Nbr:		Average Hrs per week:			
☐ Full Time ☐ Part Time ☐ Vol	Starting Salary:		Per:		Ending Salary:		Per:
Name & Title of Your Supervisor		Your Title					
Duties & Responsibilities							
Reasons for Leaving:		May we contact your present employer?: ☐ Yes ☐ No					

Employer		From (mm/yy):		To (mm/yy):			
Employer's Address		Phone Nbr:		Average Hrs per week:			
☐ Full Time ☐ Part Time ☐ Vol	Starting Salary:		Per:		Ending Salary:		Per:
Name & Title of Your Supervisor		Your Title					
Duties & Responsibilities							
Reasons for Leaving:							

Employer		From (mm/yy):		To (mm/yy):			
Employer's Address		Phone Nbr:		Average Hrs per week:			
☐ Full Time ☐ Part Time ☐ Vol	Starting Salary:		Per:		Ending Salary:		Per:
Name & Title of Your Supervisor		Your Title					
Duties & Responsibilities							
Reasons for Leaving:							

Employer		From (mm/yy):		To (mm/yy):			
Employer's Address		Phone Nbr:		Average Hrs per week:			
☐ Full Time ☐ Part Time ☐ Vol	Starting Salary:		Per:		Ending Salary:		Per:
Name & Title of Your Supervisor		Your Title					
Duties & Responsibilities							
Reasons for Leaving:							

10. PLEASE NOTE: Information requested in items A, B and C are needed to make determinations on your suitability for employment. Dishonorable separations from military service do not automatically disqualify you from employment, however, certain Federal and State laws allow us to disqualify individuals with convictions for those offenses noted below.

A. DISHONORABLE SEPARATIONS FROM MILITARY SERVICE ☐ YES ☐ NO
Within the past 5 years, were you separated from military service under conditions other than honorable?

B. CONVICTION FOR A VIOLATION OF ANY OF THE FOLLOWING: ☐ YES ☐ NO

1) Controlled substance-related offense in the three-year period immediately preceding the date of the application.
2) State or federal healthcare program-related crimes.
3) Patient abuse, neglect or mistreatment.
4) Felony conviction after August 21, 1996 of fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct in connection with a healthcare program.
5) Felony conviction after August 21, 1996 relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance**.**
6) Any act, attempt, or conspiracy to overthrow the State or the federal government by force or violence.

C. HAVE YOU BEEN THE SUBJECT OF ANY ADVERSE ACTION(S) BY ANY PROFESSIONAL OR VOCATIONAL LICENSING ORGANIZATION(S)? ☐ YES ☐ NO

D. IF YOU ANSWERED "YES," TO ANY OF THE ABOVE, PLEASE PROVIDE EXPLANATION, INCLUDING DATE AND CIRCUMSTANCES SURROUNDING THE INCIDENT UNDERLYING THE CONVICTION OR ADVERSE ACTION.

11. VETERAN'S PREFERENCE: Do you claim veteran's preference? ☐ YES ☐ NO

To receive veteran's preference, you must submit a copy of your DD-214 or honorable discharge certificate, showing dates of honorable service with this application or an official statement from the Veterans Administration or armed service dated within the past 12 months which confirms service-connected disability. Spouses or widows must also submit evidence of marriage, and as applicable, veteran's death.

12. CERTIFICATION (Please read carefully before signing)

A. I certify that all statements made on this application for employment are true and complete to the best of my knowledge. I understand and agree that any misrepresentation or omission whenever discovered, is grounds for the denial of or immediate separation from employment. Providing my SSN is voluntary and to be used only for employment purposes.

B. Offers of employment will be conditioned on the results of a complete physical examination, which includes a drug screening. The pre-employment drug-testing will normally be required to be done within twenty-four (24) hours from the time the conditional offer of employment is made. The drug testing will be conducted at an appropriate drug-testing laboratory and shall be administered in accordance with applicable state and/or federal laws. For certain job categories, applicants may be referred to a HHSC designated physician, rather than the applicant's personal physician of choice. The cost for all physical examinations, except the cost for the drug screening, shall be borne by the applicant and not the Hawaii Health Systems Corporation. The Hawaii Health Systems Corporation shall bear the cost of the drug screening.

C. If employed by the Hawaii Health Systems Corporation (HHSC), I agree to conform to the guidelines and policies of the HHSC. I understand that unless otherwise provided by collective bargaining agreements or law, and if appointed to an exempt position, my exempt employment is "at will" and may be terminated by myself or by HHSC with or without cause.

D. I consent to and authorize HHSC to communicate with all my former employers, school officials, government agencies, and persons named as references, and to make any investigation of my employment history. In consideration for HHSC's review of this application, I release HHSC and any other person or company responding to any reference or information from any claim or liability regarding any information or opinion supplied. I understand that any offer of employment is subject to satisfactory references. In consideration for employment, I further authorize HHSC to disclose information about my job performance with HHSC to any prospective employer upon request of that prospective employer. I specifically waive any claims against HHSC for such disclosure unless it is established by clear and convincing evidence that such information was knowingly false or rendered with malicious purpose and also such disclosure was not otherwise privileged.

E. I understand that other checks required by HHSC to comply with various governmental programs such as Medicare and Medicaid will be conducted and any offer of employment and continued employment will be contingent on the satisfactory return of these checks.

F. State and Federal criminal history record checks will be conducted. Depending on the circumstances, an applicant with a conviction may be denied employment.

G. Conditions for business purposes include, but are not limited to the following: overtime, shift work, rotating shift work schedule, or a work schedule other than the weekdays. I understand and accept these as conditions of my employment.

H. I understand that if I am offered employment, I will be required to submit proof of U.S. citizenship or immigration documentation establishing authorization to work in the United States.

I. I understand and agree that if I am employed by HHSC, all of the foregoing terms are continuing conditions of my employment with the Hawaii Health Systems Corporation.

Applicant's Signature	Social Security Number	Date

HAWAII HEALTH SYSTEMS
C O R P O R A T I O N

"Touching Lives Every Day"

DRUG SCREENING AUTHORIZATION FORM

Name _____

I understand that Hawaii Health Systems Corporation (HHSC) has established a policy, whereby any person who has received a conditional offer of employment, or is seeking to provide services to HHSC or wants to be considered for clinical instruction, will be tested for the presence of drugs.

1. I agree to present myself at the appointed time at the testing laboratory designated by HHSC and identify myself with a valid picture identification (i.e., Hawaii Driver's License, State Identification Card, Passport or Military Identification Card).
2. I understand that if I fail to report to the test site at my appointed time, this will be deemed as a "refusal to test", and the respective Human Resources Office may rescind any conditional offer of employment or may disapprove the request for vendor services or may not consider me for clinical instruction.
3. I authorize the testing laboratory to take from me the required specimen for testing.
4. I understand that the specimen will be tested to determine the presence of drugs, using a chain of custody procedure to ensure the integrity of the specimen and its identification.
5. I understand that my specimen will be tested for the following drugs: marijuana, cocaine, opiates, amphetamines (including crystal methamphetamine), phencyclidine (PCP), barbiturates, propoxyphene, methaqualone, benzodiazephines, and methadone.
6. I understand that over-the-counter medications or prescribed drugs may result in a positive test result and that I will have an opportunity to discuss my medications/drugs with the Medical Review Officer (MRO) if my specimen tests positive.
7. I understand that a copy of the results of this testing will be forwarded to the respective Human Resources Office of the applicable facility for review and that the facility may rescind any conditional offer of employment, or may disapprove the request for vendor services or may not consider the student/teacher for clinical instruction if the results indicate the presence of any illegal, dangerous or unauthorized drugs in my system.
8. I understand that if I do not agree with the results of the drug test, I may request a re-test (using the same sample) by contacting the Medical Review Officer (MRO) within three (3) working days of being notified of the test results.
9. I understand that if I am accepted for employment, to provide services or for clinical instruction with HHSC, I will abide by the HHSC Alcohol Free and Drug Free Working Environment Policy.
10. In addition, I agree to release to HHSC and its affiliates, agents and employees from any and all liability or responsibility related to the administration of testing, testing procedures, or any act or omissions arising there from or related thereto.

Signature: _____ Date: _____

***Please return completed form to Human Resources.**