Employment Application in PDF instructions:
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PHYSICIAN/MEDICAL STAFF EMPLOYMENT APPLICATION ONLY

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

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.

TITLE OF JOB APPLYING FOR:	**RECRUITMENT NUMBER:**

NAME:

(Last)	(First)	(Middle)

OFFICE ADDRESS:

(Street Address)	(City)	(State)	(Zip Code)

HOME ADDRESS:

(Street Address)	(City)	(State)	(Zip Code)

MAY WE CONTACT YOU AT YOUR OFFICE? ☐ YES ☐ NO

WORK NUMBER:		**HOME NUMBER:**	
CELL NUMBER:		**PAGER NUMBER:**	
EMAIL ADDRESS:			
SPECIALTY:		**SUB-SPECIALTY:**	

EDUCATION & TRAINING:

HIGH SCHOOL:

(Name)	(City)	(State)	(Zip Code)

COLLEGE:

(School Name)	(Number of Years Attended)	(Degree)

(Street Address)	(City)	(State)	(Zip Code)

MEDICAL/PROFESSIONAL SCHOOL:

(School Name)	(Number of Years Attended)	(Degree)

(Street Address)	(City)	(State)	(Zip Code)

POST GRADUATE EDUCATION OR TRAINING:

(School Name)	(Number of Years Attended)	(Degree)

(Street Address)	(City)	(State)	(Zip Code)

INTERNSHIP:

(School Name)	(Number of Years Attended)	From:	To:	(Degree)

(Street Address)	(City)	(State)	(Zip Code)

RESIDENCY TRAINING:

(Name of Program/Specialty)	(Number of Years Attended)	From:	To:	(Telephone)

(Street Address)	(City)	(State)	(Zip Code)

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FELLOWSHIP TRAINING:			From:		To:		
	(Name of Program/Specialty)	(Number of Years Attended)					(Telephone)
	(Street Address)		(City)			(State)	(Zip Code)

PROFESSIONAL REFERENCES:

MEDICAL/ PROFESSIONAL SCHOOL:		
	(Name & Title)	(Telephone)
	(Street Address)	(City) (State) (Zip Code)
INDICATE RELATIONSHIP:		

INTERNSHIP:		
	(Name & Title)	(Telephone)
	(Street Address)	(City) (State) (Zip Code)
INDICATE RELATIONSHIP:		

RESIDENCY/FELLOWSHIP:		
	(Name & Title)	(Telephone)
	(Street Address)	(City) (State) (Zip Code)
INDICATE RELATIONSHIP:		

EMPLOYMENT OR OTHER PROFESSIONAL REFERENCES: **Refer to individuals who know you well, through your training programs or current practice.**

1.						
	(Name & Title)	(Street Address)	(City)	(State)	(Zip Code)	(Telephone)
INDICATE RELATIONSHIP:						
2.						
	(Name & Title)	(Street Address)	(City)	(State)	(Zip Code)	(Telephone)
INDICATE RELATIONSHIP:						
3.						
	(Name & Title)	(Street Address)	(City)	(State)	(Zip Code)	(Telephone)
INDICATE RELATIONSHIP:						

Are you personally acquainted with any present or former member of our medical staff? **Yes** ☐ **No** ☐

Name:

WORK HISTORY, POST INTERN AND/OR RESIDENCY EXPERIENCE: **Position held, including military service. List most recent position first.**

1. POSITION:		Date:	To:	
ADDRESS:				
	(Street Address)	(City)	(State)	(Zip Code) (Telephone)
REASON FOR LEAVING:				

2. POSITION:		Date:	To:	
ADDRESS:				
	(Street Address)	(City)	(State)	(Zip Code) (Telephone)
REASON FOR LEAVING:				

3. POSITION:		Date:	To:	
ADDRESS:				
	(Street Address)	(City)	(State)	(Zip Code) (Telephone)
REASON FOR LEAVING:				

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IS ALL PREVIOUS WORK EXPERIENCE LISTED? Yes ☐ No ☐ **IF NOT, PLEASE LIST ON A SEPARATE SHEET OF PAPER AND ATTACH.**

HOSPITAL PRIVILEGES:

1.						
	(Hospital)	(Street Address)	(City)	(State)	(Zip Code)	(Telephone)
	(Type of Privileges)					
2.						
	(Hospital)	(Street Address)	(City)	(State)	(Zip Code)	(Telephone)
	(Type of Privileges)					
3.						
	(Hospital)	(Street Address)	(City)	(State)	(Zip Code)	(Telephone)
	(Type of Privileges)					

CURRENT MALPRACTICE INSURANCE CARRIER:

(Name of Carrier)			(Telephone)
(Street Address)	(City)	(State)	(Zip Code)

LICENSURE AND CERTIFICATIONS:

Primary:

Are you currently Board Certified? Sub-specialty: Which Boards? Date Certified:

Are you eligible to take your specialty boards? ☐ Yes ☐ No When:

Which exam have you taken:
☐ USMLE (Parts I, II, III) ☐ NBOME (Parts I, II, III)
☐ FLEX (1 sitting, 3 days) ☐ NBME (Parts I, II, III)

State Boards (State) Date

Current DEA Number: Expires:

ACLS certification	Expires:
BLS certification	Expires:
PALS certification	Expires:
NRP certification	Expires:

List all license numbers in all states and indicate whether expired, current or inactive

State	License Number	Effective Date

PARTICIPATION IN PROFESSIONAL ASSOCIATIONS:

1.

2.

3.

Please list any professional honors, awards, publications or research:

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1. Are you aware of any malpractice claims which have been made or may be made against you? For the purposes of this question, claims shall include but not be limited to, the filing of a Summons and Complaint, demand letters by patients or attorneys, request for mediation or receipt of letters of intent to file suit. Yes ☐ No ☐
2. Have you ever been denied a license or had your license limited, suspended, denied or revoked in any state? Yes ☐ No ☐
3. Have your hospital or clinic staff privileges ever been limited, suspended, denied or revoked? Yes ☐ No ☐
4. Have you ever been involved in any other activity that would create doubt about your ability or right to practice? Yes ☐ No ☐
5. Have you ever had your Drug Enforcement Administration Certificate or prescribing privileges limited, suspended or revoked by any state or federal agency? Yes ☐ No ☐
6. Is there any reason you could not practice full time? Yes ☐ No ☐
7. Is there anything preventing you from complying with any professional requirement? Yes ☐ No ☐

*If you answered yes to any of the above questions, please explain fully on a separate sheet of paper and attach.

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
Within the past 5 years, were you separated from military service under conditions other than honorable? ☐ YES ☐ NO

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.

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.

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. 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.

C. 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.

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

E. 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.

F. 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 _____

If desired, a curriculum vitae may be attached to this form.

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.**