HAWAIʻI HEALTH SYSTEMS CORPORATION
KAUAʻI REGION

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VOLUNTEER APPLICATION PACKET

Instructions: Please review and complete each form as applicable. Once complete, you may submit all forms and other relevant documents to the HHSC Kaua'i Region Human Resources department in person or mail to 4643 Waimea Canyon Drive, Waimea, HI 96796 or through email at krhr@hhsc.org .

- **Volunteer/Student Application**: Complete and sign.
- **Confidentiality statement**: Read and sign.
- **Pre-Employment Health History**: This is your statement of your health history. No doctor's physical is required, disregard Medical Director/ Physician signature on form.
- **Drug Screen**: (10-panel) Only applicable if you are 18 years of age or older, HR will schedule drug screen within 30 days of start.
- **Tuberculosis (TB/PPD) Test**: Volunteer is responsible to schedule their own 2-step TB skin test **OR** TB Quantiferon blood test clearance. (1 TB test within last year and 1 TB test within the last 90 days), or negative **Chest X-ray** result done within 12 (twelve) months prior to hire date. Results must be provided prior to start date.
- **Health and TB Symptoms Questionnaire**: Required for those individuals with Chest X-Ray due to position TB Skin Test.
- **Request for State and Federal Criminal History Record Checks**: Complete and sign Parts I and II.
- **Federal Criminal History Record Check**: Background check will be scheduled through FieldPrint. Refer to attached instructions.
- **Acknowledgment & Understanding:** Read, print, and sign.
- **Confidentiality Agreement**: Read and sign.

RESET FORM

HAWAIʻI HEALTH SYSTEMS CORPORATION
KAUAʻI REGION
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EMPLOYEE NAME (Print)	POSITION TITLE	DEPT

ORIENTATION CHECKLIST: Initial Upon Review

Human Resources Forms

1. _____ MCN Policy Access & Review
2. _____ Confidentiality & Security Agreement
3. _____ Confidentiality Statement
4. _____ Attendance Guidelines
5. _____ Vehicle Parking Tag (if applicable)
6. _____ Publication Form

Education/In-Service Forms

7. _____ Code of Conduct Acknowledgement Form
8. _____ Emergency Safety Code Acknowledgement Form
9. _____ EMTALA Acknowledgement Form
10. _____ HIPAA Acknowledgement Form
11. _____ Staff Info Guide Acknowledgement Form

Infection Control Office Forms

12. _____ Consent for Flu Immunization
13. _____ Hepatitis B Vaccination Form
14. _____ Latex Sensitivity/Allergy Questionnaire
15. _____ TB Symptoms Questionnaire
16. _____ Respiratory Questionnaire

By signing this form, I acknowledge, agree and received all of the information discussed above.

Volunteer Signature	Date	Human Resources/ Designee	Date

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Kaua'i Veterans Memorial Hospital | Samuel Mahelona Memorial Hospital | Kaua'i Region Clinics

4643 Waimea Canyon Drive, Waimea, HI 96796 | 4800 Kawaihau Road, Kapa'a, HI 96746

VOLUNTEER PROGRAM APPLICATION

Name:	**Telephone:**
Address:	**City, State:** **Zip code:**
Education (Highest grade completed):	**Language spoken at home:**
College/Trade:	**Written language:**
Do you have a current Driver's License? ☐ Yes or ☐ No	**Insurance Co:**

Show Evidence of Negative PPD Skin Test: _____ (date of current PPD)

OR if Positive PPD, Date Chest X-ray done: _____

***Please indicate date/result of TB Skin OR TB Quantiferon test. Be sure to attach proof of results.**

Date: _____ Results: _____

PLEASE INDICATE THE AREAS OF INTERESTS BY CHECKING THE APPROPRIATE BOXES:

☐ Nursing ☐ Occupational Therapy ☐ Physical Therapy ☐ Recreational Therapy
☐ Business Office ☐ Thrift Shop ☐ Grounds Maintenance ☐ Other: _____

Skills/Interests:

Availability (Day, Date, and Time):

Applicant's Signature:	**Date:**

If Applicant is a minor (age 14 to below 18 years of age), parental consent is mandatory.

My child, _____, has my permission to participate in the Volunteer Program at KVMH/SMMH.

Signature of Parent:	**Date:**
☐**Recommended** ☐**Not Recommended** **Signature of Dept. Head: _____**	**Date:**
☐ **Approved** ☐**Disapproved** **Signature of HR Director/Designee: _____**	**Date:**

Revised 12/17/2021

HAWAIʻI HEALTH SYSTEMS CORPORATION
KAUAʻI REGION

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ACKNOWLEDGEMENT and UNDERSTANDING

As an employee of Hawaii Health Systems Corporation, I understand that the Corporation is concerned about the health, safety and well being of the patients, residents, support employees and management. As a health care provider, health care payments from federal health care programs such as Medicare/Medicaid are essential to the financial well being of the organization. Therefore, in an effort to assure that the above are met, I will answer the following question:

☐ ☐

Have you been the subject of any adverse action(s) by any duly authorized sanctioning or disciplinary agency for either conduct-based or performance-based actions? ☐ Yes ☐ No

If yes, please explain. _____
_____

Also, I understand that during my employment at HHSC, I am required to notify my facility's Human Resources Office when I am convicted of, or plead guilty or no contest to, or enter a first offender, deferred adjudication, or other similar arrangement or program with respect to, any crime (felony or misdemeanor). (Convictions, pleas or entry into programs, other than those noted on the HHSC application or those treated as excludable by OIG or GSA, will not automatically disqualify you from employment, however, a suitability for employment review may be conducted depending on the type(s) of conviction(s).)

And, I understand that periodic checks (specifically, criminal checks, as indicated in the Letter of Understanding, the Office of Inspector General's List of Excluded Individuals/Entities – OIG and General Services Administration's List of Parties Excluded from Federal Procurement and Non procurement Programs – GSA) may be performed.

Failure to notify my respective Human Resources Office regarding any of the above concerns may result in disciplinary action up to and including discharge.

_____ _____
Print Name Date

_____
Signature

HAWAI'I HEALTH SYSTEMS CORPORATION
KAUA'I REGION

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HAWAII HEALTH SYSTEMS CORPORATION HUMAN RESOURCES 3675 KILAUEA AVENUE HONOLULU, HI 96816	**CONFIDENTIAL** REQUEST FOR STATE AND FEDERAL CRIMINAL HISTORY RECORD CHECKS

Criminal history records checks for federal and state convictions are periodically conducted as required of all persons providing services to and/or receiving clinical instruction from HHSC. Information requested here is needed to make determinations as to whether any conviction has a bearing on your fitness to provide services or eligibility to receive clinical instruction at HHSC. Convictions, other than those noted on the HHSC application, will not automatically disqualify you; however, a suitability investigation may be conducted depending on when the conviction occurred and the type(s) of conviction(s). As a general rule, individuals with a conviction that bears a rational relationship to the position and/or service area, that falls within the past 10 years (excluding periods of incarceration), may render you unsuitable. Also, certain convictions such as an assault on a patient are automatic grounds for disqualification. During this suitability investigation period, you may not, at the discretion of HHSC, be allowed to perform services or receive clinical instruction until the investigation is completed.

Please **PRINT** (black ink) or type all requested information in PARTS I and II of this form, sign and return to: HR

Please bring a valid State issued picture i.d. with you.

PART I – FULL DISCLOSURE

Have you ever been convicted of a violation of law? ☐ Yes ☐ No

NOTE: In answering this question, you must report all convictions. DO NOT report the following:
(1) Arrests not followed by convictions;
(2) Convictions which were annulled or expunged;
(3) Offenses for which you were tried as a minor or juvenile;

If you answer "YES" to the question above, use this space to provide the dates, nature and circumstances of the conviction; the sentence imposed and its current status; and any other relevant information you wish to provide.

_____

_____

_____

_____

PART II – PERSONAL DATA

Full Name: _____
Last First Middle

Any Alias(es)/Former Name(s), Including Maiden Name:

Address: _____
Street Address/City/ State/ Zip Code

- -	/ /		
Social Security No.	Date of Birth Month/Day/Year	Place of Birth	Sex

Facility/Dept: *** / . Job Title _____

Acknowledgement and release:
I certify that information provided in PARTS I and II of this form is true and correct. I understand that providing my social security number is voluntary and to be used only for employment purposes. I also consent to criminal history record checks, which may include fingerprinting. I understand that any consideration for providing services or consideration for clinical instruction is contingent upon satisfactory completion of a suitability study, if applicable. In the event of falsification and/or omission of my conviction information in PART I of this form, I acknowledge that such action would deem me unsuitable for service consideration or for clinical instruction at Hawaii Health Systems Corporation.

_____ _____
(Signature) (Date)

HAWAI'I HEALTH SYSTEMS CORPORATION
KAUA'I REGION
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Federal Criminal History Record Check information

Please print clearly

Name _____
(last, first, full middle)

Aliases _____

_____

Social Security number _____ - _____ - _____

Street address (no p.o. box) _____

_____
(city) (state) (zip code)

Date of Birth _____

Place of Birth _____

Citizenship _____

Sex (circle one) Male Female

Race (ethnicity) _____

Height _____ft. ____ in. Weight _____ lbs.

Eye color _____ Hair color _____

_____ _____
Signature Date

Please also sign the FBI fingerprint Card. Mahalo

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HR Use Only
Date Logged: _____

EMPLOYEE EMERGENCY CONTACT FORM

Please complete the following personal information which will be used only in the case of an emergency.

Name (Print) _____

Assigned Facility/Department _____ Check only if your position is Regional ☐

Position Title _____

PERSONAL CONTACT INFO:

Home Address (Street Address, City, State, Zip Code): ******Hawai'i home address only******

_____

Mailing Address (Mailing Address, City, State, Zip Code):

_____

Home Telephone#: _____ Cell#: _____

EMERGENCY CONTACT INFO:

(1) Name: _____ Relationship: _____

Address: _____

Home Telephone#: _____ Cell#: _____

(2) Name: _____ Relationship: _____

Address: _____

Home Telephone#: _____ Cell#: _____

Do you live in a tsunami/flood zone? Check if YES ☐
Do you have children attending school in a tsunami/flood zone? Check if YES ☐

Optional: If you speak/read a foreign language(s), please identify which language(s) and your level of proficiency for each:

_____

Optional: Do you know American Sign Language: YES ☐
If yes, please indicate your level of ASL proficiency: _____

☐ I have voluntarily provided the above contact information and authorize HHSC-Kaua'i Region and its representatives to contact me or any of the above only in the event of an emergency.

_____ _____
Employee Signature **Date**

Once complete, please return to your Human Resources Office. Mahalo!

Confidentiality and Security Agreement

I understand that the Hawaii Health Systems Corporation (HHSC) facility or business entity in which or for whom I work, volunteer or provide services, or with whom the entity (*e.g.*, physician practice) for which I work has a relationship (business association, contractual or otherwise) involving the exchange of health information (with HHSC), has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of its patients' health information. Additionally, HHSC must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information (collectively, with patient identifiable health information, "Confidential Information").

In the course of my employment/contract/other relationship "relationship" with HHSC, I understand that I may come into possession of Confidential Information. I will access and use this Confidential Information only when necessary to perform my job, scope of work, or contractually related duties in accordance with HHSC's Privacy and Security Policies, which are available on the HHSC intranet (on the Policies and Procedures Page). I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information.

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it.	5. I understand that I should have no expectation of privacy when using HHSC information systems (including the electronic medical record (EMR)). I acknowledge and understand that HHSC may log, access, review, and otherwise use information stored on or passing through its systems, including e-mail, to manage systems and enforce security and as needed for other corporate purposes.
2. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.	6. I will practice good workstation security measures such as locking up thumb drives when not in use, using screen savers with activated passwords appropriately, and positioning computer monitors and screens away from public view.
3. I will not discuss Confidential Information where others can overhear the conversation. It is not acceptable to discuss Confidential Information even if the patient's name is not used.	7. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards.
4. I will not engage in any unauthorized transmissions, inquiries, modifications, or purging of Confidential Information.	8. I will: a. Use only my officially assigned User-ID and password (and/or security token device). b. Use only approved licensed software. c. Use a device with virus protection software. d. Understand that there is a large variance in non-hospital computer equipment and that remote access is not guaranteed to be available in all situations. Remote access issues are supported during normal IT operational hours and off- hour issues may wait until the next business day.

9. I agree that my obligations under this Agreement will continue after my employment, contract, or other relationship with HHSC ends.	15. I will *never*: a. Share/disclose my user-ID, password, or badge number or use anyone else's; b. Use tools or techniques to break/exploit security measures, or; c. Connect to unauthorized networks through the HHSC systems or devices or connect to HHSC systems with non-HHSC devices without approval.
10. Upon termination of my HHSC relationship, I will immediately return any documents or media containing Confidential Information to HHSC.	16. I will notify my manager, HHSC point-of-contact or appropriate Information Technologies person if my password has been seen, disclosed, or otherwise compromised, and will report any activity that violates this agreement, and/or privacy and security policies, as well as any other incident that could have any adverse impact on Confidential Information.
11. I understand that I have no ownership interest in any HHSC information accessed or created by me within the course and scope of my employment, contract or other relationship with HHSC.	**The following statements apply to organizations using HHSC systems containing patient identifiable health information:**
12. I will act in the best interest of HHSC and in accordance with its Code of Conduct at all times during my relationship with HHSC.	17. I will only access the HHSC information and EMR systems to review patient records when I have consent to do so. By accessing a patient's record, I am affirmatively representing to HHSC at the time of each access that I have the requisite consent to do so, and HHSC may rely on that representation in granting such access to me.
13. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of access, suspension and loss of privileges, and/or termination of authorization to work within HHSC.	18. I acknowledge that my organization will ensure that only appropriate personnel in its office will access HHSC information systems and Confidential Information and will annually train such personnel on issues related to patient confidentiality and access. Staff working on HHSC information and EMR systems from outside-HHSC organizations will be required to have individual access.
14. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.	19. I acknowledge that my organization will accept full responsibility for the actions of its employees, subcontractors, and agents who may access HHSC software systems and Confidential Information.

Signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

Employee/Consultant/Vendor/Office Staff/Physician Signature	Facility Name	Date
Employee/Consultant/Vendor/Office Staff/Physician Printed Name	Business Entity Name	

HAWAIʻI HEALTH SYSTEMS CORPORATION
KAUAʻI REGION

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VOLUNTEER ACKNOWLEDGEMENT AND CERTIFICATION

I hereby certify that I am the independent contractor referenced below (the Contractor), or am a duly authorized officer of the Contractor. On behalf of the Contractor and its employees, officers, Board members and agents, I certify that I have received and read **Hawaii Health Systems Corporation's Code of Conduct**, and that the employees and agents of the Contractor providing services to or for the Hawaii Health Systems Corporation will receive and read the Code of Conduct. I understand that it is our responsibility to read, understand and seek guidance, should we require clarification, with regard to the standards set forth in the Code, and to act in accordance with these standards at all times in performing services for HHSC.

Printed Name of Contractor:

Signature of Contractor:

By:

Title:

Date:

HAWAIʻI HEALTH SYSTEMS CORPORATION
KAUAʻI REGION

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VOLUNTEER ACKNOWLEDGEMENT AND CERTIFICATION

I hereby certify that I have received and read the **EMERGENCY SAFETY CODE POLICIES** and I understand that compliance with the requirements set forth in this is required. I understand that it is my responsibility to read, understand, and seek guidance, should I require clarification, with regards to the complete rules and guidelines pertaining to Emergency Safety Codes.

Printed Name: Date:

Signed: Department:

HAWAIʻI HEALTH SYSTEMS CORPORATION
KAUAʻI REGION

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VOLUNTEER ACKNOWLEDGEMENT AND CERTIFICATION

I hereby certify that I have received and read the **HIPAA Power Point** and I understand that compliance with the requirements set forth in this is required. I understand that it is my responsibility to read, understand, and seek guidance, should I require clarification, with regards to the complete rules and guidelines pertaining to HIPAA.

Printed Name: Date:

Signed: Department:

HAWAIʻI HEALTH SYSTEMS CORPORATION
KAUAʻI REGION

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VOLUNTEER ACKNOWLEDGEMENT AND CERTIFICATION

I hereby certify that I have received and read the **Staff Information Guide** and I understand that compliance with the requirements set forth in this guide is a condition of my continued employment. I understand that it is my responsibility to read it, learn it, and know it in detail so that I can continue to serve the community in accordance with our hospital's Missions and Values.

Printed Name: Date:

Signed: Department:

HAWAI'I HEALTH SYSTEMS CORPORATION
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AUTHORIZATION AND RELEASE TO USE NAME, IMAGE, STATEMENT, ENDORSEMENT, RECORDING, AND/OR IMAGE OF PROPERTY IN HHSC KAUAI REGION ADVERTISING AND PUBLICATIONS

The Authorization and Release ("Authorization and Release") is effective as of _____ by and between _____ ("Participant") and HHSC KAUAI REGION and all of its affiliated companies and advertising agencies (collectively, HHSC Kauai Region). The Parties anticipate and consent to the use and reproduction of Participant's name, image, statement, endorsement, recordings and/or image of property in any HHSC KAUAI REGION advertising and/or publications (collectively, "Publications").

AUTHORIZATION

Participant hereby grants HHSC KAUAI REGION the right to use and reproduce Participant's name, image, likeness, statement, endorsement, recordings of Participant's statements, and/ or image of property in publications. This Authorization and Release is for worldwide use in any form, including electronic media and the Internet (including social media), by all affiliates of HHSC KAUAI REGION for the duration that the materials are used unless Participant revokes this Authorization and Release in writing to HHSC KAUAI REGION. This grant shall include all the necessary permissions for the rights without additional compensation.

RELEASE OF CLAIMS

Participant explicitly releases and waives the rights of privacy, publicity, false advertising, libel, slander, defamation, misappropriation, copyright, and intentional infliction of emotional distress with regard to this grant and use or reproduction in any HHSC KAUAI REGION publication or advertising.

REVOCATION

Participant may revoke this Authorization and Release at any time by sending a written statement of intent to revoke to HHSC KAUAI REGION at:

_____.

NO CONDITIONS ON TREATMENT, PAYMENT, ENROLLMENT OR ELIGIBILITY FOR BENEFITS

Participant's treatment, payment, and enrollment or eligibility for any benefits, for which the Participant is otherwise entitled will, not be conditioned on whether Participant signs this Authorization and Release.

HHSC KAUAI REGION IS NOT RESPONSIBLE FOR USE BY OTHERS AFTER PUBLICATION

Information and images published subject to this Authorization and Release may be republished by others after it is published by HHSC KAUAI REGION. Participant understands and agrees that HHSC KAUAI REGION (1) has no control over how other parties may use information disclosed pursuant to this Authorization and Release after publication and (2) is not responsible for any such use by third parties.

PARTICIPANT IS ENTITLED TO A COPY OF THIS AUTHORIZATION AND RELEASE

Participant's signature below indicates that Participant has been offered and received, or has refused, a copy of this Authorization and Release.

PARTICIPANT

SIGNATURE

Print/Type Name

STREET ADDRESS CITY/STATE/ZIP

Phone Number Email Address

For Participants below the age of 18

Signature of Parent/Guardian required
please_____

Date/Location_____
_____

p

Applicant Name: _____

Pre-Employment Health History and Physical Examination

(Rev. 031104)

Form to be completed by applicant

I. Pre-Employment Health History

Do you currently have or have you experienced any of the following conditions:

Yes No **Respiratory**
- ☐ ☐ Persistent cough
- ☐ ☐ Wheezing
- ☐ ☐ Asthma
- ☐ ☐ Bronchitis
- ☐ ☐ Pneumonia

Neuro-psychologic
- ☐ ☐ Psychiatric disorders
- ☐ ☐ Balance problems
- ☐ ☐ Speech problems
- ☐ ☐ Eye conditions
- ☐ ☐ Vision problems
- ☐ ☐ Hearing difficulties

Skin
- ☐ ☐ Rashes/sores
- ☐ ☐ Itching/burning skin
- ☐ ☐ Jaundice
- ☐ ☐ Bruise easily

Yes No **Communicable disease**
- ☐ ☐ Tuberculosis
- ☐ ☐ Chicken pox
- ☐ ☐ Hepatitis
- ☐ ☐ Measles
- ☐ ☐ Mumps
- ☐ ☐ Rheumatic/scarlet fever
- ☐ ☐ Rubella

Throat
- ☐ ☐ Difficulty swallowing
- ☐ ☐ Hoarseness

Circulation
- ☐ ☐ Heart problems
- ☐ ☐ Tightness/chest pain
- ☐ ☐ Blood pressure problems
- ☐ ☐ Frequent nosebleeds
- ☐ ☐ Dizzy spells
- ☐ ☐ Numbness of hands/feet
- ☐ ☐ Varicose veins

Yes No **Muscle/skeleton**
- ☐ ☐ Back pain
- ☐ ☐ Swollen joints
- ☐ ☐ Neck pain
- ☐ ☐ Rheumatism/arthritis
- ☐ ☐ Foot trouble
- ☐ ☐ Hand/wrist problems
- ☐ ☐ Shoulder pain
- ☐ ☐ Knee problems
- ☐ ☐ Operations

Kidney/bladder
- ☐ ☐ Kidney/bladder infections
- ☐ ☐ Kidney/bladder operations

Yes No **Miscellaneous**
- ☐ ☐ Diabetes
- ☐ ☐ Shortness of breath on exertion
- ☐ ☐ Difficulty breathing
- ☐ ☐ Venereal disease
- ☐ ☐ Cancer
- ☐ ☐ Thyroid problems
- ☐ ☐ Digestive difficulties
- ☐ ☐ Latex sensitivity

Please give details on problems noted above _____

Do you take any medications regularly? ☐Yes ☐No If yes, explain: _____

Excluding any information pertaining to HIV infection, AIDS, or ARC, do you have any current medical problems and/or are you under current medical treatment? ☐ Yes ☐ No If yes, please explain:

Do you have any allergies? ☐Yes ☐No If yes, what? _____

Have you ever been exposed to and adversely affected by: ☐ heavy lifting ☐repetitive motion
If yes, explain: _____

To be completed by applicant

I. Pre-Employment Health History (Con't)

Have you been exposed to and adversely affected by chemical and/or cleaning solvents which caused skin sensitivity, an allergic reaction, breathing difficulties, nausea, headaches and/or nosebleed? ☐ Yes ☐ No
If yes, explain: _____

_____

_____

_____

Do you have any physical defects, conditions or limitations which could affect your employment or availability for employment in the coming year? ☐ Yes ☐ No If yes, explain: _____

_____

_____

Have you ever been hospitalized? ☐ Yes ☐ No If yes, explain: _____

_____

_____

Date of your last: Medical evaluation: _____ Tuberculin skin test: _____ ☐ Positive ☐ Negative

Tetanus immunization: _____ Chest X-Ray: _____ ☐ Positive ☐ Negative

Hepatitis B vaccine: _____ _____

_____ _____

_____ _____

The above information is true to the best of my knowledge. I understand that any concealment or

falsification discovered after employment is grounds for termination. I, _____, grant Hawaii Health Systems Corporation or its representative permission to contact any physicians or hospitals for information regarding my medical care and treatment and authorize the release to Hawaii Health Systems Corporation or it's representative of any such medical records.

Applicant Signature: _____ Date: _____.

Medical Director/Physician:

Signature: _____ Date: _____.

Print Medical Director/Physician Name: _____

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Respirator Medical Evaluation Questionnaire

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A Section 1: (**Mandatory**) The *following information must be provided by every employee who has been selected to use any type of respirator (**PLEASE PRINT**)*

Name (Print)**:**	**Date:**
Job Title:	**Your Height:** ft. in.
Department:	**Weight:** lbs.
Sex (Circle one): ☐ **Male / Female** ☐	**Age:**
Telephone No.:	**Best time to call:**
(*Where you can be reached by Health Care Professional who reviews this questionnaire (include Area Code)*	
Has your employer told you how to contact the health care professional who will review this questionnaire (circle one)**:** **Yes / No**	
Check the type of respirator you will use (you can check more than one category): a) ☐ N.R. or P disposable respirator (filter-mask, non-cartridge type only) b) ☐ Other type (for example, half-or-full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus) Have you worn a respirator? If yes, what type/s? _____	

Part A. Section 2. **Mandatory:** *Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator.*

Answer each question below by checking the boxes to the right	**YES**	**NO**
1. Do you ***currently*** smoke tobacco, or have you smoked tobacco in the last month?	☐	☐
2. **Have you *ever had* any of the following conditions?**	**YES**	**NO**
a. Seizures	☐	☐
b. Diabetes (sugar disease)	☐	☐
c. Allergic reactions that interfere with your breathing	☐	☐
d. Claustrophobia (fear of closed-in places)	☐	☐
e. Trouble smelling odors	☐	☐
3**. Have you *ever had* any of the following pulmonary or lung problems?**	**YES**	**NO**
a. Asbestosis	☐	☐
b. Asthma	☐	☐
c chronic bronchitis	☐	☐

3. **Have you *ever had* any of the following pulmonary or lung problems?**	**YES**	**NO**
d. Emphysema		
e. Pneumonia		
f. Tuberculosis		
g. Silicosis		
h. Pneumothorax (collapsed lung)		
i. Lung cancer		
j. Broken ribs		
k. Any chest injuries or surgeries		
l. Any other lung problem that you've been told about		
4. **Do you *currently* have any of the following symptoms of pulmonary or lung illness?**	**YES**	**NO**
a. Shortness of breath		
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline		
c. Shortness of breath when walking with other people at an ordinary pace on level ground		
d. Have to stop for breath when walking at your own pace on level ground		
e. Shortness of breath when washing or dressing yourself		
f. Shortness of breath that interferes with your job		
g. Coughing that produces phlegm (thick sputum)		
h. Coughing that wakes you early in the morning		
i. Coughing that occurs mostly when you are lying down		
j. Coughing up blood in the last month		
k. Wheezing		
l. Wheezing that interferes with your job		
m. Chest pain when you breathe deeply		
n. Any other symptoms that you think may be related to lung problems		
5. **Have you *ever had* any of the following cardiovascular or heart problems:**	**YES**	**NO**
a. Heart attack		
b. Stroke		
c. Angina		
d. Heart failure		
e. Swelling in your legs or feet (not caused by walking)		
f. Heart arrhythmia (heart beating irregularly)		
g. High blood pressure		
h. Any other heart problem that you've been told about		
6. **Have you *ever had* any of the following cardiovascular or heart symptoms?**	**YES**	**NO**
a. Frequent pain or tightness in your chest		
b. Pain or tightness in your chest during physical activity		
c. Pain or tightness in your chest that interferes with your job		
d. In the past two years, have you noticed your heart skipping or missing a beat		
e. Heartburn or indigestion that is not related to eating		
f. Any other symptoms that you think may be related to heart or circulation problems		
7. **Do you *currently* take medication for any of the following problems?**	**YES**	**NO**
a. Breathing or lung problems		
b. Heart trouble		
c. Blood pressure		
d. Seizures		

8. **If you've used a respirator, have you *ever had* any of the following problems? (If you've never used a respirator, check the following space and go to next question (#9)**	**YES**	**NO**
a. Eye irritation		
b. Skin allergies or rashes		
c. Anxiety		
d. General weakness or fatigue		
e. Any other problem that interferes with your use of a respirator		
9. **Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?**		
10. **Have you ever lost vision in either eye (temporary or permanently)?**		
11**. Do you *currently* have any of the following vision problems?**	**YES**	**NO**
a. Wear contact lenses		
b. Wear glasses		
c. Color blind		
d. Any other eye or vision problem		
12**. Have you ever had an injury to your ears, including a broken eardrum?**		
13. **Do you *currently* have any of the following hearing problems?**	**YES**	**NO**
a. Difficulty hearing		
b. Wearing a hearing aid		
c. Any other hearing or ear problem		
14**. Have you ever had a back injury**?		
15. **Do you *currently* have any of the following musculoskeletal problems?**	**YES**	**NO**
a. Weakness in any of your arms, hands, legs, or feet		
b. Back pain		
c. Difficulty fully moving your arms and legs		
d. Pain and stiffness when you lean forward or backward at the waist		
e. Difficulty fully moving your head up or down		
f. Difficulty fully moving your head side to side		
g. Difficulty bending at your knees		
h. Difficulty squatting to the ground		
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.		
j. Any other muscle or skeletal problem that interferes with using a respirator		

Name:

_____ _____

Employee Signature **Date**

Comments:

_____

_____

_____ _____

Professional Health Care Provider Signature **Date**

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KAUAʻI REGION

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Consent for Injectable Seasonal Influenza Immunization

Name: _____ Date of Birth: _____

Physician Order: Influenza vaccine 0.5ml IM x 1 for 2022-2023 Influenza Season

_____

Dr. Ronald Fujimoto, Infection Prevention Physician Champion
HHSC Kauai Region

Please answer the following questions:

1. Have you had an allergic reaction to eggs? ☐ Yes ☐ No
2. Have you had any severe allergy to any vaccine component or a reaction after a dose of influenza vaccine? ☐ Yes ☐ No
3. Have you been paralyzed with Guillain-Barre Syndrome? ☐ Yes ☐ No
4. Are you currently ill with a fever? ☐ Yes ☐ No
5. Are you or might be pregnant? ☐ Yes ☐ No
6. Are you allergic to Latex? ☐ Yes ☐ No

I have read the Seasonal Influenza Vaccine Information Sheet and have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine and request that the vaccine is given to me.

_____ _____
Signature of person or representative Date

Date given: _____ Site of Injection: _____

Vaccine Manufacturer: Sanofi Pasteur

Lot Number: _____ Expiration Date: _____

_____
Vaccine Administrator: PRINTED NAME / Signature / Title

VIS Date: 08/06/2021

/vad 10 16 2019 / mfl 09202022

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KAUAʻI REGION

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Declination of Influenza Vaccination

My employer, Hawaii Health Systems Corporation, Kauai Region, has recommended that I receive influenza vaccination in order to protect the patients I serve. I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands of people in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to protect this facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza infection to patients in this facility.
- If I become infected with influenza, even if my symptoms are mild or non-existent, I can spread it to others and they can become seriously ill.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't change, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that I cannot get the influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including:
  - all patients in this healthcare facility
  - my co-workers
  - my family
  - my community

Despite these facts, I am choosing to decline influenza vaccination right now for the following reasons:

☐ Medical Contraindication
- ☐ Severe allergic reaction to eggs or other components of the influenza vaccine.
- ☐ History of Guillain-Barre Syndrome (GBS) within 6 weeks after a previous influenza vaccination
- ☐ Other: _____

☐ Religious or Philosophical Reasons

☐ I would like more information and education on Influenza Prevention before making a decision

☐ Received current Influenza vaccination elsewhere
- ☐ I received the influenza vaccination at _____
- ☐ I am attaching documentation of the vaccination

I have read and understand the HHSC Policy "Health Care Personnel who: (1) cannot receive influenza vaccination due to a medical contraindication or (2) chose not to receive influenza vaccination should wear a Face mask at all times in Clinical Care Areas throughout the duration of Influenza Season or Influenza Outbreak to ensure the safety of HHSC's patients and residents. Health Care Personnel shall continue to perform hand hygiene and adhere to proper etiquette when coughing and sneezing. Any Health Care Personnel demonstrating ILI (Influenza Like Illness) signs and symptoms while on duty shall be sent for medical evaluation or home in accordance with each respective HHSC facility's policies and procedures."

Signature: _____ Date: _____

Name (print): _____ Dept.: _____

Employment Status:

☐ Employee of KVMH / SMMH / Clinics
☐ Physicians / NP / PA who are affiliated (e.g. HEPA)
☐ Adult Students / trainees and volunteers
☐ Contract personnel (e.g. Agency, Travelers, Cardon)

www.immunize.org/catg.d/p4068.pdf. Item #P4068 (9/2022)

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KAUAʻI REGION

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DECLINATION OF HEPATITIS B VACCINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Employee's Name (Print): _____

Employee's Signature: _____

Social Security Number: _____ / _____ / _____

Witness (Signature): _____

Date: _____

I am declining Hepatitis B vaccine because I am certain that I have received a full series of three vaccinations prior to employment.

Employee's Signature: _____ Date: _____

Dates of prior immunization: # 1 _____ # 2 _____ # 3 _____ # 4 _____

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KAUAʻI REGION

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EMPLOYEE CONSENT FORM FOR HEPATITIS B VACCINATION

I, _____ , as an employee of KVMH / SMMH, consent to the administration of a series of three Hepatitis B vaccinations. A representative of KVMH / SMMH has informed me of the possible side-effects and complications as well as the benefits of the series of injections. I understand that a representative of Kauai Veterans Memorial Hospital / Samuel Mahelona Memorial Hospital will administer the vaccinations with no charge to me, if my job classification is Risk Category I or Risk Category II (Blood Exposure Risk).

Employee: _____
Department: _____
Risk Group: _____

Physician Order: Hepatitis B Vaccine 1.0ml 1M times 3 doses at 0, 1 month, 6 months.
Follow up with Titers (Blood test) 1-2 months after last vaccine.

_____
Infection Prevention Physician Champion-HHSC Kauai Region

First Injection:	Date Administered: _____ Person Administering: _____ Lot Number/Exp. Date : _____ Location of injection : _____ VIS Date : _____
Second Injection:	Date Administered: _____ Person Administering: _____ Lot Number/Exp. Date : _____ Location of injection : _____ VIS Date : _____
Third Injection:	Date Administered: _____ Person Administering: _____ Lot Number/Exp. Date : _____ Location of injection : _____ VIS Date : _____

Blood Titer (1-2 months after last injection/vaccination): Date: _____
Results: _____

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KAUA'I REGION
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PRINT NAME _____ **DEPARTMENT** _____

NIOSH Alert: Workers exposed to latex gloves and other products containing natural rubber latex may develop allergic reactions such as skin rashes: hives; nasal, eye, or sinus symptoms; asthma; and (rarely) shock.

Workers with ongoing latex exposure from wearing latex gloves or using latex-containing medical supplies are at risk for developing latex allergy. Such workers include health care workers (physicians, nurses, aides, pharmacists, operating room employees, laboratory technicians, gardeners, food service workers, and housekeeping personnel) may also be at risk.

Please complete this questionnaire to the best of your ability. This is not intended to be all-inclusive. Individuals who are uncertain whether they are or may be sensitive to natural rubber latex should consult their physicians.

1. Have you ever had an allergic reaction to latex products? ☐ Yes ☐ No
   If yes, what happened?
   _____

2. Has a doctor ever told you that you have a sensitivity or allergy to latex? ☐ Yes ☐ No
   If yes, to what specifically are you allergic to?
   _____

3. Do you have more than one allergic condition, or history of the following?

Contact dermatitis	☐ Yes	☐ No		Eczema	☐ Yes	☐ No	
Asthma	☐ Yes	☐ No		Autoimmune disease (e.g. lupus)	☐ Yes	☐ No	
Hay fever	☐ Yes	☐ No		Other	☐ Yes	☐ No	

4. Do you have any food allergies? ☐ Yes ☐ No
   If yes, are you allergic to the following?

☐ Bananas	☐ Pineapple	☐ Passion Fruit
☐ Avocados	☐ Potato	☐ Peanuts
☐ Chestnuts	☐ Kiwi	☐ Tomato:
☐ Papaya	☐ Cherries	☐ Other: _____

If yes, describe the reaction:
_____

5. Do you have any congenital abnormalities (e.g. spina bifida)? ☐ Yes ☐ No

6. After handling latex products, do any of the following happen to you?

Difficulty breathing	☐ Yes	☐ No		Coughing	☐ Yes	☐ No	
Shortness of Breath	☐ Yes	☐ No		Nasal, eye or sinus irritation	☐ Yes	☐ No	
Itching, Swelling, Chapping of hands	☐ Yes	☐ No		Redness, swelling	☐ Yes	☐ No	
Hives	☐ Yes	☐ No		Other: _____	☐ Yes	☐ No	

Any exposed worker who experiences these symptoms should be evaluated by a physician, because further exposure could cause a serious allergic reaction. A diagnosis is made by using the results of a medical history, physical examination, and tests. Once a worker becomes allergic to latex, special precautions are needed to prevent exposures during work as well as during medical or dental care.

Thank you for completing this questionnaire. Please sign/date and return to EMPLOYEE HEALTH/INFECTION CONTROL.

_____ _____
SIGNATURE **Date**

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KAUA'I REGION

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NAME_____ **DEPT / TITLE**_____ **DATE** _____

ANNUAL HEALTH AND TB SYMPTOMS QUESTIONNAIRE

For All Employees:

TB Risk Factors	YES	NO	Comment
1. Were you born in a country with an elevated TB rate? (*includes countries other than USA, Canada, Australia. New Zealand, or Western & Northern European countries*)	☐	☐	
2. Have you traveled to (or lived in) a country with an elevated TB rate for 4 weeks or longer within the past six (6) months?	☐	☐	
3. Have you been in contact with someone with infectious TB disease? (do not check "yes" if exposed only to someone with latent TB)	☐	☐	
4. Do you have a health problem that affects the immune system, or is medical treatment planned that may affect the immune system? (includes HIV/AIDS, organ transplant recipient, treatment with TNF-alpha antagonist, or steroid medication for a month or longer)	☐	☐	
5. Have you received any Live Vaccines within the past 4 weeks (MMR, Measles, Rubella, Mumps, Flu Mist)?	☐	☐	

For PPD / TST Candidate:

I consent to a TST (Tuberculin Skin Test) _____
Signature of Employee

Telephone Number: _____

Date/Time Admin/ Location of Test:	Manufacturer: *Sanofi Pasteur*	Lot# Exp. Date:_____	Given By:
Date/Time Read:	**Results:** mm	**Read By:**	

Physician Order: TUBERSOL 0.1m1 Intradermal x 1. Read at 48-72 hours. _____
Infection Prevention Physician Champion, HHSC Kauai Region

Please answer questions below if you have Prior Positive PPD:

POSITIVE PPD

Have you experienced any of the following symptoms:	YES	NO	Comment
Have you had a cough for 3 weeks or more? *Significant symptoms would include the cough PLUS one of the following:*			
1. Coughing up blood?			
2. Unexplained weight loss?			
3. Fever?			
4. Unusual weakness?			
5. Night Sweats?			
6. Fatigue?			

Signature of Employee : _____ Date: _____

_____ _____

Medical / IP Review **Date**

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KAUAʻI REGION

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Declination of Receiving TST/ PPD in June / July

My employer, Hawaii Health Systems Corporation Kauai Region, has recommended that I receive the Tuberculin Skin Test in June or July to be aligned with the schedule for the facilities. I acknowledge that if I refuse to take the skin test in these months I am aware of the following facts:

- Date of current PPD: _____
- The responsibility of receiving a Tuberculin Skin Test before the expiration date falls on the employee.
- The employee has 12 months from the date given above to receive the annual Tuberculin Skin Test.
- The employee shall give Employee Health a current copy of their completed Tuberculin Skin Test documentation annually.

I understand that if I fail to comply by the deadline given to me, I will be put on leave without pay until I complete the annual Tuberculin Skin Test.

Signature: _____ Date: _____

Name (print): _____ Dept.: _____

Employment Status:

☐ Employee of KVMH / SMMH / Clinics
☐ Physicians / NP / PA who are affiliated (e.g. HEPA)
☐ Adult Students / trainees and volunteers
☐ Contract personnel (e.g. Agency, Travelers, Cardon)

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KAUAʻI REGION

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VOLUNTEER ACKNOWLEDGEMENT AND CERTIFICATION

I hereby certify that I have received an overview of the following **HHSC-Kaua'i Region Policies and Procedures** and I understand that compliance with the requirements set forth in this is required. I understand that it is my responsibility to review these policies by logging into MCN Policy Manager and to read and completely understand each policy, and seek guidance from my department leader, should I require clarification with regards to the complete rules and guidelines pertaining to these policies and procedures:

- Equal Employment Opportunity
- Non-Harassment Policy No Tolerance
- Workplace Violence/Abuse No Tolerance
- Workplace Disruptive Behavior No Tolerance
- Standards of Dress, Grooming and Related Behaviors
- Use of Personal Electronic Devices & Personal Phone Calls
- Break Time for Nursing Mothers Act 249 and Fair Labor Standards Act
- New Health Insurance Marketplace
- Event Report Forms SYSTEM in MIDAS

Printed Name:_____ Date: _____

Signature:_____ Department: _____

HAWAI'I HEALTH SYSTEMS CORPORATION
KAUA'I REGION
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Keys to a Safer Work Environment

Hawaii Health Systems Corporation is firmly committed to providing a workplace that is free from acts or threats of violence. In line with this pledge, **we will not tolerate the actions of any *HHSC* employee who commits an act of violence or threatens violence upon staff, employees, patients1 or visitors.**

In order to achieve our goal of providing a workplace that is secure and free from violence, we must enlist the support of all employees. It is every employee's responsibility to report to supervisory personnel or to Human Resources any acts or threats of violence. The following are some examples of what individuals can do to defuse violence:

- We all should treat one another with dignity and respect Never embarrass, humiliate, or attack the dignity of another person, and don't allow anyone under your supervision or control to do so.
- Pay attention to what is going on the workplace such as how people are acting and don't deny your instinctive ability to sense danger. Violent incidents are almost always predictable.
- Remain calm if a situation exists. Understand that the potentially violent person is in a state of personal crisis, and may calm down if given the chance.
- Be willing to allow the person to vent, within reasonable limits. Establish an atmosphere of cooperation and mutual effort to resolve the issue at hand.
- Sincerely listen to the other person. Understand that perception is also that person's reality.
- Allow the person to suggest a solution or ask for a solution. Offer a solution when requested.
- Remember that as emotions subside, the person may be looking for a "face-saving" way out of the tense situation that was created. Help the person maintain dignity in ending the situation.
- Leave if the situation does not improve or escalates and ask for assistance.

Remember, the Hawaii Employee Assistance Services (HEAS), offers free, professional, and confidential help to employees and families with personal and work-related problems. You can ask the employee assistance professional staff about services available to assist the work unit or the individual employee. HEAS can be reached at the following numbers:

Oahu: (808) 543-8445
Kona: (808) 323-2664
Maui: (808) 877-6888
Kauai: (808) 245-5914
Hilo: (808)935-2188
Lanai: (808) 994-3571

KAUAI VETERANS MEMORIAL HOSPITAL
PO Box 337, Waimea, HI 96796
(808) 338-9431

SAMUEL MAHELONA MEMORIAL HOSPITAL
4800 Kawaihau Rd, Kapaʻa, HI 96746
(808) 822-4961

HAWAIʻI HEALTH SYSTEMS CORPORATION
KAUAʻI REGION

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VEHICLE ID/PARKING REGISTRATION FORM

Instructions: Please complete the following form and **return it to the Human Resources (HR) department** as soon as possible. HR will then route it to the Security Services department, of which a placard will be assigned to you. Each employee will receive one (1) numbered placard for any and all vehicles and/or motorcycles/moped you may drive to work. Placards should be hung on your vehicle's rear view mirror with the printed side facing the front of the vehicle. **Please list ALL vehicle information on one form before submitting it.**

PRINT

Employee Name: _____ **Facility:** _____ **Dept:** _____

Phone Number: _____

Vehicle# 1 – Make/Model: _____ License Plate#: _____ Placard#: _____

Vehicle# 2 – Make/Model: _____ License Plate#: _____ Placard#: _____

Vehicle# 3 – Make/Model: _____ License Plate#: _____ Placard#: _____

Motorcycle/Moped
Make/Model: _____ License Plate#: _____ Placard#: _____

NOTICE: Please lock your vehicle. HHSC Kaua'i Region will ***NOT BE RESPONSIBLE*** for fire, theft, damage, or loss of vehicle or for any article(s) left in your vehicle. All such risks shall be assumed by the ***VEHICLE PLACARD HOLDER.*** Please refer to Parking Policy 122-9 for complete details of facility parking policies.

I acknowledge receiving this **ID/Parking Placard** and will adhere to policies set forth in Parking Policy 122-9. I understand that Security Services may either speak to me and/or place a written notice on my vehicle's windshield should I be in violation of these policies.

Signature: _____ **Date:** _____

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KAUA'I REGION

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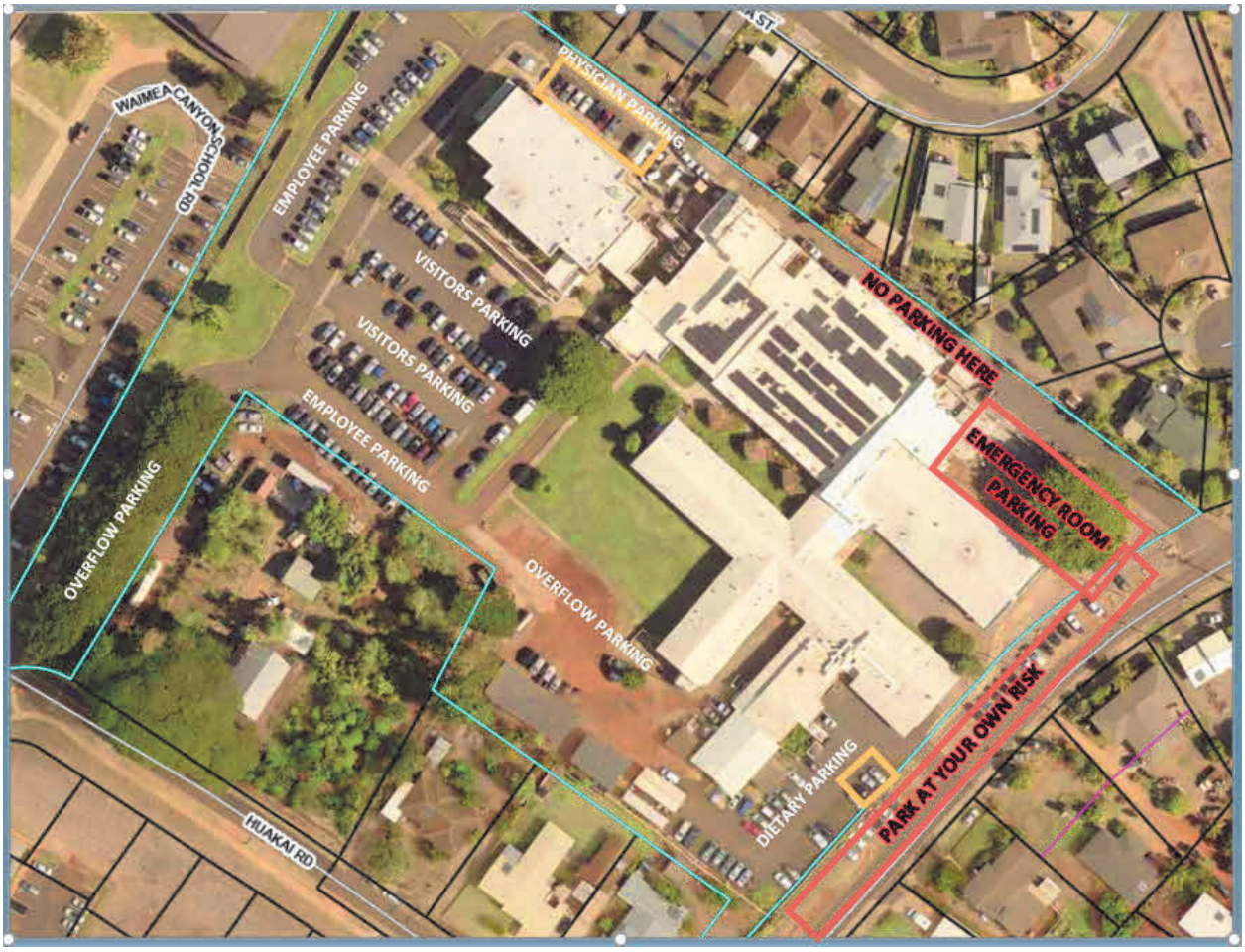
DESIGNATED PARKING AREAS

KVMH



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DESIGNATED PARKING AREAS

SMMH