HAWAI'I HEALTH SYSTEMS CORPORATION
KAUA'I REGION
E PONO MAU LOA
Always Excellent

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**: 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**: This information will be transferred over to the FBI Fingerprinting card. Card will be signed at time of fingerprinting. $20 processing fee is required.
- **Acknowledgment & Understanding:** Read, print, and sign.
- **Confidentiality Agreement**: Read and sign.
- **COVID Vaccination Card:** Copy of card must be provided prior to start date.

HAWAI'I HEALTH SYSTEMS CORPORATION
KAUA'I REGION
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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

HAWAI'I HEALTH SYSTEMS CORPORATION
KAUA'I REGION
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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):

_____

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!

HAWAII HEALTH SYSTEMS
C O R P O R A T I O N
Quality Healthcare For All

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	

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: _____

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

"Touching Lives Everyday"

DRUG SCREENING AUTHORIZATION FORM

Name _____

I understand that Hawaii Health Systems Corporation (HHSC) has established a policy, whereby any person wanting to provide services and/or 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 authorize the testing laboratory to take from me the required specimen for testing.

3. 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.

4. 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.

5. I understand that over-the-counter medications or prescribed drugs may result in a positive test result.

6. 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.

7. 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.

8. 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.

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.**

ACKNOWLEDGEMENT and UNDERSTANDING

As a person providing services to or receiving clinical instruction from the Hawaii Health Systems Corporation (HHSC), I hereby authorize HHSC to conduct periodic background checks with the following agencies: Office of Inspector General (OIG), General Services Administration, State and Federal Criminal History Data Centers, and any other agencies required or permitted by applicable laws and regulations to retain ifnroamtion concening misconduct.

Also, I understand that during my service or clinical instruction period with HHSC, I am required to notify my facility's Human Resources Office when l am convicted of, or plead guilty or no contest to, or enter a deferred adjudication, or other similar arrangement or program with respect to, any crime, felony or misdemeanor. I understand that further that 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 me from providing services to or receiving clinical instruction from HHSC. A suitability review may be conducted depending on the nature of the offense(s).

Failure to notify my respective Human Resources Office regarding any of the above concerns may result in disciplinary action up to and including termination of my servicer or clinical instruction.

_____ _____

Print Name Date

_____

Signature

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 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, middle)

Aliases _____

_____

Social Security No. _____

Street Address: _____

_____

Date of Birth _____

Place of Birth: _____

Citizenship _____

Sex (circle one): Male Female

Race: _____

Height _____ ft. _____ in. Weight: _____ lbs.

Eyes: _____ Hair _____

_____ _____
Signature Date

Please also sign the FBI Fingerprint Card. Mahalo

KAUAI VETERANS MEMORIAL HOSPITAL
4643 Waimea Canyon Dr, Waimea, HI 96796
(808) 338-9431

HAWAI'I HEALTH SYSTEMS CORPORATION
KAUA'I REGION

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

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**

ts / vad/ mfl 05 05 2021