CLEAR FORMS

KAUA'I VETERANS MEMORIAL HOSPITAL
PO Box 337, 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

E Pono Mau Loa ~ Always Excellent

Volunteer Application Form

Instructions: *Please complete each form to the best of your ability. If you are minor, it is essential that your parent(s) review each form and sign in the acknowledgment section. Once all forms are complete, kindly submit them to the Human Resources department for review. Should you have any questions or concerns, please do not hesitate to reach out to the Human Resources department for assistance. Thank you for your cooperation.*

Personal Information

Full Name: _____

Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

Availability

Preferred Days and Hours: _____

Volunteer Interests

Please indicate areas of interest (Check all that apply):

- ○ _____

Relevant Skills or Experience: _____

Health & Background Information

Have you ever been convicted of a crime? [ ] Yes [ ] No
If yes, please explain: _____

Do you have any medical conditions or physical limitations we should be aware of? [ ] Yes [ ] No
If yes, please describe: _____

Photo Release Permission

I, _____, grant HHSC Kauai Region the right to use my photograph, video, or likeness taken during my volunteer activities for promotional, educational, or other lawful purposes without compensation. I understand that these materials may be used in print, online, or social media publications.

[ ] I agree
[ ] I do not agree

Signature: _____ Date: _____

Code of Conduct

The Hawaii Health Systems Corporation (HHSC) has an established **Code of Conduct** that applies to all employees, management, Board members, Medical Staff, and agents, including volunteers.

For volunteers specifically, adherence to the following key principles is essential:

1. **Respect & Confidentiality**
    - Treat all patients, staff, and fellow volunteers with respect and dignity.
    - Maintain confidentiality regarding patient information and hospital procedures.
2. **Professionalism & Conduct**
    - Follow all rules, regulations, and policies set forth by the organization.
    - Refrain from engaging in disruptive behavior, discrimination, or harassment.
    - Dress appropriately and adhere to the hospital's dress code.

3. **Safety & Compliance**
    - Follow all safety guidelines and report any unsafe conditions immediately.
    - Abide by infection control protocols, including hand hygiene and personal protective equipment requirements.
4. **Commitment & Responsibility**
    - Arrive on time and fulfill scheduled volunteer shifts.
    - Notify the volunteer coordinator in advance if unable to attend.
    - Engage in assigned tasks with dedication and a positive attitude.
5. **Prohibited Activities**
    - Volunteers are not permitted to provide medical advice or hands-on patient care.
    - Do not solicit or promote personal business or beliefs while volunteering.
    - Refrain from taking photos or recording videos without explicit authorization.

By adhering to these guidelines, volunteers contribute to a safe, respectful, and effective healthcare environment, aligning with HHSC's mission to provide accessible, high-quality, cost-effective services that address the healthcare needs of Hawaii's unique island communities.

Acknowledgment & Signature

I certify that the above information is true and complete to the best of my knowledge. I understand that I may be subject to a background check and health screening as a condition of volunteering.

Signature: _____ Date: _____

If Applicant is a minor (age 14 – 18 years of age, parental/guardian consent is required.

Parent/Guardian Signature: _____ Date: _____

HAWAIʻI HEALTH SYSTEMS CORPORATION
KAUAʻI REGION

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

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 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 Drug Free Workplace 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.**

HAWAIʻI HEALTH SYSTEMS CORPORATION
KAUAʻI REGION

CLEAR FORM

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

HAWAI'I HEALTH SYSTEMS CORPORATION
KAUA'I REGION

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)

State of Hawaii
DEPARTMENT OF HUMAN SERVICES

Social Services Division
Adult Protective & Community Services Branch

AUTHORIZATION TO RELEASE INFORMATION FROM THE ADULT PROTECTIVE SERVICES CENTRAL REGISTRY

REQUESTING INDIVIDUAL OR AGENCY: (Print or Type all information)

Name: Hawai'i Health Systems Corporation - Kaua'i Region
Phone: (808) 338-9425 / 808-823-4116
Address: KVMH: 4643 Waimea Canyon Drive, Waimea, HI 96796
ATTN: HHSC Kaua'i Region HR Dept.
SMMH: 4800 Kawaihau Road, Kapaa, HI 96746

INDIVIDUAL TO BE CHECKED:

I authorize the Department of Human Services (DHS) or its designee to conduct a Protective Services Central Registry Check of **Adult Protective Services (APS)** on myself and to release the information to the requesting individual or agency listed above.

The information to be released shall be limited to the history of abuse or neglect in which I was identified as a perpetrator and shall include date(s) of CONFIRMED incident(s) only and type of abuse for each incident.

Full name: _____ Date of Birth: _____

Social Security Number: _____ Telephone Number: _____

Alias(es), Maiden, or Former Names: _____

Address: _____

I understand that the information I provide about me shall be used solely for the purpose of conducting an Adult Protective Services (APS) Central Registry Check. I also understand that the release of this information may be used as part of a background check for employment, volunteer, licensure, or certification purposes which may result in suspension or termination.

This authorization is good until _____/_____/_____ or until the employee's separation from HHSC.
Date Event

When no date or event is specified, the authorization shall expire one year from the date the authorization is signed.

Signature: _____ **Date:** _____

Mail or FAX this completed form to addresses on page 2.

FOR OFFICIAL USE ONLY:

Types of Confirmed Abuse or Neglect	**Date(s) of Confirmation:**
☐ Caregiver Neglect (Negligent Treatment/Maltreatment)	
☐ Financial Exploitation	
☐ Physical Abuse	
☐ Psychological Abuse	
☐ Self-Neglect (Poor Self-Care)	
☐ Sexual Abuse	

☐ NO RECORD OF CONFIRMED ADULT ABUSE ON FILE

Clearance Completed by: _____ Date: _____
DHS or Designee Worker's Name Phone Number

DHS 1507 (Rev. 01/14) Destroy superseded form in stock. Original to DHS or DHS Designee Copy to Individual

State of Hawaii
DEPARTMENT OF HUMAN SERVICES

Social Services Division
Child Welfare Services Branch

CONSENT TO RELEASE INFORMATION FROM THE
Child Protective Services System Central Registry

I, _____ hereby give my consent to have the Department of Human
(Please Print)
Services (DHS) conduct a child welfare services Child Protective Services System Central Registry check On me and to release the information to:

Name of Individual or Organization: Hawai'i Health Systems Corporation - Kaua'i Region

Relationship: Employer

Address: KVMH: 4643 Waimea Canyon Drive, Waimea, HI 96796 / SMMH: 4800 Kawaihau Road, Kapaa, HI 96766

Phone Number: KVMH: 808-338-9425 / SMMH: 808-823-4145

This consent shall terminate a year from the date of my signature below. I understand that the information I Provide about myself shall be used solely for the purpose of conducting the Child Protective Services System Central Registry check.

My Date of Birth: _____ **My Social Security Number:** _____

Any Alias, Former Name, Including Maiden Name: _____

_____

The information to be released shall be limited to the history of abuse or neglect in which I was identified as a Perpetrator and as specified below:

Child Protective Services System Central Registry:

- Date of CONFIRMED incident(s) only
- Type of abuse for each incident

I understand that the release of this information may be used as part of a background check for employment Purposed and to comply with the requirements for various social services programs within the Department of Human Services, which may result in employment suspension or termination.

_____ _____
Signature Date

Mail the original form to: Department of Human Services, Child Welfare Services Branch, Oahu Child Welfare Services Section 3, Attn: CAN Clearances, 420 Waiakamilo Road, Suite 300A, Honolulu, Hawaii 96817. Faxes will not be accepted.