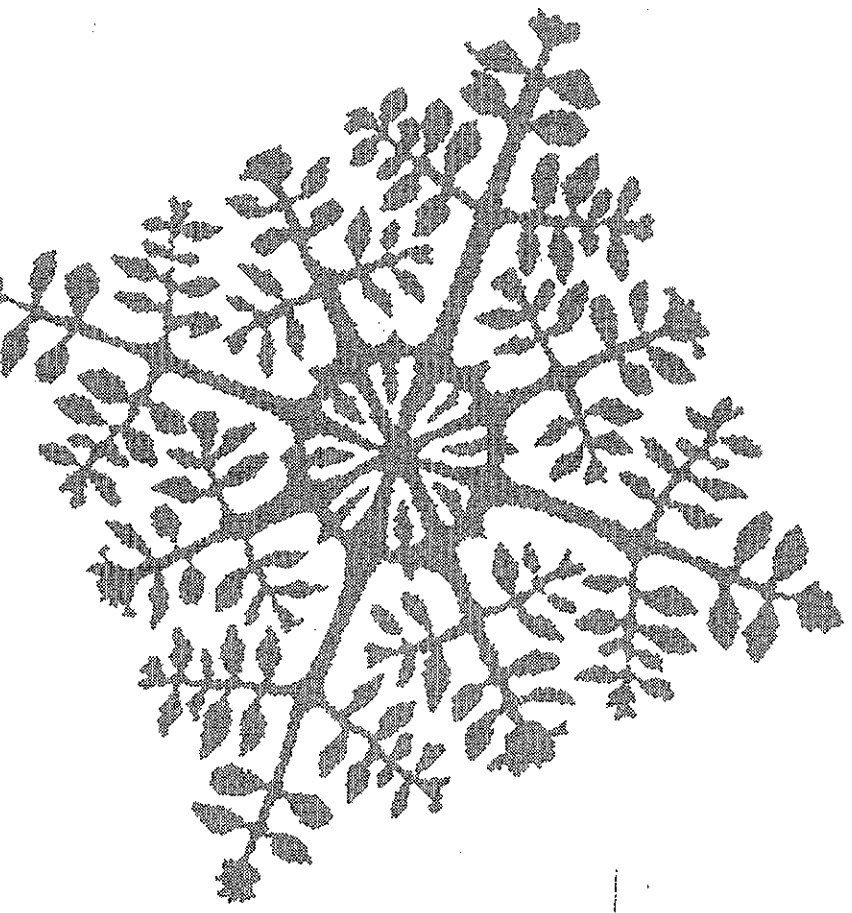
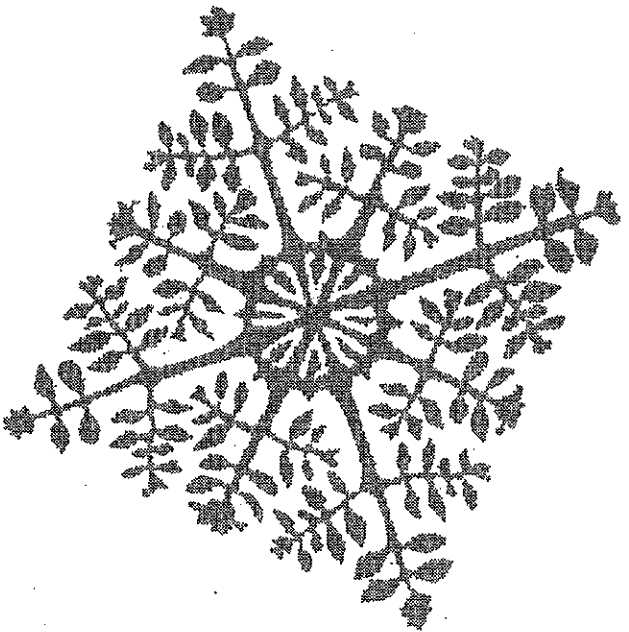
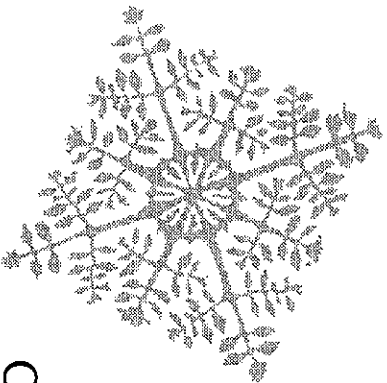


NORTH HAWAII COMMUNITY HOSPITAL  
EMPLOYMENT APPLICATION





## OUR MISSION

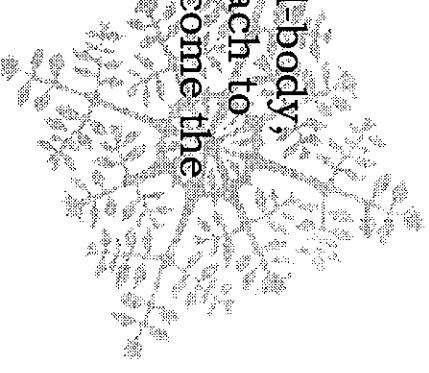
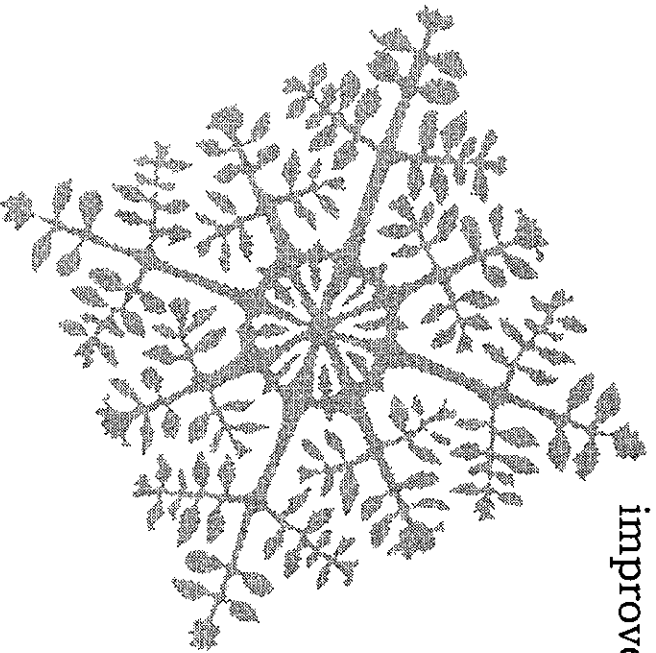
Our mission is to improve the health of the people of North Hawaii by providing high quality services at a reasonable cost.

## OUR VISION

Our vision is to treat the whole individual body, mind and spirit - through a team approach to patient-centered care, and ultimately to become the most healing hospital in the world.

## OUR VALUES

As ohana, we value an environment of aloha which nurtures trust, respect, self-expression without fear, open minds and hearts and continuous improvement.



# EMPLOYMENT APPLICATION

## NORTH HAWAII COMMUNITY HOSPITAL

PLEASE PRINT

Name \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Date \_\_\_\_\_

Mailing Address \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Period of Residence \_\_\_\_\_

Street Address (if different from mailing address) \_\_\_\_\_

Telephone No. (\_\_\_\_) \_\_\_\_\_ E-mail Address \_\_\_\_\_

Social Security No. \_\_\_\_\_ Date Available for Work \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Indicate other name(s) used if different from present name \_\_\_\_\_

Position(s) Desired: (1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_

Shift(s) Available:  Day  Night  Other  Full Time  Part Time  Temporary  Per Diem

Have you ever applied at this healthcare facility?  Yes  No

If yes, when? \_\_\_\_\_ Department \_\_\_\_\_

Why do you want to work here? \_\_\_\_\_

How were you referred to us?  Walk in  Newspaper ad  Professional publication  College recruitment  Refire  Job line  Personal referral  Other

Person to Notify in Case of Emergency \_\_\_\_\_ Telephone-Days: (\_\_\_\_) \_\_\_\_\_

Do you have any relatives who work for this organization?  Yes  No Evening/Weekends: (\_\_\_\_) \_\_\_\_\_

Has your license or certification to work in your profession ever been suspended or revoked? As a provider of service, have you ever been excluded or suspended from participation in the Medicare Program or any state Medicaid Program? (A "yes" answer to any of these questions does not automatically bar you from employment. All circumstances will be considered.)  Yes  No

Explain: \_\_\_\_\_

Place a ✓ in the box by any area in which you have significant prior work or volunteer experience:

<b>Business</b>	<input type="checkbox"/> Accounting	<input type="checkbox"/> Centex/PBX	<input type="checkbox"/> Human Resources	<input type="checkbox"/> Medical Records	<input type="checkbox"/> Ten-Key	<input type="checkbox"/> Unit Secretary
<input type="checkbox"/> Admissions	<input type="checkbox"/> Bookkeeping	<input type="checkbox"/> Cashier	<input type="checkbox"/> Collections/Credit	<input type="checkbox"/> Computers	<input type="checkbox"/> Data Entry	<input type="checkbox"/> Insurance Billing
<input type="checkbox"/> Bookkeeping	<input type="checkbox"/> Cashier	<input type="checkbox"/> Data Entry	<input type="checkbox"/> Computers	<input type="checkbox"/> Invoicing/Inventory	<input type="checkbox"/> Purchasing	<input type="checkbox"/> Medical Terminology
<input type="checkbox"/> Cashier	<input type="checkbox"/> Data Entry	<input type="checkbox"/> Purchasing	<input type="checkbox"/> Invoicing/Inventory	<input type="checkbox"/> Medical Records	<input type="checkbox"/> Typing _____ WPM	<input type="checkbox"/> Word Processing
<input type="checkbox"/> Medical Records	<input type="checkbox"/> Typing _____ WPM	<input type="checkbox"/> Word Processing	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other
<b>General</b>	<input type="checkbox"/> Building Trades	<input type="checkbox"/> Electronics	<input type="checkbox"/> Engineering	<input type="checkbox"/> Food Service	<input type="checkbox"/> Grounds	<input type="checkbox"/> Housekeeping
<input type="checkbox"/> Building Trades	<input type="checkbox"/> Electronics	<input type="checkbox"/> Engineering	<input type="checkbox"/> Food Service	<input type="checkbox"/> Grounds	<input type="checkbox"/> Housekeeping	<input type="checkbox"/> Laundry
<input type="checkbox"/> Electronics	<input type="checkbox"/> Engineering	<input type="checkbox"/> Food Service	<input type="checkbox"/> Grounds	<input type="checkbox"/> Housekeeping	<input type="checkbox"/> Laundry	<input type="checkbox"/> Maintenance
<input type="checkbox"/> Engineering	<input type="checkbox"/> Food Service	<input type="checkbox"/> Grounds	<input type="checkbox"/> Housekeeping	<input type="checkbox"/> Laundry	<input type="checkbox"/> Maintenance	<input type="checkbox"/> Medical Records
<input type="checkbox"/> Food Service	<input type="checkbox"/> Grounds	<input type="checkbox"/> Housekeeping	<input type="checkbox"/> Laundry	<input type="checkbox"/> Maintenance	<input type="checkbox"/> Medical Records	<input type="checkbox"/> Security
<input type="checkbox"/> Grounds	<input type="checkbox"/> Housekeeping	<input type="checkbox"/> Laundry	<input type="checkbox"/> Maintenance	<input type="checkbox"/> Medical Records	<input type="checkbox"/> Security	<input type="checkbox"/> Other
<input type="checkbox"/> Housekeeping	<input type="checkbox"/> Laundry	<input type="checkbox"/> Maintenance	<input type="checkbox"/> Medical Records	<input type="checkbox"/> Security	<input type="checkbox"/> Other	<input type="checkbox"/> Other
<input type="checkbox"/> Laundry	<input type="checkbox"/> Maintenance	<input type="checkbox"/> Medical Records	<input type="checkbox"/> Security	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other
<input type="checkbox"/> Maintenance	<input type="checkbox"/> Medical Records	<input type="checkbox"/> Security	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other
<input type="checkbox"/> Medical Records	<input type="checkbox"/> Security	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other
<input type="checkbox"/> Security	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other
<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other
<b>Patient Care</b>	<input type="checkbox"/> Behavioral Medicine	<input type="checkbox"/> Central Service	<input type="checkbox"/> Emergency Room	<input type="checkbox"/> Geriatric	<input type="checkbox"/> Home Health	<input type="checkbox"/> ICU/CCU
<input type="checkbox"/> Behavioral Medicine	<input type="checkbox"/> Central Service	<input type="checkbox"/> Emergency Room	<input type="checkbox"/> Geriatric	<input type="checkbox"/> Home Health	<input type="checkbox"/> ICU/CCU	<input type="checkbox"/> Medical
<input type="checkbox"/> Central Service	<input type="checkbox"/> Emergency Room	<input type="checkbox"/> Geriatric	<input type="checkbox"/> Home Health	<input type="checkbox"/> ICU/CCU	<input type="checkbox"/> Medical	<input type="checkbox"/> OB/GYN
<input type="checkbox"/> Emergency Room	<input type="checkbox"/> Geriatric	<input type="checkbox"/> Home Health	<input type="checkbox"/> ICU/CCU	<input type="checkbox"/> Medical	<input type="checkbox"/> OB/GYN	<input type="checkbox"/> Occupational Therapy
<input type="checkbox"/> Geriatric	<input type="checkbox"/> Home Health	<input type="checkbox"/> ICU/CCU	<input type="checkbox"/> Medical	<input type="checkbox"/> OB/GYN	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Orthopedics
<input type="checkbox"/> Home Health	<input type="checkbox"/> ICU/CCU	<input type="checkbox"/> Medical	<input type="checkbox"/> OB/GYN	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Orthopedics	<input type="checkbox"/> Pediatrics
<input type="checkbox"/> ICU/CCU	<input type="checkbox"/> Medical	<input type="checkbox"/> OB/GYN	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Orthopedics	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Physician Office
<input type="checkbox"/> Medical	<input type="checkbox"/> OB/GYN	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Orthopedics	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Physician Office	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> OB/GYN	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Orthopedics	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Physician Office	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Respiratory Therapy
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Orthopedics	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Physician Office	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Respiratory Therapy	<input type="checkbox"/> Surgery (OR)
<input type="checkbox"/> Orthopedics	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Physician Office	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Respiratory Therapy	<input type="checkbox"/> Surgery (OR)	<input type="checkbox"/> Surgical
<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Physician Office	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Respiratory Therapy	<input type="checkbox"/> Surgery (OR)	<input type="checkbox"/> Surgical	<input type="checkbox"/> X-Ray
<input type="checkbox"/> Physician Office	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Respiratory Therapy	<input type="checkbox"/> Surgery (OR)	<input type="checkbox"/> Surgical	<input type="checkbox"/> X-Ray	
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Respiratory Therapy	<input type="checkbox"/> Surgery (OR)	<input type="checkbox"/> Surgical	<input type="checkbox"/> X-Ray		
<input type="checkbox"/> Respiratory Therapy	<input type="checkbox"/> Surgery (OR)	<input type="checkbox"/> Surgical	<input type="checkbox"/> X-Ray			
<input type="checkbox"/> Surgery (OR)	<input type="checkbox"/> Surgical	<input type="checkbox"/> X-Ray				
<input type="checkbox"/> Surgical	<input type="checkbox"/> X-Ray					
<input type="checkbox"/> X-Ray						

Circle highest year of education completed: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 16+

School Name and Address \_\_\_\_\_ Major \_\_\_\_\_ Diploma or Degree Received \_\_\_\_\_

High School: \_\_\_\_\_

College / Trade: \_\_\_\_\_

Licenses & Certificates \_\_\_\_\_ Registration Number & State \_\_\_\_\_ Date of Expiration \_\_\_\_\_

In the spaces provided below, list all employment or volunteer service for your last three employers. Give most recent first. Attach additional sheet if necessary.

DATES Month/Year	Company Name	Rate of Pay	Years/Months of Full-time Employment
From	Street	City	Position/Title
To	State	ZIP	Supervisor
Brief Description of Duties:			

DATES Month/Year	Company Name	Rate of Pay	Years/Months of Full-time Employment
From	Street	City	Position/Title
To	State	ZIP	Supervisor
Brief Description of Duties:			

DATES Month/Year	Company Name	Rate of Pay	Years/Months of Full-time Employment
From	Street	City	Position/Title
To	State	ZIP	Supervisor
Brief Description of Duties:			

My present employer  May  May not be contacted

Other languages you speak \_\_\_\_\_ write \_\_\_\_\_ read \_\_\_\_\_ sign language \_\_\_\_\_

If employed, can you submit proof of legal right to work in the United States?  Yes  No

**IMPORTANT — READ BEFORE SIGNING**

I hereby certify that the facts set forth above are true and complete, and I authorize the Organization and its agents to investigate any and all of the statements that I have made. I also authorize all persons and institutions, including my previous employers and the schools that I attended, to provide the Organization with any information that it requests in connection with this application. I hereby release all of these persons and institutions and the Organization from any and all liability for any damages arising from the investigation. I understand that if employed, false statements on this application or omissions of material information may result in my termination. If employed, I agree to abide by all Organization rules and regulations as they now or may exist.

I understand that my employment is contingent upon my successful completion of a pre-employment, post offer, physical examination which may include drug testing. I further understand that, within the time frame specified by the Organization, I must produce applicable documents showing that I am a United States citizen or alien lawfully authorized to work in the United States.

I understand and agree that, if employed, either the Organization or I will be free to terminate the employment relationship at any time, without cause and without notice. I understand and agree that this writing shall constitute the entire agreement between the Organization and me on the subject of the length of my employment, and the circumstances under which it may be terminated, and that there are no oral or collateral agreements pertaining to these issues. I also understand and agree that no representative of the Organization, other than its President, has the authority to enter into any future agreement, either express or implied, restricting in any way the Organization's right to terminate employment and, that to the extent the President enters into such a future agreement, it may only be in writing.

In the event that I am dissatisfied or disagree with any action or failure to act, taken by the Organization, its employees, agents or representatives, I agree to submit the matter to the Organization's grievance and arbitration procedure for final and binding resolution and will not initiate a law suit, thereby waiving any right I might have to a jury trial.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

(Please Do Not Write Below This Line)

Comments: \_\_\_\_\_

License, Registration, Certification Verified \_\_\_\_\_ Proof of Right to work Verified \_\_\_\_\_

Hired \_\_\_\_\_ Starting Date \_\_\_\_\_ Job Code \_\_\_\_\_ Position \_\_\_\_\_ Screened By \_\_\_\_\_

Department \_\_\_\_\_ No./Cost Center \_\_\_\_\_ Shift \_\_\_\_\_ Rate of Pay \_\_\_\_\_ WS \_\_\_\_\_ Step \_\_\_\_\_

Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ Per Diem \_\_\_\_\_ Temporary \_\_\_\_\_

Supervisor \_\_\_\_\_ Date \_\_\_\_\_ Department Head \_\_\_\_\_ Date \_\_\_\_\_

Vice President \_\_\_\_\_ Date \_\_\_\_\_ Human Resources Department \_\_\_\_\_ Date \_\_\_\_\_



# NORTH HAWAII COMMUNITY HOSPITAL

67-1125 MAKAHAHOA HIGHWAY • KAUOELA, HI 96743

## Employment Data Record — Research Data Supplement

Employees are treated during employment without regard to race, color, sex, sexual orientation, national origin, age, marital or veteran status, arrest and court record, medical condition or disability, or any other legally protected status.

As an employer with an Affirmative Action Program, we comply with government regulations, including Affirmative Action responsibilities where they apply.

The purpose for this Date Record is to comply with government record keeping, reporting and other legal requirements. Periodic reports are made to the government on the following information. The completion of this Date Record is optional. If you choose to volunteer the requested information, please note that all Data Records are kept in a Confidential File and are not a part of your Employment Application or personnel file. Please Note: YOUR COOPERATION IS VOLUNTARY. INCLUSION OR EXCLUSION OF ANY DATA WILL NOT AFFECT ANY EMPLOYMENT DECISION.

### VOLUNTARY SURVEY

Date \_\_\_\_\_

North Hawaii Community Hospital complies with the Rehabilitation Act of 1973 and the ADA. If you wish to claim status as a disable applicant, please tell us about reasonable accommodations, which could be made in the workplace in order for you to perform the job properly and safely. Submission of the information is strictly voluntary and will be kept confidential.

If you are disabled, a Disabled Veteran, or a Vietnam Era Veteran, as these terms are defined below, and you would like to be included in our Affirmative Action Program, check the appropriate definition and give all the information requested.

- Y \_\_\_\_\_ Disabled Individual: a person who: (a) has a physical or mental impairment which substantially limits one or more major life activities; (b) has a record of such an \_\_\_\_\_ impairment; or: (c) is regarded as having such an impairment.
- 2 \_\_\_\_\_ Disabled Veteran: a person entitled to disability compensation under the Veterans Administration with a 30 percent or more disability, or a person discharged or released from active duty for a disability incurred or aggravated in the line of duty.
- 1 \_\_\_\_\_ Veteran of the Vietnam Era: a person who served on active duty for a period of more than 180 days, any part of which occurred between August 5, 1964 and May 7, 1975, and was discharged or released therefrom with other than a dishonorable discharge; or, a person who was discharged or released from active duty for a service connected disability if any part of such active duty was performed between August 5, 1964 and May 7, 1975.

Disabled individuals and Disabled Veterans, please give the following information:

Give description of the mental or physical disability you have or have had:

Tell us about any accommodations which we could make which would enable you to perform the job properly and safely, including special equipment, changes in physical lay-out of the job, or any other accommodations:

Complete only after hire: Current job: \_\_\_\_\_  Male  Female Age: \_\_\_\_\_

Check one of the following (Ethnic Origin):

White — (Not of Hispanic origin): Persons having origins of any of the original peoples of Europe, North Africa or the Middle East.

Hispanic — Persons of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish Culture origin.

American Indian/Alaskan Native — Persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.

Black — (Not of Hispanic origin): Persons having origins in any of the Black racial groups of Africa.

Asian or Pacific Islander — Persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands.  Chinese  Hawaiian  Filipino  Japanese  Vietnamese

Signature \_\_\_\_\_

Social Security No. \_\_\_\_\_

Date: \_\_\_\_\_