

APPLICATION FOR EMPLOYMENT

PLEASE PRINT LEGIBLY.
FILL IN ALL AREAS COMPLETELY

The Kuakini Health System is an equal opportunity and affirmative action employer. Facts relating to race, color, religion, national origin, sex, age, marital or veteran status, disability, or any other classification protected by state or federal law, are not requested by this application and are not considered in determining your qualifications for employment. The Kuakini Health System hires only United States citizens or aliens lawfully authorized to work in the United States. Verification of identity and work authorization will be required upon hiring as a condition of employment.

Date _____

Print Name _____ (Last) _____ (First) _____ (Middle) Soc. Sec. Number _____
Message Phone _____

Local Address _____ (Street) _____ (Apt. No.) _____ (City) _____ (Zip Code) Home Phone _____

Permanent Mailing Address _____ (Street) _____ (Apt. No.) _____ (City)

EMPLOYMENT DESIRED

Position _____

Specify hours if part time _____

Full Time Temporary Part Time Call-In (Relief)
 Shifts Available: Day Evening Nights Rotation Call-In (Relief)
 Days Available: Monday-Friday Saturdays Sundays Holidays
 Are you able to perform the essential functions of this job with or without reasonable accommodation? _____

How long do you expect to work? _____

Date available for work _____

EMPLOYMENT RECORD: STARTING WITH present or MOST RECENT, list all previous employers. Include self-employment, military service, summer and part-time jobs. Please attach additional sheets if necessary, following the same format. MAY WE CONTACT YOUR PRESENT EMPLOYER? YES () NO ()

| Name and Address of Former Employer | Dates Employed | Position and Duties | Salary | Reason for Leaving |
|--|-------------------------|---------------------|---------------------------|--------------------|
| COMPANY NAME Phone No. & Street City & State Zip | From Mo./Yr. To Mo./Yr. | | Starting \$ Leaving \$ | Supervisor's Name |
| COMPANY NAME Phone No. & Street City & State Zip | From Mo./Yr. To Mo./Yr. | | Starting \$ Leaving \$ | Supervisor's Name |
| COMPANY NAME Phone No. & Street City & State Zip | From Mo./Yr. To Mo./Yr. | | Starting \$ Leaving \$ | Supervisor's Name |
| COMPANY NAME Phone No. & Street City & State Zip | From Mo./Yr. To Mo./Yr. | | Starting \$ Leaving \$ | Supervisor's Name |

SPECIAL SKILLS & QUALIFICATIONS

CLERICAL

Typing _____ WPM Shorthand _____ WPM 10-Key
 Word processor Transcribing machine Calculator Speak, read or write any other language? If yes, please indicate _____
 Others: _____

Professional: Do you have or have you ever applied for a Hawaii Professional License, Certificate, or Registration? Yes No
 Are you currently: Registered Licensed Certified
 Eligible for: Registration Licensure Certification

| | | | |
|--------|------|--------------------|--|
| Number | Type | Date of Expiration | If pending give date application started |
| | | | |

Describe any other training or skills you have which may be related to the position you are seeking:

| EDUCATION | Name of School | Address | No. of Years Attended | Degrees |
|----------------------------|----------------|---------|-----------------------|---------|
| Elementary | | | | |
| Jr. High/ Intermediate | | | | |
| High School | | | | |
| College | | | | |
| Other (trade school, etc.) | | | | |

GENERAL INFORMATION

Have you worked for Kuakini before? Yes No

List any relatives employed by Kuakini Medical Center

Name(s) _____

Who referred you to Kuakini Medical Center?

Advertisement
 Agency

Employee Please indicate _____
 Acquaintance

Have you ever worked for Kuakini under another name?
 Yes No

If yes, what name(s)

Which company or organization

Have you ever been fired or requested to resign?
 Yes No

If yes, explain or describe

REFERENCES (Please list two persons not related who can attest to your experience, character and qualifications)

| Name | Address | City and State | Phone | Occupation | Years known |
|------|---------|----------------|-------|------------|-------------|
| | | | | | |

CERTIFICATION OF RELEASE BY APPLICANT

I hereby certify and represent that all statements made by me in this application are true and accurate. I understand and agree that any false statement, misrepresentation, or omission of fact(s) in this application or other required or submitted supporting documents (such as a resume, letters of reference, licenses, diplomas or educational transcripts) can result in denial of employment or discharge from employment (if I am employed, regardless of when such misrepresentation or omission is discovered.)

I hereby authorize THE KUAKINI HEALTH SYSTEM and its employees and/or agents to make a thorough investigation into my background and to communicate with any of my prior employers, educational institutions, persons or other organizations to ascertain any pertinent facts or opinions regarding my prior employment, education, or general background. I further authorize any and all of my prior employers to release to the Health System any and all facts or opinions regarding my prior employment. I release from any liability all persons or companies supplying such information. I further indemnify the Health System against any liability which might result in making any such investigation into my background.

I understand that nothing contained in this employment application, or in the granting of an interview, is intended to create an employment contract between THE KUAKINI HEALTH SYSTEM and myself. No promises or guarantees regarding employment have been made to me, and I understand that no promise or guarantee is binding upon the Health System unless made in writing by the President and CEO or other authorized agent. If an employment relationship is established, I understand that unless I am governed by a collective bargaining agreement, my employment is on an "at-will" basis, and may be terminated at any time by the Health System, or myself, with or without cause, and with or without notice, by either side .

I understand that a condition of employment is to satisfactorily pass any post-offer physical examination and any subsequent post-employment periodic examination which the Health System may require. I hereby authorize the full release of any and all medical records maintained (including any such records created in the future for any reason, should I be hired) by any physician, hospital, clinic, or medical facility regarding my physical condition to the Health System and/or its authorized physician or agents.

It is the policy of the Health System to hire only U.S. citizens and aliens who are authorized to work in this country. If I am employed, I understand that I will be required to produce original documents establishing my identity and authorization to work according to the requirements set forth in the Immigration and Reform Control Act of 1966 and to complete the U.S. Immigration and Naturalization Services I-9. I understand that if employed, I will be required to submit proof of age or citizenship, social security number or any other pertinent information .

_____ Date

_____ Social Security Number

_____ Signature of Applicant