PHYSICIAN/MEDICAL STAFF EMPLOYMENT APPLICATION ONLY

HAWAII HEALTH SYSTEMS CORPORATION

CORPORATE OFFICE
3675 Kilauea Avenue, Honolulu 96816

OAHU REGION
Maluhia (Kalihi, Palama, Kapalama)
Leahi Hospital (Kaimuki, Waialae, Kahala)

MAUI REGION
Maui Memorial Medical Center (Wailuku)
Kula Hospital
Lana'i Community Hospital

KAUAI REGION
Samuel Mahelona Memorial Hospital (Kapaa)
Kauai Veterans Memorial Hospital (Waimea)

EAST HAWAII REGION
Hilo Medical Center
Hale Ho'ola Hamakua (Honokaa)
Kau Hospital

WEST HAWAII REGION
Kona Community Hospital
Kohala Hospital

It is Hawaii Health Systems Corporation's policy to provide equal opportunity in all areas of the employment practices and to assure that there is no discrimination against its employees or applicants on the basis of race, sex (including pregnancy), sexual orientation, age, religion, color, ancestry, national origin, disability, marital status, U. S. veteran status, national guard participation, arrest and court record (except as permitted by law) or other protected status.

TITLE OF JOB APPLYING FOR:	**RECRUITMENT NUMBER:**

NAME:		
(Last)	(First)	(Middle)

OFFICE ADDRESS:			
(Street Address)	(City)	(State)	(Zip Code)

HOME ADDRESS:			
(Street Address)	(City)	(State)	(Zip Code)

MAY WE CONTACT YOU AT YOUR OFFICE? ☐ YES ☐ NO

WORK NUMBER:		**HOME NUMBER:**	
CELL NUMBER:		**PAGER NUMBER:**	
EMAIL ADDRESS:			
SPECIALTY:		**SUB-SPECIALTY:**	

EDUCATION & TRAINING:

HIGH SCHOOL:			
(Name)	(City)	(State)	(Zip Code)

COLLEGE:		
(School Name)	(Number of Years Attended)	(Degree)

(Street Address)	(City)	(State)	(Zip Code)

MEDICAL/PROFESSIONAL SCHOOL:		
(School Name)	(Number of Years Attended)	(Degree)

(Street Address)	(City)	(State)	(Zip Code)

POST GRADUATE EDUCATION OR TRAINING:		
(School Name)	(Number of Years Attended)	(Degree)

(Street Address)	(City)	(State)	(Zip Code)

INTERNSHIP:		**From:**	**To:**	
(School Name)	(Number of Years Attended)			(Degree)

(Street Address)	(City)	(State)	(Zip Code)

RESIDENCY TRAINING:		**From:**	**To:**	
(Name of Program/Specialty)	(Number of Years Attended)			(Telephone)

(Street Address)	(City)	(State)	(Zip Code)

FELLOWSHIP TRAINING:			**From:**		**To:**		
	(Name of Program/Specialty)	(Number of Years Attended)					(Telephone)
(Street Address)		(City)		(State)			(Zip Code)

PROFESSIONAL REFERENCES:

MEDICAL/ PROFESSIONAL SCHOOL:			
(Name & Title)			(Telephone)
(Street Address)	(City)	(State)	(Zip Code)
INDICATE RELATIONSHIP:			

INTERNSHIP:			
(Name & Title)			(Telephone)
(Street Address)	(City)	(State)	(Zip Code)
INDICATE RELATIONSHIP:			

RESIDENCY/FELLOWSHIP:			
(Name & Title)			(Telephone)
(Street Address)	(City)	(State)	(Zip Code)
INDICATE RELATIONSHIP:			

EMPLOYMENT OR OTHER PROFESSIONAL REFERENCES: Refer to individuals who know you well, through your training programs or current practice.

1.						
	(Name & Title)	(Street Address)	(City)	(State)	(Zip Code)	(Telephone)
INDICATE RELATIONSHIP:						
2.						
	(Name & Title)	(Street Address)	(City)	(State)	(Zip Code)	(Telephone)
INDICATE RELATIONSHIP:						
3.						
	(Name & Title)	(Street Address)	(City)	(State)	(Zip Code)	(Telephone)
INDICATE RELATIONSHIP:						

Are you personally acquainted with any present or former member of our medical staff? Yes ☐ No ☐

Name:

WORK HISTORY, POST INTERN AND/OR RESIDENCY EXPERIENCE: Position held, including military service. List most recent position first.

1. POSITION:		**Date:**		**To:**	
ADDRESS:					
	(Street Address)	(City)	(State)	(Zip Code)	(Telephone)
REASON FOR LEAVING:					
2. POSITION:		**Date:**		**To:**	
ADDRESS:					
	(Street Address)	(City)	(State)	(Zip Code)	(Telephone)
REASON FOR LEAVING:					
3. POSITION:		**Date:**		**To:**	
ADDRESS:					
	(Street Address)	(City)	(State)	(Zip Code)	(Telephone)
REASON FOR LEAVING:					

IS ALL PREVIOUS WORK EXPERIENCE LISTED? Yes ☐ No ☐ **IF NOT, PLEASE LIST ON A SEPARATE SHEET OF PAPER AND ATTACH.**

HOSPITAL PRIVILEGES:

	(Hospital)	(Street Address)	(City)	(State)	(Zip Code)	(Telephone)
1.						
(Type of Privileges)						
2.						
(Type of Privileges)						
3.						
(Type of Privileges)						

CURRENT MALPRACTICE INSURANCE CARRIER:

(Name of Carrier)			(Telephone)
(Street Address)	(City)	(State)	(Zip Code)

LICENSURE AND CERTIFICATIONS:

Are you currently Board Certified? Primary: ______ Sub-specialty: ______ Which Boards? ______ Date Certified: ______

Are you eligible to take your specialty boards? ☐ Yes ☐ No When: ______

Which exam have you taken: ☐ USMLE (Parts I, II, III) ☐ NBOME (Parts I, II, III)

☐ FLEX (1 sitting, 3 days) ☐ NBME (Parts I, II, III)

State Boards (State) ______ Date ______

Current DEA Number: Expires:

ACLS certification Expires:

BLS certification Expires:

PALS certification Expires:

NRP certification Expires:

List all license numbers in all states and indicate whether expired, current or inactive

State	License Number	Effective Date

PARTICIPATION IN PROFESSIONAL ASSOCIATIONS:

1.

2.

3.

Please list any professional honors, awards, publications or research:

1. Are you aware of any malpractice claims which have been made or may be made against you? For the purposes of this question, claims shall include but not be limited to, the filing of a Summons and Complaint, demand letters by patients or attorneys, request for mediation or receipt of letters of intent to file suit. Yes ☐ No ☐

2. Have you ever been denied a license or had your license limited, suspended, denied or revoked in any state? Yes ☐ No ☐

3. Have your hospital or clinic staff privileges ever been limited, suspended, denied or revoked? Yes ☐ No ☐

4. Have you ever been involved in any other activity that would create doubt about your ability or right to practice? Yes ☐ No ☐

5. Have you ever had your Drug Enforcement Administration Certificate or prescribing privileges limited, suspended or revoked by any state or federal agency? Yes ☐ No ☐

6. Is there any reason you could not practice full time? Yes ☐ No ☐

7. Is there anything preventing you from complying with any professional requirement? Yes ☐ No ☐

*If you answered yes to any of the above questions, please explain fully on a separate sheet of paper and attach.

PLEASE NOTE: Information requested in items A, B and C are needed to make determinations on your suitability for employment. Dishonorable separations from military service do not automatically disqualify you from employment, however, certain Federal and State laws allow us to disqualify individuals with convictions for those offenses noted below.

A. DISHONORABLE SEPARATIONS FROM MILITARY SERVICE ☐ YES ☐ NO
Within the past 5 years, were you separated from military service under conditions other than honorable?

B. CONVICTION FOR A VIOLATION OF ANY OF THE FOLLOWING: ☐ YES ☐ NO

1) Controlled substance-related offense in the three-year period immediately preceding the date of the application.
2) State or federal healthcare program-related crimes.
3) Patient abuse, neglect or mistreatment.
4) Felony conviction after August 21, 1996 of fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct in connection with a healthcare program.
5) Felony conviction after August 21, 1996 relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.
6) Any act, attempt, or conspiracy to overthrow the State or the federal government by force or violence.

C. HAVE YOU BEEN THE SUBJECT OF ANY ADVERSE ACTION(S) BY ANY PROFESSIONAL OR VOCATIONAL LICENSING ORGANIZATION(S)? ☐ YES ☐ NO

D. IF YOU ANSWERED "YES," TO ANY OF THE ABOVE, PLEASE PROVIDE EXPLANATION, INCLUDING DATE AND CIRCUMSTANCES SURROUNDING THE INCIDENT UNDERLYING THE CONVICTION OR ADVERSE ACTION.

VETERAN'S PREFERENCE: Do you claim veteran's preference? ☐ YES ☐ NO

To receive veteran's preference, you must submit a copy of your DD-214 or honorable discharge certificate, showing dates of honorable service with this application or an official statement from the Veterans Administration or armed service dated within the past 12 months which confirms service-connected disability. Spouses or widows must also submit evidence of marriage, and as applicable, veteran's death.

CERTIFICATION (Please read carefully before signing)

A. I certify that all statements made on this application for employment are true and complete to the best of my knowledge. I understand and agree that any misrepresentation or omission whenever discovered, is grounds for the denial of or immediate separation from employment. Providing my SSN is voluntary and to be used only for employment purposes.

B. I consent to and authorize HHSC to communicate with all my former employers, school officials, government agencies, and persons named as references, and to make any investigation of my employment history. In consideration for HHSC's review of this application, I release HHSC and any other person or company responding to any reference or information from any claim or liability regarding any information or opinion supplied. I understand that any offer of employment is subject to satisfactory references. In consideration for employment, I further authorize HHSC to disclose information about my job performance with HHSC to any prospective employer upon request of that prospective employer. I specifically waive any claims against HHSC for such disclosure unless it is established by clear and convincing evidence that such information was knowingly false or rendered with malicious purpose and also such disclosure was not otherwise privileged.

C. I understand that other checks required by HHSC to comply with various governmental programs such as Medicare and Medicaid will be conducted and any offer of employment and continued employment will be contingent on the satisfactory return of these checks.

D. State and Federal criminal history record checks will be conducted. Depending on the circumstances, an applicant with a conviction may be denied employment.

E. I understand that if I am offered employment, I will be required to submit proof of U.S. citizenship or immigration documentation establishing authorization to work in the United States.

F. I understand and agree that if I am employed by HHSC, all of the foregoing terms are continuing conditions of my employment with the Hawaii Health Systems Corporation.

________________________ ________________________ ________________________
Applicant's Signature Social Security Number Date

If desired, a curriculum vitae may be attached to this form.