Aloha Habilitation Services
100 Kahelu Avenue, Suite 110, Mililani, Hawaii 96789
(808) 622-4200 • Fax (808) 622-4211
www.alohahab.com / info@alohahab.com

Name : _____
Application Date: _____
Start : _____ **End :** _____

EMPLOYEE APPLICATION PACKET

1) Pre-Hire *(Completed During Application Process)*

- ☐ Application for Employment (All sections must be completed)
- ☐ Resumé
- ☐ Health Report Form** (EXP: _____ HR INITIALS: _____)
- ☐ **2-Step** TB Clearance Card** (EXP: _____ HR INITIALS: _____)
- ☐ TB Screening Evaluation Report *(Required if positive TB only)*** (EXP: _____HR INITIALS: _____)
- ☐ First Aid / CPR** (EXP: _____ HR INITIALS: _____)
- ☐ Fieldprint** (FBI Fingerprint and APS/CAN Screen with Criminal History included)
  (www.fieldprinthawaii.com / **CODE: FPAlohaHS25***)*

  (*1ST COMPLETED:* _____ ***RENEW ON ~OR~ BEFORE:*** _____HR Initials:_____)

2) Post-Hire *(**Will Not Start Rendering Services Until All Is Completed**)*

- ☐ Automobile Insurance Liability Declaration Policy** (EXP: _____ HR INITIALS: _____)
  (Must have coverage limits as followed: Bodily Injury Liability of $100,000/$300,000 and Property Damage Liability of $50,000)
- ☐ Traffic Abstract (EXP: _____ HR INITIALS: _____)
- ☐ Social Security Card
- ☐ Licensed Home Certification (Adult Foster, DD/DOM Home, Adult Residential Care Home, Expanded ARCH) ** (EXP: _____ HR INITIALS: _____)
- ☐ Driver's License** (EXP: _____HR INITIALS:_____) **~OR~**
  State I.D.** (EXP: _____ HR INITIALS: _____)
- ☐ Motor Vehicle Registration (EXP: _____ HR INITIALS: _____)
- ☐ Motor Vehicle Safety Check (EXP: _____ HR INITIALS: _____)
- ☐ Hawaii Nursing License (RN, LPN, CNA), if available** (EXP: _____ HR INITIALS: _____)
- ☐ Policies on Abuse/Criminal History Background Checks (EXP: _____ HR INITIALS: _____)
- ☐ I-9 Employment Eligibility Verification Form
- ☐ Federal Tax Form (W-4)
- ☐ Hawaii State Tax Form (HW-4)
- ☐ Medical Waiver Form (HC-5)
- ☐ Orientation Packet**

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Hire Date:	End Date:
Renewed:	
FOR OFFICE USE	
Job/Position Applying For:	

Application for Employment

GENERAL INFORMATION:

Last Name	First Name	Social Security No.
Address		Telephone No.
City	State	Zip Code
Email		

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.*

Name & Address of Current/Former Employer	Dates Employed	Position & Duties	Salary	Reason for Leaving
Company Name Phone	From Mo./Yr.		Starting $ per	
No. & Street	To Mo./Yr.		Leaving $ per	
City & State Zip		Supervisor's Name		
Company Name Phone	From Mo./Yr.		Starting $ per	
No. & Street	To Mo./Yr.		Leaving $ per	
City & State Zip		Supervisor's Name		
Company Name Phone	From Mo./Yr.		Starting $ per	
No. & Street	To Mo./Yr.		Leaving $ per	
City & State Zip		Supervisor's Name		

(ATTACH EXTRA SHEETS, IF LISTING MORE THAN THREE (3) EMPLOYERS)

AVAILABILITY:

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
to	to	to	to	to	to	to
to	to	to	to	to	to	to
to	to	to	to	to	to	to
to	to	to	to	to	to	to

REFERENCES: *(NOT RELATIVES)*

Name	**Occupation**
Address	**Telephone No.**
Name	**Occupation**
Address	**Telephone No.**
Name	**Occupation**
Address	**Telephone No.**

EDUCATION:

	Name of School	Address	Yrs. Attended	Degrees
Elementary				
Jr. High/ Intermediate				
High School				
College				
Other (trade school, etc.)				

MEDICAL INFORMATION:

After an offer of employment is made, but before employment duties begin, applicants may be required to undergo a physical or medical examination at Company expense and by a Company-chosen physician, with the offer of employment conditioned on the result of such examination. Employees at any time during the course of their employment may be required to undergo a medical examination at Company expense and by a Company-chosen physician.

Applicant's Initials

Are you able to perform the essential functions of this job with or without reasonable accommodation? Yes _____ or No _____

OTHER:

Do you know anyone presently working for our company? Yes ☐ or No ☐ If so, who? _____

NOTE:

It is the policy of this Company to hire only U.S. citizens and aliens who are authorized to work in this country. (As a condition of employment, you will be required to produce original documents establishing your identity and authorization to work, and to complete the U. S. Immigration and Naturalization Service's Form I-9.)

I certify that all statements made on this application are true and complete to the best of my knowledge. I understand that my application will not be considered if it is incomplete. Further, I understand that any misrepresentation or omission when discovered, will subject me to discharge and I hereby authorize any investigation of the above or related work experience, education, or reputation information for purposes of consideration of my application for employment.

This application is not a contract and cannot create a contract. I understand that if I am employed, my employment is "at will" and can be terminated at any time, either by the Company or myself, with, without cause or reason and with or without notice.

_____ _____

Application Date Applicant's Signature

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HEALTH REPORT

Name: _____ **Birth Date:** _____ **Age:** _____

Address: _____ **Telephone No.:** _____

_____ **Work No.:** _____

Height: _____ **Blood Pressure:** _____

Weight: _____ **Heart Rate:** _____

1. **Communicable Diseases:** _____
   _____
2. **Any significant history of chronic or disabling illness, surgery, or other recent illness, which would affect this person's ability to care for people with developmental disabilities / intellectually disabled?**
   _____
   _____
3. **Does this person have any restrictions?** ☐ **Yes** ☐ **No**
   If yes, please explain:
   _____
   _____
4. **In your opinion, is this person able to cope with the added strain and responsibilities of caring for people with developmental disabilities / intellectually disabled?** ☐ **Yes** ☐ **No**
   If no, please state reason(s):
   _____
   _____

_____ _____
Signature of Medical Provider **Name of Medical Provider (Please Print)**

Date of Exam: _____ **Phone Number :** _____

September 2015

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TUBERCULOSIS (TB) SCREENING CLEARANCE CERTIFICATE

NAME: _____ **BIRTH DATE:** _____

ADDRESS: _____

PHONE: _____ **MOBILE:** _____

This is your certificate of the tuberculosis (TB) examination which attests that you are free of communicable TB at this time. This certificate fulfills TB clearance requirements per Hawaii Administrative Rules Title 11, Chapter 164, Department of Health, August 2001.

☐ One-Step Tuberculin Skin Test ☑ Two-Step Tuberculin Skin Test

TB Test Result(s)

Tuberculin Skin Test

1st Date Given: _____ Site: L R By: _____

Date Read: _____ Induration: ____ mm By: _____

Result: ☐ Positive ☐ Negative

2nd Date Given: _____ Site: L R By: _____

Date Read: _____ Induration: ____ mm By: _____

Result: ☐ Positive ☐ Negative

Chest X-ray (Radiologist's report is attached)

Date: _____ Reading: _____

Referred to Lanakila Comprehensive Health Center for follow-up: ☐ Yes ☐ No

_____ _____
Print Name **Date of Exam**

_____
Signature and Title of Physician / Physician Assistant / APRN

Address: _____ **Phone Number :** _____

_____ **Fax Number :** _____

July 2017

** TB SCREENING EVALUATION REPORT **

This form must *ONLY* be used if you have had a history of positive Tuberculosis

~ And ~

2-Step TB Skin Screening *CANNOT* be completed.

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TUBERCULOSIS (TB) SCREENING EVALUATION REPORT

(This form needs to be used by the individual who have had a positive skin test and 1 negative chest x-ray)

NAME: _____ **DATE OF BIRTH:** _____

ADDRESS: _____

PHONE: _____ **MOBILE:** _____

All individuals who have previously tested positive and were found to be free of active TB based on a standard chest X-ray and with appropriate medical examination shall be screened for symptoms consistent with pulmonary TB at the time of the annual evaluation.

TB Clearance Symptom Check

Positive (+) TB Skin Test → Date: _____

Negative (-) Chest X-Ray → Date: _____

Are any of the following symptoms present?	**YES**	**NO**
Productive cough of 3 weeks or more duration	☐	☐
Fever	☐	☐
Night Sweats	☐	☐
Weight Loss	☐	☐
Malaise / Fatigue	☐	☐
Hemoptysis	☐	☐

Comments: ***(Please check one of the following)***

☐ Referred for chest x-ray to rule out TB

☐ Does not visibly appear to have any symptoms of TB

☐ Other (Please Explain): _____

_____ _____

Print Name **Date of Exam**

_____

Signature of Physician / Physician Assistant / Advanced Practice Registered Nurse (APRN)

Address: _____ **Phone Number :** _____

_____ **Fax Number :** _____

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FIELDPRINT HAWAII

To schedule an FBI Fingerprinting, APS/CAN, and Criminal History appointment:

1. Visit www.fieldprinthawaii.com
2. Click the red ***"Schedule An Appointment"*** button on the right.
3. Enter an email address under the ***"New Users/Sign Up"*** and click the ***"Sign Up"*** button. Follow the instructions to create a Password and Security Question and then click "Sign Up and Continue."
4. Select ***"I Know My Fieldprint Code"*** and enter the code provided to you. Enter the highlighted code –

   FBI FINGERPRINT, APS/CAN, AND CRIMINAL HISTORY CODE: *FPAlohaHS25*

   COST: $68.00

   At this point, you are ready to enter your demographic information and schedule a Fingerprint appointment at the location of your choosing or request the name based APS and CAN checks.
5. At the end of the process, ***print the Confirmation Page. Take the Confirmation Page with you to your Fingerprint appointment, along with two (2) forms of identification. At least one form of ID must be a valid, government issued photo ID, such as a driver's license.***
6. You **HAVE** to use Aloha Hab's Code in order to complete the screening. Aloha Hab **CANNOT** accept results from another agency.

Fieldprint has representatives available at 1-877-614-4364 to answer your questions Monday through Friday, 8 AM to 8 PM Eastern Time. After the backgrounds have been processed, applicants will receive an email notification when the results are ready to be viewed on www.fieldprinthawaii.com or http://www.fieldprinthawaii.com.