



APPLICATION FOR EMPLOYMENT

ALL POTENTIAL EMPLOYEES ARE EVALUATED WITHOUT REGARD TO RACE, COLOR, RELIGION, GENDER IDENTITY, NATIONAL ORIGIN, AGE, MARITAL OR VETERAN STATUS, THE PRESENCE OF A NON-JOB RELATED DISABILITY OR ANY OTHER LEGALLY PROTECTED STATUS.

| GENERAL INFORMATION | | | |
|------------------------------------|--------|-----|------|
| Name: | | | |
| Street Address: | City: | ST: | Zip: |
| Email: | Phone: | | |
| Position/Job you are applying for: | Date: | | |

On what date would you be available for work?

Desired Wage/Salary:

Are you a U.S. citizen, or are you otherwise authorized to work in the U.S. without any restriction? Yes No

Have you ever been involuntarily terminated or asked to resign from any position of employment? Yes No

If yes, please describe circumstances: _____

If selected for employment, are you willing to submit to a pre-employment drug screening test? Yes No

| EDUCATION | | | | |
|-------------|----------|----------------|-----------------|----------|
| School Name | Location | Years Attended | Degree Received | Major(s) |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| OTHER TRAINING, LICENSURE, CERTIFICATION | | | |
|--|---------------------|-----------------|--|
| Name/Number | Issuing Board/State | Expiration Date | Was license ever revoked? (if yes, explain why) |
| | | | |
| | | | |
| | | | |
| | | | |

EMPLOYMENT HISTORY *(Within the past five years, most recent first.)*

1.

| | | | |
|---------------------------|--|--|--------------|
| Employer | | Job Title | |
| Dates Employed | | Prior Position Held within Company (if any) | |
| Address | | City/ST/Zip | |
| Supervisor | | Job Title | Phone |
| Duties Performed | | | |
| Reason for Leaving | | | |

2.

| | | | |
|---------------------------|--|--|--------------|
| Employer | | Job Title | |
| Dates Employed | | Prior Position Held within Company (if any) | |
| Address | | City/ST/Zip | |
| Supervisor | | Job Title | Phone |
| Duties Performed | | | |
| Reason for Leaving | | | |

3.

| | | | |
|---------------------------|--|--|--------------|
| Employer | | Job Title | |
| Dates Employed | | Prior Position Held within Company (if any) | |
| Address | | City/ST/Zip | |
| Supervisor | | Job Title | Phone |
| Duties Performed | | | |
| Reason for Leaving | | | |

4.

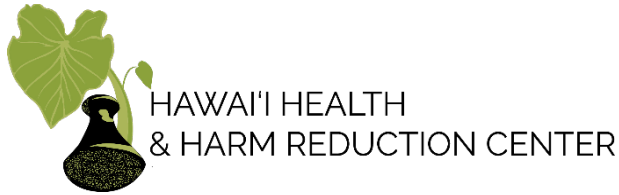
| | | | |
|---------------------------|--|--|--------------|
| Employer | | Job Title | |
| Dates Employed | | Prior Position Held within Company (if any) | |
| Address | | City/ST/Zip | |
| Supervisor | | Job Title | Phone |
| Duties Performed | | | |
| Reason for Leaving | | | |

5.

| | | | |
|---------------------------|--|--|--------------|
| Employer | | Job Title | |
| Dates Employed | | Prior Position Held within Company (if any) | |
| Address | | City/ST/Zip | |
| Supervisor | | Job Title | Phone |
| Duties Performed | | | |
| Reason for Leaving | | | |

PROFESSIONAL REFERENCES (not relatives)

| | | | |
|----------------|--|--------------------|--|
| Name: | | Occupation: | |
| E-mail: | | Phone: | |
| Name: | | Occupation: | |
| E-mail: | | Phone: | |
| Name: | | Occupation: | |
| E-mail: | | Phone: | |



ACKNOWLEDGMENT AND AUTHORIZATION

I certify that answers given herein are true and complete to the best of my knowledge.

I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision.

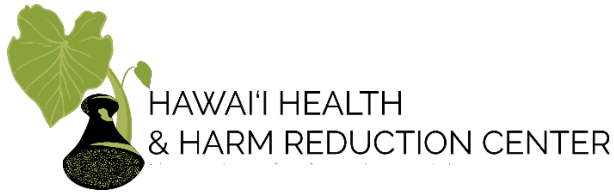
I hereby understand and acknowledge that, unless otherwise defined by applicable law, any employment relationship with this organization is of an "at will" nature, which means that the Employee may resign at any time and the Employer may discharge Employee at any time with or without cause. It is further understood that this "at will" employment relationship may not be changed by any written document or by conduct unless such change is specifically acknowledged in writing by an authorized executive of this organization.

In the event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge. I understand, also, that I am required to abide by all rules and regulations of the Hawai'i Health & Harm Reduction Center.

Signature of Applicant

Date

*Attachment-Employee Attestation (Application cannot be processed without signed attestation)



677 Ala Moana Blvd. Suite #226 Honolulu, HI 96813

Ph. (808) 521-2437

AUTHORIZATION TO RELEASE INFORMATION

REGARDING:

| | |
|--|--|
| Applicant's name: | |
| Applicant's current address: | |
| Applicant's date of birth: | |
| Applicant's social security number: | |
| Applicant's driver's license number: | |
| Driver's license issuing state & expiration date: | |

I, the undersigned, authorized and consent to any person, firm, organization, or corporation provided a copy (including photocopy or facsimile copy) of this **Authorization to Release Information** by the Hawaii Health & Harm Reduction Center to release and disclose to the Hawaii Health & Harm Reduction Center any and all information or records requested regarding me, including, but not necessarily limited to, my employment records, education, volunteer experience, motor vehicle records, military records, criminal information records (if any), and background. I have authorized this information to be released, either in writing or via telephone, in connection with my application for employment at the Hawaii Health & Harm Reduction Center.

Any person, firm, organization, or corporation providing information or records in accordance with this authorization is released from any and all claims or liability for compliance. Such information will be held in confidence in accordance Hawaii Health & Harm Reduction Center guidelines.

Signature of Prospective Employee

Date

CERTIFICATION & ATTESTATION

Suspension, Debarment, Revocation & Drug Free Workplace Requirements Employees and Independent Service Contractors



- A. I certify that I have not been debarred, suspended, or otherwise excluded from participation in any state or federally funded programs. I understand that debarment, suspension, or exclusion from participating in state or federally funded programs will result in immediate termination of employment, employment contracts or independent contracts without penalty to or claim of damages against the Hawai'i Health & Harm Reduction Center or the State of Hawaii, Adult Mental Health Division.
- B. If employed, or contracted for services, I agree to conform to the guidelines and policies of the Hawai'i Health & Harm Reduction Center and the State of Hawaii, Adult Mental Health Division. I understand that my employment and/or contract is at-will and can be terminated at any time with or without advance notice or cause.
- C. I understand and agree that the Hawai'i Health & Harm Reduction Center may make a full and complete investigation of my personal, employment history and credentialing verification (with primary sources) and authorize any former employer, persons, firms, corporation, school, government agency, licensing boards, criminal background agencies, or other entities to provide the company with any other information (including fact or opinion) they may have regarding me. In consideration of the company's review of my potential employment and/or contracting status. I release the Hawai'i Health & Harm Reduction Center and all providers of any information from any liability which may arise as a result of furnishing any receiving this information, with the exception of any liability arising from a violation of the Fair Credit Reporting Act ("FCRA"). I understand and agree that if offered employment or a contract by the Hawai'i Health & Harm Reduction Center, any such employment or contract offer shall be dependent upon the receipt of satisfactory references, licensure, and background checks as determined by the company. If employed or contracted I further authorize the company to provide truthful information (including fact or opinion) regarding my employment/contract to any potential or future employer and release and waive any claims against the Hawai'i Health & Harm Reduction Center or the State of Hawaii, AMHD for truthfully communicating any such information to a potential or future employer or contractor.
- D. I understand and agree that I may be required to submit to drug testing and a complete post-offer medical examination as part of my employment or contract. I also understand and agree that I may be required to submit to a complete medical examination during my employment/contract with the company, provided that such examination is job-related and consistent with business necessity. The cost of such examinations will be paid by the Hawai'i Health & Harm Reduction Center. I authorize the physician conducting the examination and any laboratory testing and any specimen obtained by the physician or collection site to disclose the results of the examination and laboratory tests to the Hawai'i Health & Harm Reduction Center in accordance with state and/or federal laws. The Hawai'i Health & Harm Reduction Center will keep such results confidential and disclose the results only to persons who need to know or where required by Law. Also I agree to fully cooperate and provide the company with any additional consent(s) and/or release(s) as required by the Hawai'i Health & Harm Reduction Center to investigate my employment/contract application.
- E. I also agree to obtain a TB test prior to having direct contact with the Hawai'i Health & Harm Reduction Center consumers.
- F. The Hawai'i Health & Harm Reduction Center may inquire into and consider any criminal conviction record that you may have. The company may withdraw employment offers and contract agreements if you have a criminal conviction record which bears a rational relationship to the duties and responsibilities of the position/contract for which you are carrying out for the company.
- G. I understand and will conform to the Hawai'i Health & Harm Reduction Center and State of Hawaii's Drug Free Workplace Act.
- H. I understand and will report throughout the course of my contract or employment with the Hawai'i Health & Harm Reduction Center any restrictions, suspensions, debarment of my licensure and my ability to participate with state and federal Medicaid and Medicare programs. I further agree and will report any disciplinary action taken against me by any licensing agency or boards.

Signature of Employee/Independent Contractor

Date