H.I.H.T.S
Hawai'i Institute of Healthcare
& Training Services

1059 Kilauea Ave., Ste B, Hilo HI 96720

PH: 808-933-1295 Fax: 808-961-2507
Email: education@hihts.org website: www.hihts.org

APPLICATION FOR NURSE ASSISTANT TRAINING PROGRAM

Name: _____ SS# : _____
Address: _____ Ph: (Res)_____
_____ (C)_____ (W) _____
Birthday:_____
Email (please print)_____
Are you 18 years or older? [ ] Yes [ ] No
What languages do you speak?
_____
U.S. Citizen? [ ]Yes [ ]No Alien/Green Card? [ ] Yes [ ] No Alien Card #:_____
How did you hear about Hawaii Institute of Healthcare and Training Services? _____
Have you ever been convicted of a crime or had traffic violation(s) by any court? [ ] Yes [ ] No
(If Yes, please explain nature of the incident and current status) _____
_____
If applicable, will you be able to provide letters from your probation officer? _____
If applicable, will you be able to provide at least three (3) letters of recommendation? _____
Emergency Contact Person: _____ Phone: _____
Address: _____

Course Code	Cost	Course Title	Date(s)	Time

Company/Agency Name: _____ Contact Person: _____
Address: _____ Email: _____
Phone: _____ Fax: _____
Covered Cost _____

FOR OFFICE USE ONLY

Registration No.: _____ Acct. No. _____ Initial: _____

NON-REFUNDABLE PRE –REGISTRATION FEE: $250.00

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STUDENT AGREEMENT

I, _____(student name), agree to release and hold harmless Hawaii Institute and Healthcare & Training Services, its staff and clients, who provides my training and clinical practice from any accidents or misconduct that arises during the period of my training.

I certify that all statements made here on this application are true to my knowledge and agree to pay all tuition costs.

_____ _____
Student's Name (printed) Date

_____ _____
Student Signature Date

I give consent to use any video, photography, digital images, testimonials on HIHTS website, all social media (i.e. Instagram, Facebook, twitter) to promote any and all classes. (If signature is not provided, consent is not given).

_____ _____ _____
Student's signature Printed name Date

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PHYSICAL EXAMINATION FORM

Name: _____ Social Security No.: _____
Address: _____ Ph (Res): _____
_____ Mobile#: _____
_____ Work: _____
Date of Birth: _____ [ ] Male [ ] Female

PERSONAL HISTORY (Please Check Appropriate Boxes)

1. Have you had any of the following?

Measles	[ ] Yes	[ ] No
German Measles	[ ] Yes	[ ] No
Mumps	[ ] Yes	[ ] No
Chicken Pox	[ ] Yes	[ ] No
Malaria	[ ] Yes	[ ] No
Tuberculosis	[ ] Yes	[ ] No

2. Are you allergic to the following?

Aspirin	[ ] Yes	[ ] No
Penicillin	[ ] Yes	[ ] No
Sulfa	[ ] Yes	[ ] No

Others: _____ (Please Specify)

3. Have you had surgery? [ ] Yes [ ] No
If YES, kindly specify: _____

MEDICAL BACKGROUND

1. Have you received treatment or counseling for alcohol, drug related or emotional problems? ____
If YES, kindly specify: _____
2. Has your physical activity been restricted during the past five (5) years? [ ] Yes [ ] No
3. Do you have a history of any severe or chronic condition(s)? [ ] Yes [ ] No
If YES, kindly specify: _____
4. Do you have any type of handicap which limits function? _____
5. Are you able to lift fifty (50) lbs.? [ ] Yes [ ] No

RESULT OF P.P.D.

1ST Step Date _____ Results: _____
2nd Step Date _____ Results: _____

In case of emergency, please notify: _____ Phone: _____
Address: _____
Attending Physician: _____ Date: _____

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PHYSICAL EXAMINATION VERIFICATION

(Physician to fill out)

I have examined _____, and have found him/her not to have any communicable disease or any health condition. He/she is physically and emotionally fit for the Nurse Assistant course and/or employment.

_____
Physician's Name (Print)

_____
Physician's Signature

_____
Date

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CONFIDENTIAL REQUEST FOR STATE FEDERAL CRIMINAL HISTORY RECORD CHECKS

Criminal history records checks for federal and state convictions are periodically conducted as a requirement of all persons providing services to and/or receiving clinical/instruction from any and all clinical facilities. Information requested here is needed to make determinations as to whether any conviction has a bearing on your fitness to provide services or eligibility to receive clinical instruction. Convictions, other than those noted on the application will not automatically disqualify you, however, a suitability investigation may be conducted depending on when the conviction occurred and the type of conviction.

As a general rule, individuals with a conviction that bears a relationship to the position and/or service area that falls within the past 10 years (excluding periods of incarceration), may render you unsuitable. Also, certain convictions such as an assault on a patient are automatic grounds for disqualification. During this suitability investigation period, you may not at the discretion of the training facility be allowed to perform clinical instruction until the investigation is completed.

PART 1 FULL DISCLOSURE

Have you ever been convicted of a violation of law? Yes [ ] No [ ]

Note: In answering this question, you must report all convictions. DO NOT report the following:

1. Arrests not followed by convictions
2. Convictions which were annulled or expunged
3. Offenses for which you were tried as a minor

If you answer YES to the question above, use this space to provide the dates, nature and circumstances of the conviction, the sentence imposed and its current status and any other relevant information you wish to provide.

PART II PERSONAL DATA

FULL NAME _____

(please include any alias(es), Former names, maiden name

Address: _____City_____Zip_____

SS#: _____ Date of Birth _____

Place of Birth _____ Gender: FEMALE [ ] MALE [ ]

ACKNOWLEDGE OF RELEASE:

I certify that information provided in PARTS I AND II of this form is true and correct. I understand that providing my social security number is voluntary and to be used for clinical instruction purposes. I also consent to criminal history record checks, which may include fingerprinting. I understand that any consideration for clinical instruction is contingent and/or omission of my conviction information in PART I of this form, I acknowledge that such action would deem me unsuitable for clinical instruction at the clinical facility.

_____ _____

Student Signature Date

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DRUG SCREENING AUTHORIZATION FORM

I UNDERSTAND THAT CLINICAL FACILITY THROUGH HAWAII INSTITUTE OF HEALTHCARE AND TRAINING SERVICES (HIHTS) HAS A POLICY THAT ANY PERSON WANTING TO BE CONSIDERED FOR CLINICAL INSTRUCTION WILL BE TESTED FOR THE PRESENCE OF DRUGS.

1. I agree to present myself at the appointed time at the designated testing laboratory and identify myself with valid picture identification (i.e., Hawaii Driver's License, State Identification Card, Passport or Military Identification Card.)
2. I authorize the testing laboratory to take from me the required specimen for testing.
3. I understand that the specimen will be tested to determine the presence of drugs, using a chain of custody procedure to ensure the integrity of the specimen and its identification.
4. I understand that my specimen will be tested for the following drugs: Amphetamines, Marijuana, PCP, Cocaine, Barbiturates, Methadone, Phencyclidine, and Opiates.
5. I understand that over-the-counter- medications or prescribed drugs may result in positive test results.
6. I understand that a copy of the results of this testing will be forwarded to the Training program and the clinical facility for review. Clinical Facility may rescind Clinical instructions if the results indicate the presence of any illegal, dangerous, or unauthorized drugs in my system.
7. I understand that if I do not agree with the results of the drug test, I may request a re-test (using the same sample) by contacting the Medical Review Officer (MRO) within three (3) working days of being notified of the test results.
8. I understand that if I am accepted for clinical instruction, I will abide by the Drug Free Workplace Policy.

I agree to release Hawaii Institute of Healthcare & Training Services (HIHTS) and its affiliates, from any and all liability or responsibility related to the administration of testing, testing procedures, or any act or missions arising there from or related thereto.

_____ _____

Signature Date

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STUDENT NAME: _____

ADMISSION REQUIREMENTS:

- Eighteen (18) years of age or older
- High school graduate or G E D
- Valid picture ID
- No criminal record of any kind
- TB Clearance, 2 steps or CXR
- Flu shot (if flu season)
- Physical check up
- Application forms (completed)
- Enrollment Agreement
- CPR Certificate
- First Aid Certificate
- Pre-registration fee (non-refundable, this saves your seat)

IMMUNIZATIONS or HEALTH RECORDS **(**obtained throughout the course dates):

COVID-19 vaccine

TDP (tetanus/diphtheria/pertussis)-within past 10 years

Hepatitis B series (3shots)

Measles

Mumps

Rubella

Varicella (chickenpox) Doctor's note of verification is fine.

Alternate-Antibody test (MMR/Varicella) If records are lost, have physician administrator a TITERS test

OTHER REQUIREMENTS:

1. Scrub Uniform (any color for class), for clinical rotation, must wear red top and black pants.

2. White Shoes only

3. Notebook/Pen/Pencil

4. Must be able to read and write.

5. Must wear a facial mask at all times.

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REQUIREMENTS NEEDED – Prior to Clinicals

- Criminal History and Record check (may be fingerprinted)
- Drug Testing
- Other forms related to " Clinicals" may apply
- **Tuition Balance needs to be paid in full before ORIENTATION**

Schedule for Charges:

$250.00 Non-Refundable Pre-Registration first day of class

$500.00 1st throughout the course

$500.00 2nd throughout the course

$305.00 3rd throughout the course

Total cost $1,555.00

Failure to pay may result in cancellation of registration or suspension of class. Only cash, cashier's checks are accepted. Checks payable to Hawaii Institute of Healthcare & Training Services.

Signature: _____ Date: _____

By signing the statement, I acknowledge that I have been given the opportunity to read and ask questions about the requirements, policies and regulations set forth. Further, by signing this statement, I agree to abide by all the provisions contained in this application and understand that further explanation of requirements and policies can be obtained on this application.

I also understand that I won't be able to join the clinical rotation if:

1. All my requirements are not met (ie. as listed above)
2. My written exams do not meet the criteria (grade below 80%).
3. My skills are not satisfactory to perform in the facility
4. I have too many absences not meeting the required hours in class.

Student Signature: _____ Printed Name: _____

Date: _____

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