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: hihts.org

APPLICATION FORM PHLEBOTOMY PROGRAM

Name: _____ Social Security Number:_____-____-_____

Address: _____ Birthday_____

City_____ State_____ Zip_____

Phone: _____Cell_____ Work) _____

Email Address (please print:)_____

18 years old or older? Yes ▢ No ▢

US Citizen? Yes ▢ No ▢ Green Card? Yes ▢ No ▢

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 on space provided below:

_____

_____

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: _____

How did you hear about Hawaii Institute Healthcare & Training Services _____

♦♦

Agency Sponsored? Yes ▢ No ▢ Name of Agency _____

Contact Person _____ Phone Number _____

Tuition Fee: $1,300.00 w/Externship **Tuition Fee: $1,000.00 w/o Externship**

NON REFUNDABLE REGISTRATION: $250.00

Optional:

Review Class for the national exams: $100.00

NHA Certification Exam and study guide: $195.00

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STUDENT AGREEMENT

I agree to release and hold harmless Hawaii Institute Healthcare & Training Services, its staff and clients who provide 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 the best of my knowledge and agree to pay all tuition costs.

Student's Name (Printed) Signature

Date

FOR STUDENTS WITH EXTERNSHIP

I understand that externship requirements should be submitted to H I H T S one month before externship begins and due to the facility's limited schedule for externship, rescheduling is strictly not allowed. Externship time cannot be refunded for "no show" on the designated dates. The only excused absences will be:

a).Providing a doctor's note when sick
b).Death in family

Student Name (printed) Signature

CONSENT FOR VIDEO OR PHOTOGRAPHY:
I give consent to use any video, photography, digital images and testimonials and all social media (eg. Facebook, instagram, etc) on HIHTS website to promote any and all classes. (If signature is not provided, consent is not given)

Student's signature over printed name Date

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PHYSICAL EXAMINATION FORM

Name: _____ SS#: _____ - ____ - _____

Address: _____ Res Ph#: _____ Cell _____

City _____ State_____ Zip_____ DOB: _____

Email (please print:)_____ _____

Any serious illness? Yes ▢ No ▢

If YES, please explain _____

Any Surgery or Injury? Yes ▢ No ▢

If YES, please explain _____

Have you received treatment or counseling for alcohol, drug related or emotional problems? Yes • No •
If YES, please specify _____

Do you have any type of handicap which limits function? _____

Are you able to lift fifty pounds? Yes ▢ No ▢

Results of PPD

1st Step Date Taken: _____ Date Read: _____
Results: _____ Results: _____

2nd Step Date Taken: _____ Date Read: _____
Results: _____ Results: _____

Chest X-Ray if Positive PPD

Date: _____ Results: _____

Attending Physician: _____ Date: _____

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PHYSICAL EXAMINATION VERIFICATION
(To be completed by Physician)

Significant Medical History pertinent to the student's ability to participate in the Phlebotomy Technician Course:

_____

Are there medications which may affect the student's mental or physical performance?

_____

Current complaints affecting the student's ability in the Phlebotomy Technician Course?

_____

I have examined _____, and have found him/her not to have any communicable disease or any health condition that is hazardous to him/herself, patients, visitors or anybody.

He/she is physically and emotionally fit for the Phlebotomy Technician Course and/or employment.

_____
Physician's Name (Print)

_____ _____

Physician's Signature Date

I, _____, (student name) give permission to release this health information to

Hawaii Institute Healthcare & Training Services.

_____ _____
Student Signature

_____
Date

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REQUEST FOR STATE AND FEDERAL CRIMINAL HISTORY RECORD CHECKS

Criminal history records checks for federal and state convictions are periodically conducted as a required of all persons providing services to and/or receiving clinical/instruction from Kaiser Permanente. 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 at KP. 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_____

Social Security No: _____ 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 (*For externship students only*)

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, Benzodiazepines, Barbiturates, Methadone, and Propoxyphene.

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, Kaiser Permanente, from any and all liability or responsibility related to the administration of testing, testing procedures, or any act or missions arising therefrom or related thereto.

_____ _____
SIGNATURE DATE

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ADMISSION REQUIREMENTS (class only)

- Eighteen (18) years of age or older
- Valid Picture ID
- High school graduate or G E D
- Physical Examination Form
- TB clearance, 2 steps or CXR
- Application forms (completed)
- Enrollment Agreement
- Pre-registration fee (non-refundable)
- Covid Vaccination

IF DOING EXTERNSHIP: **Immunizations or health records: (obtained throughout the course)**

- TDP (tetanus/diphtheria/pertussis) – within past 10 years
- TB clearance, 2 steps or CXR
- Covid Vaccine 1 & 2
- Hepatitis B series (3 shots, only 1 shot required for class)
- Measles
- Mumps
- Rubella
- Varicella (chickenpox)
- Boosters/Titers accepted
- CPR / FIRST AID Certificate

OTHER REQUIREMENTS:

1. Scrub uniform
2. White Shoes
3. Notebook/Pen/Pencil
4. Facial Mask at all times

REQUIREMENTS NEEDED - prior to Externship

- Criminal History and Record Check (may include fingerprinting) /Drug Testing – by facility
- Requirements need to be turned in one month prior to externship dates.

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

_____ _____ _____

Signature Print Date

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TUITION/Payment Option Plans:

SCHEDULE OF CHARGES OF CLASS ONLY
$250.00 Non-Refundable Pre-Registration
$400.00 1st Week of Class
$350.92 2nd Week of Class
Total cost: $1,000.00

SCHEDULE OF CHARGES OF CLASS W/EXTERNSHIP):
$250.00 Non-Refundable Pre-Registration
$550.00 1st Week of Class
$500.00 2nd Week of Class
Total cost: $1,300.00

Schedule of charges for Class WITH REVIEW AND NATIONAL EXAM
$250.00 Non refundable Pre-Registration
$400.00 (First week of the course)
$350.00 (2nd week of the course)
$100.00 (Review Classes to be paid before finals)
$195.00 National exam and study guide (to be paid before finals)
Total Cost: $1,295.00

Schedule of Charges for Class/w EXTERNSHIP/REVIEW/NATIONAL EXAM
$250.00 Non refundable Pre-Registration
$550.00 First week of the course
$500.00 2nd week of the course
$100.00 (Review classes to be paid before finals)
$195.00 to be paid prior to test date
TOTAL: $1,595.00

TUITION DISCLAIMER:
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 Healthcare & Training Services (HIHTS.)**

Signature of Student: _____ **Date:** _____