REHABILITATION HOSPITAL OF THE PACIFIC
Rebuilding Lives Together

226 North Kuakini Street, Honolulu, Hawaii 96817
EMAIL: HR@REHABHOSPITAL.ORG | PH: (808) 566-3878
www.rehabhospital.org

APPLICATION FOR EMPLOYMENT

All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity and expression, national origin, disability, protected veteran status or any other characteristic protected by state and federal law.

POSITION DESIRED: _____ DATE AVAILABLE: _____ MINIMUM SALARY ACCEPTABLE:_____

FIRST NAME:_____ LAST NAME:_____ MIDDLE INITIAL: _____

PHONE: (_____)_____ MESSAGE/CELL PHONE:(_____)_____ EMAIL ADDRESS: _____

MAILING ADDRESS: _____
STREET CITY STATE ZIP CODE

HOME ADDRESS: _____
STREET CITY STATE ZIP CODE

HAVE YOU EVER BEEN EMPLOYED BY REHABILITATION HOSPITAL OF THE PACIFIC? ☐ YES ☐ NO

- IF YES, STATE JOB TITLE(S) AND DATE(S): _____

HAVE YOU EVER APPLIED FOR A POSITION AT REHABILITATION HOSPITAL OF THE PACIFIC WITHIN THE PAST YEAR? ☐ YES ☐ NO

- IF SO, PLEASE STATE THE JOB POSITION(S) YOU APPLIED FOR AND THE DATE(S): _____

DO YOU KNOW ANYONE EMPLOYED BY REHABILITATION HOSPITAL OF THE PACIFIC? ☐ YES ☐ NO

- IF YES, LIST NAME(S) AND RELATIONSHIP(S): _____

WERE YOU REFERRED BY A REHAB EMPLOYEE? ☐ YES ☐ NO IF YES, BY WHOM: _____

HAVE YOU EVER BEEN DISCIPLINED OR DISCHARGED BY AN EMPLOYER? ☐ YES ☐ NO

- IF SO, FOR WHAT REASON? _____

EDUCATIONAL RECORD

	SCHOOL NAME AND LOCATION	NUMBER OF YEARS ATTENDED	COURSE OR MAJOR	DEGREE OR DIPLOMA
HIGH SCHOOL				
COLLEGE				
GRADUATE SCHOOL				
TECHNICAL OR BUSINESS SCHOOL				

CLERICAL/COMPUTER SKILLS

CHECK ALL THAT APPLY:

☐ TYPING _____ WPM
☐ SHORTHAND
☐ 10-KEY
☐ DATA ENTRY
☐ COMPUTER
☐ REPORT WRITER
☐ MS WORD/GOOGLE DOCS
☐ MS EXCEL/GOOGLE SHEETS
☐ POWERPOINT/GOOGLE SLIDES
☐ OTHERS:

EMPLOYMENT DESIRED

SHIFT:
☐ DAY
☐ EVENING
☐ NIGHT

STATUS:
☐ FULL TIME
☐ PART TIME*
☐ CALL IN*

PREFERENCE:
☐ INPATIENT
☐ OUTPATIENT

*SPECIFY TOTAL HOURS/WEEK AVAILABLE TO WORK: _____

AND WHEN (DAYS AND TIMES): _____

SITE: _____

PROFESSIONAL CERTIFICATION OR LICENSE

STATE: NUMBER:

_____

_____

_____

EMPLOYMENT / INTERNSHIP / VOLUNTEER RECORD

Starting with present or most recent, list all previous employers. Include self-employment, military service, summer and part-time jobs. Attach additional sheets if necessary, following the same format.

1.	EMPLOYER	DATES EMPLOYED FROM	JOB DUTIES
	ADDRESS		
	JOB TITLE		
	SUPERVISOR/JOB TITLE	TO	
	BUSINESS PHONE ALTERNATE PHONE		
	SUPERVISOR'S EMAIL ADDRESS	HOURS WORKED/WEEK	MAY WE CONTACT THIS EMPLOYER FOR REFERENCE? ☐ YES ☐ NO IF NO, WHY:
	REASON FOR LEAVING		
2	EMPLOYER	DATES EMPLOYED FROM	JOB DUTIES
	ADDRESS		
	JOB TITLE		
	SUPERVISOR/JOB TITLE	TO	
	BUSINESS PHONE ALTERNATE PHONE		
	SUPERVISOR'S EMAIL ADDRESS	HOURS WORKED/WEEK	MAY WE CONTACT THIS EMPLOYER FOR REFERENCE? ☐ YES ☐ NO IF NO, WHY:
	REASON FOR LEAVING		
3	EMPLOYER	DATES EMPLOYED FROM	JOB DUTIES
	ADDRESS		
	JOB TITLE		
	SUPERVISOR/JOB TITLE	TO	
	BUSINESS PHONE ALTERNATE PHONE		
	SUPERVISOR'S EMAIL ADDRESS	HOURS WORKED/WEEK	MAY WE CONTACT THIS EMPLOYER FOR REFERENCE? ☐ YES ☐ NO IF NO, WHY:
	REASON FOR LEAVING		
4	EMPLOYER	DATES EMPLOYED FROM	JOB DUTIES
	ADDRESS		
	JOB TITLE		
	SUPERVISOR/JOB TITLE	TO	
	BUSINESS PHONE ALTERNATE PHONE		
	SUPERVISOR'S EMAIL ADDRESS	HOURS WORKED/WEEK	MAY WE CONTACT THIS EMPLOYER FOR REFERENCE? ☐ YES ☐ NO IF NO, WHY:
	REASON FOR LEAVING		

COMMENTS AND ACCOMPLISHMENTS

Summarize skills, qualifications, areas of specialization, or any other pertinent job-related information which may assist us in the evaluation of your qualifications for this position.

_____

_____

_____

_____

REFERENCES: List three references who are NOT related to you.

	Name	Email Address	Telephone	Position/Relationship
1.	_____	_____	(___) _____	_____
2.	_____	_____	(___) _____	_____
3.	_____	_____	(___) _____	_____

NOTICE TO APPLICANTS

In compliance with Federal and State Equal Opportunity Laws and the policy of REHAB, new employees are selected on the basis of qualifications without regard to race, color, religion, national origin, ancestry, sex (including pregnancy), sexual orientation, age, disability, protected veterans status, marital status, civil union status, credit history, genetic information, gender identity or expression, status as a domestic or sexual violence victim, arrest and court record or any other protected classifications (except where there are bona fide occupational qualifications, or where the court record has a rational relationship to the functions and responsibilities of the job).

It is also the policy of REHAB to hire only individuals who are authorized to work in this country.

CERTIFICATION (READ CAREFULLY BEFORE SIGNING)

I hereby certify that all statements on this application are true and complete to the best of my knowledge. I understand that any misrepresentation or omission of material fact is sufficient grounds for cancellation of this application or, if I am employed by REHAB, for immediate discharge from employment.

I authorize REHAB to contact and obtain information from all references, employers and educational institutions listed, and to investigate any of the above information for purposes of verification. If I receive a conditional offer of employment, I understand that the offer is subject to the results of a background check, including an inquiry into my criminal conviction record for the past ten years (excluding periods of incarceration to the extent permitted by law). I understand that the purpose of such inquiry is to determine whether I have a conviction record within the past ten years that bears a rational relationship to the duties and responsibilities of the position which I may be offered. I understand that if I do not sign the necessary consent forms to facilitate a background check, the employment offer will be withdrawn. I hereby hold REHAB and its representatives harmless and release them from any liability of any kind for any statements, acts or omissions in the course of or as a result from making such investigations and inquiries, and release all previous employers, schools or persons from any liability in responding to such inquiries in connection with my application.

I understand that if I am offered a position at REHAB, I must satisfactorily pass the entrance health evaluation, including a drug test, and will submit to subsequent periodic examinations and background checks; and, that I will be required to produce original documents establishing my identity and authorization to work in the United States and to complete the U.S. Immigration and Customs Enforcement's USCIS Form I-9 within three (3) business days from my first day of employment. I further understand that I may be requested to submit proof of age or any pertinent information.

If hired, I understand that I am not and cannot be guaranteed continued employment with REHAB. I understand that employment with REHAB is on an "at-will" basis, which means that it is for an indefinite period of time and can be terminated, either by REHAB or myself, at any time, with or without cause or notice, unless your position is subject to the collective bargaining agreement with a recognized union by REHAB.

I also give permission to REHAB to take and publish my picture, in any medium and for an unlimited period of time, if hired, without providing additional compensation or other benefit to me.

I HAVE READ AND FULLY UNDERSTAND THE FOREGOING AND SEEK EMPLOYMENT WITH REHAB.

TERMS OF ACCEPTANCE and SIGNATURE

I, the applicant for this Application for Employment, warrant the truthfulness of the information provided in this application. By typing my name into this electronic record, I acknowledge that I am providing my electronic signature and agree to conduct this transaction by electronic means within the meaning of the Hawaii Revised Statutes Chapter 489E.

ELECTRONIC SIGNATURE*

_____ _____

Please type your First and Last Name | Date

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

NOTICE OF POST-OFFER DRUG TESTING AND APPLICANT'S CONSENT FORM

I, _____, give my consent to be tested for drugs by Diagnostic Laboratory Svcs, Inc. and/or Quest Diagnostics.
(Print full name of employee/applicant)

I understand that such testing is required by REHABILITATION HOSPITAL OF THE PACIFIC ("REHAB") as part of its Drug-Free Workplace Policy, a copy of which I have received and read. REHAB is committed to providing a safe and healthy environment for all employees, patients and the public. It is also committed to eliminating the hazards in the workplace created by drug abuse and has adopted a Drug-Free Workplace policy. Accordingly, all job offers will be contingent upon a new hire passing a drug test prior to employment. REHAB will not hire anyone who has a positive test result.

I also understand and agree to the following:
1. If I receive a conditional offer of employment, I will be required to do a drug test, and must report to the designated collection site within twenty-four (24) hours of the offer. Because of administrative complexities, however, out-of-state hires may be given additional time to complete the drug test. Final employment can only be provided to those who successfully pass the pre-employment drug test. Refusal to consent to a drug test, as defined above, or a verified positive test result, will terminate any further action toward employment with REHAB.

2. I will be tested for the following drugs: amphetamines (including crystal methamphetamine), cocaine metabolite (benzoylecgonine), opiates, phencyclidine (PCP), and THC (marijuana).

3. Over-the-counter medication or prescribed drugs may result in a positive test result. Accordingly, I will notify the Medical Review Officer if I have taken any over-the-counter medication or prescribed drugs within the previous thirty (30) days.

4. Testing for drugs shall be performed by a laboratory licensed by the State of Hawaii Department of Health and pursuant to the rules set forth in Title 11, Chapter 113 of the Hawaii Administrative Rules.

5. If I refuse to be tested, fail to report within the required time, leave the designated collection site without providing a sufficient urine specimen, refuse to sign a release and authorization to submit to any drug screen test, refuse to sign the consent form to permit the Medical Review Officer to provide the results to REHAB, refuse or fail to submit to substance abuse testing in any way, dilute or tamper with a specimen in any way (including an invalid specimen), fail to provide a specimen for testing, refuse to cooperate with testing personnel, testing procedures or the Medical Review Officer, and/or fail the test, I will not be eligible for hire at REHAB.

6. I understand and agree that the test results will be reported to REHAB by the Medical Review Officer, including the identification of the controlled substance(s) for positive results. The test results will be treated as confidential information.

7. A finding by confirmatory testing of the presence of drugs in levels at or above the cutoff levels established by applicable Hawaii regulations or the State of Hawaii Director of Health will be communicated to REHAB's Medical Review Officer, who may, among other things, conduct a medical interview with me and/or order a reanalysis of the original specimen by a laboratory, if necessary.

8. The Medical Review Officer will verify a positive test result if the positive result is consistent with substance abuse. The Medical Review Officer shall also notify me and the Company of all verified positive test results. The Medical Review Officer shall designate as negative results all positive test results that cannot be verified.

9. Negative test results shall be communicated to REHAB's Designated Employer Representative who is the Director, Human Resources.

10. I authorize the testing facility to disclose to the Medical Review Officer and/or REHAB the results of any substance abuse test administered by the medical testing facility on behalf of REHAB during my application for employment. I understand that the purpose of the disclosure is to determine if I have violated REHAB's Drug-Free Workplace policy. I understand that I will need to sign additional authorizations for receipt, use and disclosure of test results for drugs by REHAB and/or the laboratory.

11. I understand that my records are protected under State and Federal regulations, including regulations governing Confidentiality of Alcohol and Drug Abuse Patient records, 42 CFR Part 2, and HRS §329B-6. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically upon my rejection for employment with REHAB.

TERMS OF ACCEPTANCE and SIGNATURE

I, the applicant, acknowledge that I have read and understand the terms of this Notice and by digitally signing below, hereby give my consent to be tested pursuant to the terms set forth herein. By typing my name into this electronic record, I acknowledge that I am providing my electronic signature and agree to conduct this transaction by electronic means within the meaning of the Hawaii Revised Statutes Chapter 489E.

ELECTRONIC SIGNATURE*

_____ _____

Please type your First and Last Name Date

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

CONFIDENTIAL VOLUNTARY QUESTIONNAIRE

As an equal opportunity employer and government contractor, we are obligated by Federal regulations to monitor our employment practices to ensure nondiscrimination, measure the effectiveness of our affirmative action program and produce required reports. To assist in this process, you are invited to
complete this questionnaire which will be greatly appreciated.

You are **NOT** required by law to provide the information requested. If you elect to provide the data, it will be detached from your application, be kept confidential, and used only in accordance with government regulations and Affirmative Action Policy. Refusal to provide this data will not adversely affect consideration for employment.

Race/Ethnic Group:

- ☐ Hispanic or Latino
- ☐ White (not Hispanic or Latino)
- ☐ Black or African American (not Hispanic or Latino)
- ☐ Asian (not Hispanic or Latino)
- ☐ Native Hawaiian or Other Pacific Islander (not Hispanic or Latino)
- ☐ American Indian or Alaskan Native (not Hispanic or Latino)
- ☐ Two or more races (not Hispanic or Latino)

Sex: ☐ Male ☐ Female

Position you are applying for: _____ Date: _____

How were you referred to REHAB?

- ☐ Newspaper Advertisement
- ☐ Job Search Websites (source: _____)
- ☐ Relative/Friend
- ☐ Walk-In
- ☐ Employment Agency
- ☐ REHAB Employee (name: _____)
- ☐ Other: _____)

TERMS OF ACCEPTANCE and SIGNATURE

I, the applicant, acknowledge that I have read and understand the terms of this Voluntary Questionnaire and by digitally signing below, warrant the truthfulness of the information provided in this application. By typing my name into this electronic record, I acknowledge that I am providing my electronic signature and agree to conduct this transaction by electronic means within the meaning of the Hawaii Revised Statutes Chapter 489E.

ELECTRONIC SIGNATURE*

_____ _____

Please type your First and Last Name Date

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

INVITATION TO SELF-IDENTIFY ("Pre-Offer" invitation as required by 41 CFR 60-300.42 (a))

This employer is a Government contractor subject to the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended by the Jobs for Veterans Act of 2002, 38 U.S.C. 4212 (VEVRAA), which requires Government contractors to take affirmative action to employ and advance in employment: (1) disabled veterans; (2) recently separated veterans; (3) active duty wartime or campaign badge veterans; and (4) Armed Forces service medal veterans. These classifications are defined as follows:

- A "disabled veteran" is one of the following: (a) a veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs; or (b) a person who was discharged or released from active duty because of a service-connected disability.
- A "recently separated veteran" means any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval, or air service.
- An "active duty wartime or campaign badge veteran" means a veteran who served on active duty in the U.S. military, ground, naval or air service during a war, or in a campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense.
- An "Armed forces service medal veteran" means a veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985.

Protected veterans may have additional rights under USERRA—the Uniformed Services Employment and Reemployment Rights Act. In particular, if you were absent from employment in order to perform service in the uniformed service, you may be entitled to be reemployed by your employer in the position you would have obtained with reasonable certainty if not for the absence due to service. For more information, call the U.S. Department of Labor's Veterans Employment and Training Service (VETS), toll-free, at 1-866-4-USA-DOL.

If you believe you belong to any of the categories of protected veterans listed above, please indicate by checking the appropriate box below. As a Government contractor subject to VEVRAA, we request this information in order to measure the effectiveness of the outreach and positive recruitment efforts we undertake pursuant to VEVRAA.

☐ I IDENTIFY AS ONE OR MORE OF THE CLASSIFICATIONS OF PROTECTED VETERAN LISTED ABOVE

☐ I AM NOT A PROTECTED VETERAN

TERMS OF ACCEPTANCE and SIGNATURE

I, the applicant, acknowledge that I have read and understand the terms of this Invitation to Self-Identify, and by digitally signing below, warrant the truthfulness of the information provided in this application. By typing my name into this electronic record, I acknowledge that I am providing my electronic signature and agree to conduct this transaction by electronic means within the meaning of the Hawaii Revised Statutes Chapter 489E

ELECTRONIC SIGNATURE*

Please type your First and Last Name _____ Date _____

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

VOLUNTARY SELF-IDENTIFICATION OF DISABILITY

Form CC-305 | OMB Control Number 1250-0005
Expires 1/31/2020

WHY ARE YOU BEING ASKED TO COMPLETE THIS FORM?

Because we do business with the government, we must reach out to, hire, and provide equal opportunity to qualified people with disabilities[1]. To help us measure how well we are doing, we are asking you to tell us if you have a disability or if you ever had a disability. Completing this form is voluntary, but we hope that you will choose to fill it out. If you are applying for a job, any answer you give will be kept private and will not be used against you in any way.

If you already work for us, your answer will not be used against you in any way. Because a person may become disabled at any time, we are required to ask all of our employees to update their information every five years. You may voluntarily self-identify as having a disability on this form without fear of any punishment because you did not identify as having a disability earlier.

HOW DO I KNOW IF I HAVE A DISABILITY?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition.

Disabilities include, but are not limited to:

- Autism
- Bipolar disorder
- Blindness
- Cancer
- Cerebral Palsy
- Deafness
- Diabetes
- Epilepsy
- HIV/AIDS
- Impairments requiring use of a wheelchair
- Intellectual disability (aka mental retardation)
- Major depression
- Missing limbs/partially missing limbs
- Multiple sclerosis (MS)
- Muscular Dystrophy
- Obsessive compulsive disorder
- Post-traumatic stress disorder (PTSD)
- Schizophrenia

Please check one of the boxes below:

- ☐ YES, I HAVE A DISABILITY (or previously had a disability)
- ☐ NO, I DO NOT HAVE A DISABILITY
- ☐ I DO NOT WISH TO ANSWER

TERMS OF ACCEPTANCE and SIGNATURE

I, the applicant, acknowledge that I have read and understand the terms of this Voluntary Self-Identification of Disability, and by digitally signing below, warrant the truthfulness of the information provided in this application. By typing my name into this electronic record, I acknowledge that I am providing my electronic signature and agree to conduct this transaction by electronic means within the meaning of the Hawaii Revised Statutes Chapter 489E.

ELECTRONIC SIGNATURE*

_____ _____

Please type your First and Last Name | Date

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

REASONABLE ACCOMMODATION NOTICE

Federal law requires employers to provide reasonable accommodation to qualified individuals with disabilities. Please tell us if you require a reasonable accommodation to apply for a job or to perform your job. Examples of reasonable accommodation include making a change to the application process or work procedures, providing documents in an alternate format, using a sign language interpreter, or using specialized equipment.

[1] Section 503 of the Rehabilitation Act of 1973, as amended. For more information about this form or the equal employment obligations of Federal contractors, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.