Hawaii Institute of Healthcare & Training Services (HIHTS)

Professional Training Program
1059 Kilauea Ave.
Hilo, Hawaii 96720
Tel.: (808) 933-1295 or (808) 933-1266 Fax: (808) 933-2722
Email: hihts@live.com Website: www.hihts.us

APPLICATION FOR NURSE AIDE TRAINING

Name: _____ Social Security No.: _____
Address: _____ Phone: (Residence): _____
_____ (Cell)_____ (Work)_____
Birthday_____
Email (please print)_____
Are you 18 years age 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: _____ Phone: _____
_____ Fax: _____
Covered Cost _____

FOR OFFICE USE ONLY

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

NON-REFUNDABLE PRE –REGISTRATION FEE: $250.00

TO REGISTER PLEASE CALL: 933-1295

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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 or photography on HIHTS website to promote any and all classes. (If signature is not provided, consent is not given)

_____ _____ _____
Student's signature Printed name Date

CONFIDENTIAL

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 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 maybe 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

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 testing laboratory designated and indentify 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 a 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

Hawaii Institute Healthcare & Training Services
Nurse Aide Training

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STUDENT NAME: _____

ADMISSION REQUIREMENTS:

- Eighteen (18) years of age or older
- High school graduate or G E D
- TB Clearance, 2 steps or CXR
- 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):
TDP (tetnus/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
2.White Shoes
3.Notebook/Pen/Pencil

REQUIREMENTS NEEDED – Prior to Clinicals

- Criminal History and Record check (may be fingerprinted)
- Drug Testing – by facility
- Other forms related to clinicals may apply
- **Tuition Balance needs to be paid in full before clinicals**

SCHEDULE OF CHARGES:
$250.00 Non-Refundable Pre-Registration first day of class
$500.00 1st throughout the course time
$500.00 2nd throughout the course time
Total cost $1,250.00

TUITION DISCLAIMER:
Failure to pay may result in cancellation of registration or suspension of class. Only cash ,checks, and credit Cards are accepted. Checks payable to: **Hawaii Institute of Health Care and Training Services (HIHTS)**

Signature of Student:_____ Date:_____