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# CARE Hawaii, Inc.

875 Waimanu St.

Honolulu, HI 96813

Telephone: (808) 533-3936

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## Application for Employees and Fee-for-Service Providers

*Due to the State of Hawaii standards we are unable to accept faxed or copied applications.*

To be considered for a position, whether as an employee or a fee-for-service- provider within our company, you must complete **all portions** of this application. If you fail to submit the additional required supporting documents with your application we will not process your application. In addition to completing this application you must submit a **DATED resume or curriculum vitae**. It must be specific regarding the time spent at each position.

**\*\*GAPS in employment must be explained in writing.**

Please let us know if you need assistance in the completion of this application. If more space is needed than provided on this original, please attach additional sheets and reference the questions being asked. If a question is not applicable to you please mark **N/A** in the space. Your application and accompanying material are confidential and becomes our property. **You must notify this office in writing of any changes to your name, address, telephone number, or availability.**

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**Please type or print legibly in ink.**

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

All other names used (for purposes of checking past work record/history):

\_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

E-mail: \_\_\_\_\_ Cellular phone: \_\_\_\_\_

Home phone: \_\_\_\_\_ Alternate phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Pager: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Are you legally authorized to work in the U.S.? (circle) Yes No

[Note: If offered employment, you will be required to submit the Immigration & Naturalization Form I-9 as required by the 1986 Immigration Reform and Control Act.]

Position for which you are applying for: \_\_\_\_\_

How were you referred to the company? \_\_\_\_\_

Do you have friends or relatives working for the Company? \_\_\_\_\_

## Education/Training

### **IMPORTANT:**

**To comply with State of Hawaii standards, you are required to submit original transcripts of all college work. All official transcripts must be sent directly from your school to **CARE Hawaii, Inc.** We need to review all courses completed.** You must also provide, on a separate sheet of paper, a chronological listing of all previous experiences including education and training experience including but not limited to private practice and teaching. Also, please provide a narration of any breaks in experience.

A. Name and location of last grade school attended: (elementary, intermediate, high school)					Highest grade level completed:
<b>B. In-Service Training, Business, Trade, College, Graduate, or Professional Schools</b>					
Name of School and Address (include Street, City, State, Zip Code, Telephone #)	Course of Major, Field of Study, or Type of training	Number of years attended	Did you graduate and/or receive a degree, diploma or certificate?	Kind of Diploma or Certificate Received	Date Transcript Requested for CARE Hawaii

**Practicum:**

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Hospital/Agency

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Mailing Address

City

State

Zip

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Specialty

Date of Completion (month/year)

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Dates of internship (From – To)

Telephone Number

- Did you successfully complete the program?  Yes  No (If no, give a brief narration)
- If you participated or were a part of any other practicum please note on a separate sheet of paper and attach.

**Internship:**

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Hospital

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Mailing Address

City

State

Zip

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Specialty

Date of Completion (month/year)

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Dates of internship (From – To)

Telephone Number

- Did you successfully complete the program?  Yes  No (If no, give a brief narration)
- If you participated or were a part of any other internship please note on a separate sheet of paper and attach.

**Professional Medical School Information (*For applicants who are medical doctors*):**

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School Attended

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Mailing Address

City

State

Zip

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Degree Received

Date of Graduation (month/year)

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Dates of attendance (From – To)

Telephone Number

**Foreign Medical Graduates: Attach a photocopy of your ECFMG Certificate**

**Residencies:**

1) \_\_\_\_\_  
Institution

\_\_\_\_\_  
Mailing Address City State Zip

\_\_\_\_\_  
Specialty Date of Completion (month/year)

\_\_\_\_\_  
Dates of residency (From – To) Telephone Number

- Did you successfully complete the program?  Yes  No (If no, give a brief narration)

2) \_\_\_\_\_  
Institution

\_\_\_\_\_  
Mailing Address City State Zip

\_\_\_\_\_  
Specialty Date of Completion (month/year)

\_\_\_\_\_  
Dates of residency (From – To) Telephone Number

- Did you successfully complete the program?  Yes  No (If no, give a brief narration)
- If you participated or were a part of any other residencies please note on a separate sheet of paper.

**Fellowship:**

\_\_\_\_\_  
Institution

\_\_\_\_\_  
Mailing Address City State Zip

\_\_\_\_\_  
Specialty Date of Completion (month/year)

\_\_\_\_\_  
Dates of fellowship (From – To) Telephone Number

- Did you successfully complete the fellowship program?  Yes  No (If no, give a brief narration)
- If you participated or were a part of any other fellowships please note on a separate sheet of paper.

**Specialty and Board Certification:**

Please list those specialty American Boards by where you were/are certified if any:

- 1) American Board of: \_\_\_\_\_  
Specialty: \_\_\_\_\_ Sub-Specialty: \_\_\_\_\_  
Certificate #: \_\_\_\_\_ Expiration Date, if any: \_\_\_\_\_  
Recertification date, if any: \_\_\_\_\_
  
- 2) American Board of: \_\_\_\_\_  
Specialty: \_\_\_\_\_ Sub-Specialty: \_\_\_\_\_  
Certificate #: \_\_\_\_\_ Expiration Date, if any: \_\_\_\_\_  
Recertification date, if any: \_\_\_\_\_

If you are certified with a board other than the American Board or if you are certified with more than two specialty boards, please note on a separate sheet of paper and attach.

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**Affiliations/Experience:**

List all present and previous hospital, agency, and clinical affiliations in chronological order:

1) Name of Organization	Dates (From – To)		
Mailing Address	City	State	Zip Code
2) Name of Organization	Dates (From – To)		
Mailing Address	City	State	Zip Code
3) Name of Organization	Dates (From – To)		



**Other Certification(s): (Please indicate the kind, registration number, and the State or other licensing authority.):**

Type of Certification	Issuing Authority	Certification Number (if any)	Dated Issued (Month/day/year)	Expiration Date

Special skills: (List any special skills or training)

**A. Have you attended any Felix Staff/Service Development Institute (FSSDI) Trainings, which are required for providers who want to provide assessment and Therapeutic Aide services? Yes\* \_\_\_\_ No \_\_\_\_**

**\*IMPORTANT: If you have attended any FSSDI trainings please submit a copy of FSSDI CERTIFICATE showing date you were certified.**

**C. Knowledge of Language Other Than English**

Language	Speak	Read	Write

**D. Are you CPR certified? Yes \_\_\_\_ No \_\_\_\_ (If yes, please submit your CPR certification card with your application.)**

**E. Are you certified in First Aid? Yes \_\_\_\_ No \_\_\_\_ (If yes, please submit your First Aid certification card with your application.)**

**F. Do you have a current driver's license? Yes \_\_\_\_ Type (e.g. 3): \_\_\_\_ NO (not #) \_\_\_\_ (If yes, it is required that you submit copy of current driver's license)**

**G. Do you have access to a vehicle that is covered by auto insurance? Yes \_\_\_\_ No \_\_\_\_ (If yes, it is required that you submit current auto documents (including auto insurance, safety check & registration.)**

**H. Please submit documentation of your TB clearance.**

## Employment History

Include all previous work experience: Full-time, part-time, and volunteer experience. Begin with your present or last job held. Describe in detail nature of work personally performed by you. Also, give dates and explain unemployed periods. Attach additional sheet if you need more space.

**To comply with State of Hawaii standards we are required to send out Confidential Reference Inquiry Forms to each employer listed. Complete addresses are needed in this section.)**

Employer:	Dates of Service To: From:
Address:	Average hours per week:
Telephone Number(s):	Starting hourly rate or monthly salary:
Name and title of your Supervisor:	Final hourly rate or monthly salary:
Your Title:	
Job duties:	
Reason for leaving:	

Employer:	Dates of Service To: From:
Address:	Average hours per week:
Telephone Number(s):	Starting hourly rate or monthly salary:
Name and title of your Supervisor:	Final hourly rate or monthly salary:
Your Title:	
Job duties:	
Reason for leaving:	



Employer:	Dates of Service To: From:
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Name and title of your Supervisor:	Final hourly rate or monthly salary:
Your Title:	
Job duties:	
Reason for leaving:	

Employer:	Dates of Service To: From:
Address:	Average hours per week:
Telephone Number(s):	Starting hourly rate or monthly salary:
Name and title of your Supervisor:	Final hourly rate or monthly salary:
Your Title:	
Job duties:	
Reason for leaving:	

Employer:	Dates of Service To: From:
Address:	Average hours per week:
Telephone Number(s):	Starting hourly rate or monthly salary:
Name and title of your Supervisor:	Final hourly rate or monthly salary:
Your Title:	
Job duties:	
Reason for leaving:	

## Professional and/or Personal References

**As part of our screening process, we may send out Professional and/or Personal Reference Inquiry Forms. Complete addresses are needed in this section.** Please provide three references, preferably from your specialty area (not including relatives, current partners, or associates in practice). References should be professionals who have significant personal experience and can attest to your job capabilities, ethical character, and ability to work with others.

1. Reference Name: \_\_\_\_\_  
Title: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street City State Zip Code

Telephone Number(s): \_\_\_\_\_

How does this person know of your professional abilities? \_\_\_\_\_

2. Reference Name: \_\_\_\_\_  
Title: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street City State Zip Code

Telephone Number(s): \_\_\_\_\_

How does this person know of your professional abilities? \_\_\_\_\_

3. Reference Name: \_\_\_\_\_  
Title: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street City State Zip Code

Telephone Number(s): \_\_\_\_\_

How does this person know of your professional abilities? \_\_\_\_\_

## Provider Directory

Our agency publishes Provider Directories at periodic intervals, which list your personal address, telephone and other information that you have provided. This directory may be used by our administration, other providers, care coordinators, etc. who may need to reach you. Please specify any information that you **DO NOT WISH** to have published:

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## Billing Information

Primary office address: \_\_\_\_\_

Office telephone: \_\_\_\_\_ Office fax number: \_\_\_\_\_

Office contact person: \_\_\_\_\_ Office Days & hours: \_\_\_\_\_

Do you have 7 day/week, 24-hour/day back-up and or on-call coverage? (circle) Yes No

Tax ID Name (To appear on check): \_\_\_\_\_

Address to send check (If other than mailing address): \_\_\_\_\_

General Excise Tax License Number (Please submit a copy for verification): \_\_\_\_\_

**Professional Liability Coverage Information:**

Please list the names and complete address of ALL current and past liability coverage carriers covering the entire period of your professional career. Attach additional sheets if necessary. Please include a photocopy of your current professional liability coverage, declaration page only.

1. Company \_\_\_\_\_ Policy # \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Coverage amount: Per claim Per aggregate Effective date Expiration Date

Please list any and all exclusions or limitations \_\_\_\_\_

2. Company \_\_\_\_\_ Policy # \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Coverage amount: Per claim Per aggregate Effective date Expiration Date

Please list any and all exclusions or limitations \_\_\_\_\_

3. Company \_\_\_\_\_ Policy # \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Coverage amount: Per claim Per aggregate Effective date Expiration Date

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Please list any and all exclusions or limitations

**Provider Organization Information:**

Please indicate all provider organizations of which you are a member and your corresponding provider numbers:

Name: \_\_\_\_\_ SS#: \_\_\_\_\_  
(Last Name) (First Name) (MI)

Aloha Care #: \_\_\_\_\_

Champus/Tricare #: \_\_\_\_\_

HMAA Provider #: \_\_\_\_\_

HMSA Provider #: \_\_\_\_\_

HMSA-QUEST#: \_\_\_\_\_

Medicaid #: \_\_\_\_\_

MEDICARE #: \_\_\_\_\_

UHA #: \_\_\_\_\_

VA #: \_\_\_\_\_

Other #: \_\_\_\_\_

Other #: \_\_\_\_\_

**CARE Hawaii, Inc.  
875 Waimanu St.  
Honolulu, Hawaii 96813  
Telephone: (808) 533-3936**

**AUTHORIZATION FOR RELEASE OF INFORMATION**

**All applicants must complete and sign this form as part of your application.**

I, \_\_\_\_\_, hereby authorize representatives of **CARE Hawaii, Inc., Adult Mental Health Division** (hereafter referred to as AMHD), **Department of Justice** (hereafter referred to as DOJ), **Medicaid Waiver Program** and/or **Crisis Network Services** (hereafter referred to as CNS) to consult with representatives of other hospitals, institutions, government agencies, previous employers, and other persons or entities (hereafter collectively referred to as “persons” or “entities”) to obtain and verify information concerning my professional qualifications, competence, moral character, ethical qualifications, and physical and mental condition and to conduct criminal background checks and Adult Abuse and Neglect checks.

I consent to release by any and all hospitals, institutions, government agencies, previous employers, and other persons or entities to **CARE Hawaii, Inc., AMHD, DOJ, Medicaid Waiver Program and/or CNS** all information and documents that may be relevant to an evaluation of my professional qualifications, competence, moral character, ethical qualifications and physical and mental condition.

I hereby release all representatives of **CARE Hawaii, Inc., AMHD, DOJ, Medicaid Waiver Program and/or CNS** and all such persons or entities from any and all liability for their acts performed in good faith and without malice in giving, obtaining, and verifying such information in connection with evaluating my applications, my credentials, and my qualifications.

I understand and agree that I, as an applicant, have the burden of producing adequate information to demonstrate to the satisfaction of **CARE Hawaii, Inc., AMHD, DOJ, Medicaid Waiver Program and/or CNS** my professional qualifications, clinical competence, moral character, ethical qualifications and physical and mental condition and for resolving doubts thereto. I further understand and agree that it is my responsibility to inform **CARE Hawaii, Inc.** of any changes in the information provided through the application during the application period or at any subsequent time.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Applicant: \_\_\_\_\_

**CARE Hawaii, Inc.**  
**875 Waimanu St.**  
**Honolulu, Hawaii 96813**  
**Telephone: (808) 533-3936**

**AFFIRMATION:**

I represent that information provided in or attached to this credentialing/employment application form is accurate. I understand that any false or misleading statements or omission regarding this application, whether intentional or not, whenever discovered are grounds for and is cause for automatic and immediate rejection of this application and may result in the denial of appointment and clinical privileges. Upon subsequent discovery of such misrepresentation, misstatement, or omission, **CARE Hawaii, Inc.** may immediately terminate my appointment.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Applicant: \_\_\_\_\_

**RELEASE AND IMMUNITY:**

I understand and agree that by applying for a position with **CARE Hawaii, Inc.**, regardless of whether I obtain the position:

1. I authorize the release of all information necessary for an evaluation of my qualifications for initial appointment and or privileges;
2. I authorize **CARE Hawaii, Inc.**, it's staff and their representatives to consult with any prior associate and others who may have information bearing on my professional competence, character, qualifications, including ethical, and ability to work well with others;
3. I agree to release from liability **CARE Hawaii, Inc.**, its staff, or anyone acting by and/or for it, who act without malice for any matter relating to this application for inclusion and referral, the evaluation of my qualifications or any matter related to appointment or clinical privileges; and
4. I release from liability **CARE Hawaii, Inc.** and its staff for all matters relating to appointment and clinical privileges or qualifications for the same, if such acts are made without malice.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Applicant: \_\_\_\_\_

**CARE Hawaii, Inc.**  
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**Honolulu, Hawaii 96813**  
**Telephone: (808) 533-3936**

**Disciplinary/Corrective Action Form**

**All applicants must complete and sign this form as part of your (fee-for-service or employment) application.**

Name \_\_\_\_\_ SSN# \_\_\_\_\_  
(Last) (First) (Middle Initial)

The information requested below is needed to determine your suitability for employment. Convictions, dismissals from employment or less than honorable discharges from military service will not necessarily bar employment or a fee-for-service relationship with CARE Hawaii, Inc. Factors such as date of the offense, seriousness, and nature of the violation and rehabilitation will be taken into consideration.

**1. Have any of the following actions ever been taken, or are in the process of being taken, which resulted or may result in: revocation, censure, written reprimand, restriction, non-renewal or denial of right or privilege, suspension, fine, reduction, limitation, placed on probation, required performance of public service, a course of education training, counseling or monitoring, resignation, leave of absence, withdrawal of an application, termination or non-renewal of a contract, or voluntary<sup>1</sup>/involuntary relinquishment or voluntary<sup>1</sup>/involuntary non-renewal?**

YES NO

- |                       |                       |   |
|-----------------------|-----------------------|---|
| <input type="radio"/> | <input type="radio"/> | License in any state  |
| <input type="radio"/> | <input type="radio"/> | Other professional registration/license/certification                         |
| <input type="radio"/> | <input type="radio"/> | State/Federal DEA registration, if applicable                                 |
| <input type="radio"/> | <input type="radio"/> | Academic appointment  |
| <input type="radio"/> | <input type="radio"/> | Membership or loss or limitation of clinical privileges at any hospital staff |
| <input type="radio"/> | <input type="radio"/> | Other institutional affiliation   |
| <input type="radio"/> | <input type="radio"/> | Professional society/membership   |
| <input type="radio"/> | <input type="radio"/> | Participation in any third party payor program                                |
| <input type="radio"/> | <input type="radio"/> | Other institutional affiliation or status                                     |
| <input type="radio"/> | <input type="radio"/> | Board certification   |
| <input type="radio"/> | <input type="radio"/> | Any other disciplinary actions  |

**A. Has your license to practice your profession in any jurisdiction ever been denied, limited, suspended, revoked, not renewed, or subject to probationary conditions, or have been fined or received a letter of reprimand – or is such action pending?**

\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Not Applicable  
(Month/year)

If Yes, please explain:

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**B.** Have you ever voluntarily relinquished privileges or a license anywhere at any time?  
**Voluntary relinquishment or voluntary non-renewal is a disciplinary action when the relinquishment is done to avoid an adverse action, preclude an investigation, or is done while the licensee is under investigation related to professional conduct.**

\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Not Applicable  
(Month/year)

If Yes, please explain:

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**2. Dismissals**

**A.** Have you been fired or asked to resign from employment?

\_\_\_\_ Yes \_\_\_\_\_ No  
(Month/year)

If Yes, please explain:

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**B.** Has your contract with any medical organization (i.e. hospital, health plan, health maintenance organization (HMO), professional association, medical school, or other health delivery entity or system) ever been suspended, terminated, or not renewed ---or is such action pending?

\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Not Applicable  
(Month/year)

If Yes, please explain:

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**3. Qualification standards**

**A. TB Clearance**

Are you able to submit documentation of your TB clearance with this application? This is a legal requirement. \_\_\_\_ Yes \_\_\_\_ No

If No, please explain:

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**B. Reasonable Accommodation**

Are you able to perform the procedures and essential functions of the position for which you have applied with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to clients?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If No, please explain:

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**C. Criminal Convictions**

Have you ever been convicted of a crime, pled guilty or “no contest” to a crime (within the past 10 years)? **Include ALL felony and misdemeanor convictions for traffic and/or criminal cases**

\_\_\_\_\_ Yes \_\_\_\_\_ No

If Yes, please explain:

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**D. Illegal Drug**

Do you presently or have you used any illegal drugs in the past two years?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If Yes, please explain:

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**4. Malpractice Information**

**A.** Have there been, or are there pending, any suits, malpractice claims, settlements or arbitration proceedings involving your professional practice?

\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Not Applicable  
(Month/year)

If Yes, please explain:

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**B.** Have you been denied professional liability insurance or has your coverage ever been cancelled?

\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Not Applicable  
(Month/year)

If Yes, please explain:

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**Please sign and date to acknowledge that all the information (Questions 1 – 4) that you have provided are true to the best of your knowledge.**

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Signature

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Date

# Employment/Fee-for-Service Application Agreement

## Please Read Carefully Before Signing:

1. I certify that all statements made on or in connection with this application including those regarding my education, training, and certification employment record and certification are true and correct to the best of my knowledge. I agree and understand that any material misstatements or omissions from this application constitute cause for denial of my application and/or termination of for participation with CARE HAWAII, INC. programs.
2. I hereby signify my willingness to appear for interviews in regard to my application if deemed necessary.
3. I acknowledge that I, as an applicant for participation in the Company (CARE Hawaii, Inc.), have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualification.
4. As an equal opportunity employer, this Company's policy in accordance with Federal and State Law, prohibits discrimination in employment or practices on the basis of based on race, color religion, sex, national origin, disability, age, marital status, military service, veteran status or any other characteristic protected by law.
5. If employed by or offered a contract for a position to participate as a fee-for-service provider with the Company (CARE Hawaii, Inc.), I agree to conform to the Bylaws, policies and procedures of the Company. I understand that if employed, my employment is at will and can be terminated at any time and for any reason with or without advance notice.
6. **I understand and agree that nothing in this credentials form/application is intended to imply or create an employment contract or a fee-for-service contract, or obligation or promise by the Company.**
7. **I understand and agree that only the Chief Executive Officer in conjunction with the approval of the Human Resources Manager of CARE Hawaii has any authority to enter into any agreement to employ me or contract my services for any specified period of time or to modify the at-will nature of my employment or terms and conditions of service contract. I acknowledge that any modifications to the terms and conditions of my employment or service contract must be in writing and signed by the Chief Executive Officer and I will not rely on anything else.**
8. I understand and agree that if offered employment or a fee-for-service contract by the Company (CARE Hawaii, Inc.), I will disclose criminal conviction information in accordance with the law, and that such employment or contract offer shall be dependent upon the receipt of a satisfactory conviction record as determined by the Company. The company may withdraw a conditional employment offer if you have a criminal conviction record which bears a rational relationship to the duties and responsibilities of the position which you are applying.
9. I understand and agree that if offered employment on a fee-for-service contract by the Company (CARE Hawaii, Inc.), I will disclose military service information in accordance with the law, and that such employment or fee-for-service contract offer shall be dependent upon the receipt of satisfactory military record.
10. I verify that I am appropriately qualified to perform all the procedures I currently perform in the practice of my profession.
11. I pledge to provide continuous care to my patients, and to refrain from delegating responsibility or care of my patients to any person not qualified to undertake that responsibility.
12. **I understand that this application is an ongoing process and I must notify CARE Hawaii offices of any changes to information provided.**
13. Arbitration Agreement: In consideration for the Company's (CARE Hawaii, Inc.) examination and investigation of my application and in order to promptly resolve any legal dispute I may have with the Company regarding my recruitment, hiring, employment or termination of employment or fee for services relationship and contract, I agree to submit any and all such claims to final and binding arbitration pursuant to the Federal Arbitration Act, 9 U.S.C. § 1 et seq. and the Hawaii Arbitration Act in Honolulu, Hawaii.

\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_  
Date

14. **I understand that all information submitted and obtained as a part of the application and credentialing process (verification of education, work experience, licensure, certifications, etc.) may be submitted for review /approval by the Department of Health and/or Department of Justice.**
15. A photo static copy of this original statement constitutes my written authorization and request to release any and all documents relevant to this application. Said photo static copy shall have all the same force and effect as the signed original.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Print Name of Applicant

\_\_\_\_\_  
Date

**CARE Hawaii Incorporated will treat this provider credentials application and any information secured in connection herewith in strict confidence and will employ all reasonable safeguards to protect the Applicant's privacy.**

# VOLUNTARY DISCLOSURE FORM

THIS INFORMATION IS ASKED FOR RECORD KEEPING PURPOSES ONLY AND WILL NOT BE KEPT AS PART OF YOUR APPLICATION

Name: \_\_\_\_\_  
Last First MI

Application Date: \_\_\_\_\_

Position Applied For: \_\_\_\_\_

- Race:  White  
 Hispanic  
 African American  
 Asian/Pacific Islander  
 Chinese  
 Filipino  
 Hawaiian or Part-Hawaiian  
 Japanese  
 Korean  
 Samoan  
 Vietnamese  
 Other: \_\_\_\_\_

Sex:  Male  Female

- Referred by:  Agency Name \_\_\_\_\_  
 College Recruitment (Name) \_\_\_\_\_  
 Employee Referral (Name) \_\_\_\_\_  
 Employment Office (Name) \_\_\_\_\_  
 Internal Posting \_\_\_\_\_  
 Internet/E-Recruitment \_\_\_\_\_  
 Newspaper Ad (Name) \_\_\_\_\_  
 Unsolicited Resume \_\_\_\_\_  
 Walk-In \_\_\_\_\_  
 Other: \_\_\_\_\_