# APPLICATION FOR RESEARCH ALLIED HEALTH PROFESSIONAL
## (Non-QMC Research Administrator or Research Support Personnel)

1. **IDENTIFIYING INFORMATION OF THE RESEARCH ALLIED HEALTH PROFESSIONAL**
(For completion by the Research Allied Health Professional)

Research Allied Health Professional's Name in Full:

_____
(Last) (First) (Middle) (Jr., Sr., III, etc.)

Indicate any other names used:

_____
(Last) (First) (Middle) (Jr., Sr., III, etc.)

Office Address:

_____
(Number) (Street) (Suite #)

_____
(City) (State) (Zip Code)

Office Telephone: _____ Answering Service: _____

Residence Address:

_____
(Number) (Street) (Suite #)

_____
(City) (State) (Zip Code)

Residence Telephone: _____

Mobile Telephone: _____

e-mail address: _____

Social Security Number: _____

Birth Date: _____

Principal Investigator: _____

Sponsor Name: _____

Title of Study:

_____

2. **TRAINING PERTINENT TO PROPOSED SERVICES TO BE RENDERED**
(For completion by the Research Allied Health Professional. ATTACH documentation of satisfactory completion of training and/or certification.)

2.1 Type of Training: _____

From: _____ To: _____

Name of Institution: _____

Department: _____

Address: _____
(Number) (Street) (Suite #)

_____
(City) (State) (Zip Code)

Telephone Number: _____

2.1 Type of Training: _____

From: _____ To: _____

Name of Institution: _____

Department: _____

Address: _____
(Number) (Street) (Suite #)

_____
(City) (State) (Zip Code)

Telephone Number: _____

2.1 Type of Training: _____

From: _____ To: _____

Name of Institution: _____

Department: _____

Address: _____
(Number) (Street) (Suite #)

_____
(City) (State) (Zip Code)

Telephone Number: _____

3. **HEALTH CARE FACILITIES/RESEARCH CENTERS – PAST/PRESENT**

For completion by the Research Allied Health Professional. Please list in CHRONOLOGICAL order, beginning with the most current, ALL health care facilities at which you currently and previously exercised the proposed services. Attach additional sheets if necessary.

3.1 Name of Health Care Facility: _____

Address: _____
(Number) (Street) (Suite #)

_____
(City) (State) (Zip Code)

Telephone Number: _____

Dates of Affiliation: From: _____ To: _____
(Month/Year) (Month/Year)

Description of Services Provided:

_____

Were you an employee of this Health Care Facility? Yes ☐ No ☐

If you were not an employee of the Health Care Facility, please complete the following information:

Name of Sponsor for services provided: _____

Address: _____
(Number) (Street) (Suite #)

_____
(City) (State) (Zip Code)

Sponsor's Professional Degree: _____

Describe your relationship held with the Health Care Facility at which you exercised your services, if you were not an employee:

_____

3.2 Name of Health Care Facility: _____

Address: _____
(Number) (Street) (Suite #)

_____
(City) (State) (Zip Code)

Telephone Number: _____

Dates of Affiliation: From: _____ To: _____
(Month/Year) (Month/Year)

Description of Services Provided:

_____

Were you an employee of this Health Care Facility? Yes ☐ No ☐

If you were not an employee of the Health Care Facility, please complete the following information:

Name of Sponsor for services provided: _____

Address: _____
(Number) (Street) (Suite #)

_____
(City) (State) (Zip Code)

Sponsor's Professional Degree: _____

Describe your relationship held with the Health Care Facility at which you exercised your services, if you were not an employee:

_____

4. **OTHER EMPLOYMENT OR PERIOD OF ACTIVITIES NOT REFLECTED IN OTHER SECTIONS INCLUDING ANY FORMAL DEGREE GRANTED OR CERTIFYING EDUCATION TAKEN**

(For completion by the Research Allied Health Professional. Please list in chronological order, beginning with the most current. Attach additional sheets if necessary.)

4.1 Name of Institution or Company: _____

Address: _____
(Number) (Street) (Suite #)

_____
(City) (State) (Zip Code)

Telephone Number: _____

Dates of Employment/Attendance: From: _____ (Month/Year) To: _____ (Month/Year)

Type of Employment, Degree or Certificate conferred: (Attach a copy of your degree or certificate.)

4.2 Name of Institution or Company: _____

Address: _____
(Number) (Street) (Suite #)

_____
(City) (State) (Zip Code)

Telephone Number: _____

Dates of Employment/Attendance: From: _____ (Month/Year) To: _____ (Month/Year)

Type of Employment, Degree or Certificate conferred: (Attach a copy of your degree or certificate.)

5. **LICENSURES – PAST AND PRESENT**

(For completion by the Research Allied Health Professional. Please list all current and valid licenses you now hold AND licenses you held in the past which are no longer valid for the proposed services to be exercised.)

5.1 CURRENT AND VALID LICENSE TO PRACTICE IN THE STATE OF HAWAII. ("Current and valid" includes that you do not have delinquent licensure fees.) ATTACH a photocopy of your State of Hawaii license

License Number: _____

Date Issued: _____ Expiration Date: _____

Type of License: _____

Restrictions, if any:

_____

5.2 LICENSURE IN OTHER STATES

License Number: _____

Date Issued: _____ Expiration Date: _____

Type of License: _____

Restrictions, if any:

_____

5.3 LICENSURE IN OTHER COUNTRIES

License Number: _____

Date Issued: _____ Expiration Date: _____

Type of License: _____

Restrictions, if any:

_____

6. **MALPRACTICE FINANCIAL RESPONSIBILITY**

For completion by the Research Allied Health Professional. PLEASE LIST the names and complete address of ALL current and past professional malpractice financial responsibility companies, institutions, organizations with whom you hold or have held malpractice financial responsibility. Attach additional sheets if necessary.)

6.1 CURRENT COVERAGE. ATTACH A PHOTOCOPY of your current written evidence of malpractice financial responsibility, as required in the Malpractice Financial Responsibility Policy.

Please check type of malpractice financial responsibility:

☐ Certificate of Insurance ☐ Self Insurance

☐ Indemnity Bond ☐ Letter of credit

☐ Collateral Security (trust or escrow)

Company, institution, or organization with whom held:

Address: _____
(Number) (Street) (Suite #)

_____
(City) (State) (Zip Code)

Policy # _____

Amount of coverage: $ _____ /$ _____
(Per claim) (Aggregate)

Effective Date: _____ Expiration Date: _____

6.2 PAST COVERAGE

Company, institution, or organization with whom held: _____

Address: _____
(Number) (Street) (Suite #)

_____
(City) (State) (Zip Code)

Policy # _____

Amount of coverage: $ _____ /$ _____
(Per claim) (Aggregate)

Effective Date: _____ Expiration Date: _____

6.3 PAST COVERAGE

Company, institution, or organization with whom held: _____

Address: _____
(Number) (Street) (Suite #)

_____
(City) (State) (Zip Code)

Policy # _____

Amount of coverage: $ _____ /$ _____
(Per claim) (Aggregate)

Effective Date: _____ Expiration Date: _____

7. **INDIVIDUAL PROFESSIONAL REFERENCES**

(For completion by the Research Allied Health Professional. PLEASE LIST at least three (3) references who have CURRENT, PERSONAL, FIRST-HAND KNOWLEDGE of your current competency in the services for which application for sponsorship is being made.)

PLEASE NOTE: References will be asked if they have personally observed your performance in the services for which application for sponsorship is being made.

7.1 Name: _____

Relationship to applicant (Supervisor, coworker, etc.): _____

Occupation/Profession: _____

Address: _____
(Number) (Street) (Suite #)

_____
(City) (State) (Zip Code)

Telephone Number: _____

7.2 Name: _____

Relationship to applicant (Supervisor, coworker, etc.): _____

Occupation/Profession: _____

Address: _____
(Number) (Street) (Suite #)

_____
(City) (State) (Zip Code)

Telephone Number: _____

7.1 Name: _____

Relationship to applicant (Supervisor, coworker, etc.): _____

Occupation/Profession: _____

Address: _____
(Number) (Street) (Suite #)

_____
(City) (State) (Zip Code)

Telephone Number: _____

## RESEARCH ALLIED HEALTH PROFESSIONAL'S CONSENT AND RELEASE

I FULLY UNDERSTAND THAT ANY SIGNIFICANT MIS-STATEMENTS IN OR OMISSIONS FROM THE APPLICATION TO THE QUEENS' MEDICAL CENTER SUBMITTED FOR PROPOSED SPONSORED SERVICES TO BE RENDERED SHALL CONSTITUTE CAUSE FOR DENIAL OF APPROVAL. ALL INFORMATION SUBMITTED WITHIN THE APPLICATION IS TRUE TO MY BEST KNOWLEDGE AND BELIEF.

I UNDERSTAND AND AGREE that I have the burden of producing adequate information for proper evaluation of my qualifications, clinical competence, moral character and ethical qualifications and for resolving any doubts thereto.

I HEREBY SIGNIFY my willingness to appear for interviews with regard to the proposed sponsored services to be rendered and authorize representatives of The Queen's Medical Center and/or its Medical Staff to consult with representatives of other hospitals and/or their Medical Staffs, institutions, government agencies including licensing agencies, professional liability insurance companies, professional associations, accreditation agencies and others who may have information bearing on my professional qualifications, clinical competence, moral character ethical qualifications and physical and mental condition. I HEREBY FURTHER CONSENT to the inspection by representatives of the Queen's Medical Center and/or its Medical Staff of all records at other hospitals, institutions, government agencies including licensing agencies, professional liability insurance companies, professional associations, accreditation agencies and others that may be material to an evaluation of my professional qualifications, clinical competence, moral character, ethical qualifications and physical and mental condition for the proposed sponsored services to be rendered and continuance or renewal thereof. I HEREBY RELEASE from liability all representatives of The Queen's Medical Center and/or its Medical Staff for their acts performed in good faith and without malice in connection with this application, my credentials and my qualifications.

I HEREBY RELEASE from any liability any and all individuals, hospitals, institutions, government agencies including licensing agencies, professional liability insurance companies, professional associations, accreditation agencies, and others who provide information to representatives of The Queen's Medical Center and/or its Medical Staff in good faith and without malice, concerning my professional qualifications, clinical competence, physical and mental condition, moral character, and ethical qualifications for the proposed sponsored services to be rendered at The Queen's Medical Center (unless such information is false and the person providing it knew the information was false) and I HEREBY CONSENT to the release of such information for the proposed sponsored services to be rendered at The Queen's Medical Center.

I HEREBY AUTHORIZE AND CONSENT to the release of information by representatives of The Queen's Medical Center and/or its Medical Staff, to other hospitals and/or their Medical Staffs, institutions, government agencies including licensing agencies, professional liability insurance companies, professional associations, accreditation agencies, and others, upon request, regarding any information The Queen's Medical Center and/or its Medical Staff may have concerning me, as long as such release of information is done in good faith and without malice. I HEREBY RELEASE from liability all representatives of The Queen's Medical Center and/or it's Medical Staff for so doing.

I HEREBY AUTHORIZE any company, organization, institution and financial institution with whom I have held, currently hold, or will hold malpractice financial responsibility to release, at any time requested by The Queen's Medical Center, any and all information relating to my professional liability coverage and claims information.

I HEREBY AUTHORIZE and direct any company, organization, institution or financial institution with whom I currently hold or may in the future hold malpractice financial responsibility to inform The Queen's Medical Center at any time that my malpractice financial responsibility coverage is canceled or amended, in part of whole, together with detailed information as to such cancellation or amendments, whichever is applicable.

I AGREE to provide The Queen's Medical Center with written evidence of my malpractice financial responsibility at any time upon request. I FURTHER AGREE to notify The Queen's Medical Center (c/o Human Resources) of any cancellation or amendment, in part or whole, of the malpractice financial responsibility, together with detailed information as to alternative approved malpractice financial responsibility coverage to be obtained or changes planned, whichever is applicable.

I ACKNOWLEDGE that a copy of this consent and release form shall be as binding as the original.

_____
Signature

_____
Typed or Printed Name

_____
Date