



Hawaii Association of Certified Nurses Aides

QUALITY CARE FOR THE SENIORS OF HAWAII

Membership Application (\$25.00/year)

Membership Renewal (\$25.00/year)

*Required Information		
Name:		Telephone:
Address:		
City:	State:	Zip:
Email Address:		
Certificate #:	Original Date:	Expiration Date:
<input type="checkbox"/> Adult CPR	Date Completed:	
<input type="checkbox"/> Standard First Aid	Date Completed:	
<input type="checkbox"/> TB Clearance	Date:	
Drivers License:		Expiry Date:
**Optional Information		
Date of Birth:		SS#:
How did you hear about us?		
Please check one:		
<input type="checkbox"/> Internet <input type="checkbox"/> Friends/Family <input type="checkbox"/> Support Group <input type="checkbox"/> Dr. Office <input type="checkbox"/> TV/Radio <input type="checkbox"/> Newspaper <input type="checkbox"/> Other _____ _____		
I authorize HACNA to disclose my name and telephone number to prospective employers.		
Signature: _____		

I hereby certify that the facts set forth above are true and complete; and I authorize HACNA to verify any and all of the statements that I have made this application. I understand that, false statements on this application or omissions of material information may result in the termination of my membership.

Signature: _____

Date: _____

P.O. Box 88776, Honolulu, HI 968300
Phone/Fax: (808) 923-5918 Email: HACNA@hawaii.rr.com



Hawaii Association of Certified Nurses Aides

QUALITY CARE FOR THE SENIORS OF HAWAII

Mahalo for your interest in becoming a part of the Hawaii Association of Certified Nurses Aides.

Please be sure to include the following documents with your application:

- Resume
- Nurses Aide Certificate
- CPR/First Aid
- Drivers License
- Traffic Abstract
- Criminal Background Check
- Other Certificates of Learning

Availability for Volunteer work:

Days Available:

- Monday
- Tuesday
- Wednesday
- Thursday
- Friday
- Saturday
- Sunday

Hours Available:

Monday:

Tuesday:

Wednesday:

Thursday:

Friday:

Saturday:

Sunday:

Volunteer Activity:

- | | | |
|---|--------------------------------------|--|
| <input type="checkbox"/> Telephone Calls | <input type="checkbox"/> Mailers | <input type="checkbox"/> Canvassing |
| <input type="checkbox"/> Meeting Setup | <input type="checkbox"/> Marketing | <input type="checkbox"/> Refreshments for meetings |
| <input type="checkbox"/> Information for Newsletter | <input type="checkbox"/> Fundraisers | Members Committee |
| <input type="checkbox"/> Other: _____ | | |



Hawaii Association of Certified Nurses Aides

QUALITY CARE FOR THE SENIORS OF HAWAII

AUTHORIZATION TO RELEASE INFORMATION

To _____ :

As an applicant for membership with HACNA (Hawaii Association of Certified Nurses Aides) I have been asked to furnish information for use in reviewing my background and qualifications. In this connection, I hereby authorize the investigation of my past and present work, character, attendance of the last year worked, education, military and police records to ascertain any and all information which may be pertinent to my employment qualifications and experience at your company. This includes all information contained in my employment records.

The release in any manner of any and all information by you is authorized, and I do hereby release all persons, firms, agencies or companies, whomsoever, from any damages resulting from furnishing such information.

This authorization shall be valid for three (3) months from the date of my signature below. You may retain this copy of my release for your files. Thank you for your assistance.

Name: _____
Type or print name

Signature

Date

Signature of Witness

Date



Hawaii Association of Certified Nurses Aides

QUALITY CARE FOR THE SENIORS OF HAWAII

P.O. Box 88776, Honolulu, HI 968300
Phone/Fax: (808) 923-5918 Email: HACNA@hawaii.rr.com