PU'ULU LAPA'AU
HAWAI'I PROGRAM FOR HEALTHCARE PROFESSIONALS
200 North Vineyard Blvd, Building B, Suite 271
Honolulu, Hawaii 96817
Phone: 808-593-7444
Fax: 808-593-8999

Application for New Program Participant

Name: _____ Date of Birth: ____/___ /_____
(Last) (First) (MI)

Cultural/Ethnic Identity: _____Pronouns: _____ Age: _____

Home Address: _____
(Street Number and Address) (City) (State) (Zip)

Mailing Address: _____
(Street Number and Address) (City) (State) (Zip)

Phone: (_____)_____Daytime/Cell No: (_____)_____

Email Address: _____

1) License/Degree (MD / DO / PA / DDS / RN / APRN / PhD or other):_____

2) Specialty: _____

3) Do you have a current healthcare professional license or certification? ☐ No ☐ Yes
Please list all current and former license numbers and states where you are or were practicing:
_____

4) Check all that apply:
☐ Active, unrestricted Hawaii license ☐ Resident/training license
☐ In school ☐ Applying for Hawaii license ☐ Conditional license
☐ License suspended ☐ Other: _____

5) Which best describes your current practice (select one):
☐ Clinically practicing ☐ Student/unlicensed ☐ In training
☐ Working, but not in healthcare ☐ Working in healthcare but not actively seeing patients
☐ On medical leave or disability status ☐ Not currently working

6) What is your practice setting (select all that apply): ☐ Inpatient ☐ Outpatient
☐ Single-specialty group ☐ Multispecialty group ☐ Solo practitioner
☐ Full-time ☐ Part-Time ☐ Other: _____

7) List all institutions where you are currently practicing: _____
_____

8) Who referred you to Pu'ulu Lapa'au? _____

For questions 9 – 15, add additional sheets if necessary:

9) Describe any workplace concerns related to your referral to Pu'ulu Lapa'au: _____

_____

10) Do you have any pending legal or disciplinary issues, including malpractice cases? ☐ No ☐ Yes
If yes, describe: _____

11) Legal issues (select all that apply): ☐ NONE
☐ Prior arrest, conviction, or legal issues related to substance use/possession (e.g. DUI, disorderly conduct)
☐ Domestic violence, assault ☐ Any sexually related offense ☐ Other criminal or civil legal issues

12) Are you currently monitored by a healthcare professional monitoring program, or have you ever been monitored by a healthcare professional monitoring program? ☐ No ☐ Yes
If Yes, please list state(s): _____

13) Have there ever been any actions affecting your ability to provide healthcare? For example, healthcare board denials or suspensions? ☐ No ☐ Yes
If Yes, please explain: _____

14) The following are issues of concern:

			If yes, please explain:
Substance abuse/dependence	☐ No	☐ Yes	_____
Medical or Psychiatric	☐ No	☐ Yes	_____
Disruptive Behavior	☐ No	☐ Yes	_____
Competency	☐ No	☐ Yes	_____

Other: please describe: _____

15) Have you received any treatment (e.g. outpatient treatment, residential treatment, hospitalization) related to the issue(s) of concern: ☐ No ☐ Yes Describe: _____

_____

16) What medical or psychiatric issues are you CURRENTLY being treated for? _____

_____

17) List any PREVIOUSLY diagnosed medical conditions not listed above: _____

_____

18) Have you ever been hospitalized for a psychiatric concern: ☐ No ☐ Yes
If yes, where and when? _____

19) Do you have any history of suicide attempts? ☐ No ☐ Yes
If yes, when and how? _____

20) Have you ever sought treatment for alcohol or other substance use? ☐ No ☐ Yes
If yes, where and when? _____

21) List any family history of medical, psychiatric, or substance use disorders: _____
_____

22) If applicable, please list your PCP: _____
Therapist: _____ Psychiatrist: _____

23) List all medications you are currently taking (medication, dose, and frequency):
_____
_____
_____
_____

24) Have you had any of the following? (check all that apply) ☐ Developmental delay
☐ Learning disabilities ☐ Head injury ☐ Dementia ☐ Overdose from any substance
☐ Other neurological conditions _____ ☐ NONE

25) Would you say you have been obsessed about your weight, looks, diet, or exercise routine in the past?
☐ No ☐ Yes If yes, when? _____

26) Have you ever sought or thought about seeking treatment for an eating disorder or compulsive exercise?
☐ No ☐ Yes If yes, when and where? _____

27) Have you ever sought or thought about seeking help for problematic sexual behaviors?
☐ No ☐ Yes If yes, when and where? _____

28) Have you ever sought or thought about seeking help for compulsive gambling, shopping/spending, internet gaming, or workaholism? ☐ No ☐ Yes If yes, when and where? _____
_____

29) Have you experienced traumatic or very upsetting events that continue to cause you problems?
☐ No ☐ Yes If yes, when? _____

30) Do you own any firearms? ☐ No ☐ Yes

31) Are finances a concern for you? ☐ No ☐ Yes If yes, describe: _____

30) Please describe your lifetime use of each substance listed below:

Alcohol: Lifetime use? ☐ No ☐ Yes If yes, describe _____

Date of last use: _____

Nicotine: Lifetime use? ☐ No ☐ Yes If yes, describe _____

Date of last use: _____

Cannabinoids: Lifetime use? ☐ No ☐ Yes If yes, describe _____

Date of last use: _____

Benzodiazepines: Lifetime use? ☐ No ☐ Yes If yes, describe _____

Date of last use: _____

Sleeping pills: Lifetime use? ☐ No ☐ Yes If yes, describe _____

Date of last use: _____

Opioids: Lifetime use? ☐ No ☐ Yes If yes, describe _____

Date of last use: _____

Cocaine: Lifetime use? ☐ No ☐ Yes If yes, describe _____

Date of last use: _____

Methamphetamine: Lifetime use? ☐ No ☐ Yes If yes, describe _____

Date of last use: _____

Kratom: Lifetime use? ☐ No ☐ Yes If yes, describe _____

Date of last use: _____

Hallucinogens: (e.g. MDMA, ketamine, PCP, psilocybin, LSD) Lifetime use? ☐ No ☐ Yes If yes, describe _____

Date of last use: _____

Other: _____ Lifetime use? ☐ No ☐ Yes If yes, describe _____

Date of last use: _____

31)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	○0	○1	○2	○3
2. Feeling down, depressed, or hopeless	○0	○1	○2	○3
3. Trouble falling or staying asleep, or sleeping too much	○0	○1	○2	○3
4. Feeling tired or having little energy	○0	○1	○2	○3
5. Poor appetite or overeating	○0	○1	○2	○3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	○0	○1	○2	○3
7. Trouble concentrating on things, such as reading the newspaper or watching television	○0	○1	○2	○3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	○0	○1	○2	○3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	○0	○1	○2	○3

By signing below, I certify that the information I have provided is complete, true and correct. I understand this application form will not be reviewed until all requested information is received. I understand I may be asked for additional information. I understand I will be required to meet with the Medical Director in Honolulu, Hawaii to complete the application process. Finally, I understand that submission of this application form and an application fee does NOT constitute a contractual agreement between the applicant and Pu'ulu Lapa'au.

Signature: _____ Date:_____

Submit form by:
e-mail: maryann.lentz@hawaiiphp.org OR fax: 808-593-899 OR upload: hawaiiphp.org/forms

Application fees: $250 (MD, DO, DDS, and Nurses), $200 (Physician Assistants, Psychologists), $100 (Residents), $50 (Medical and Nursing Students).

Please send the non-refundable application fee, payable to Puʻulu Lapaʻau, to the address below:

Puʻulu Lapaʻau: Hawaiʻi Program for Healthcare Professionals
200 North Vineyard Blvd, Building B, Suite 271
Honolulu, Hawaii 96817