The Hawai‘i Maternal and Child Health Leadership Education in Neurodevelopmental and Related Disabilities (MCH LEND) Program is a federally-funded program through the Health Resources and Services Administration (HRSA) Maternal Child Health Bureau (MCHB) since 1994. We appreciate your interest and look forward to receiving your application. Thank you for your time and consideration!

**PROGRAM REQUIREMENTS 2016-2017**

*Appointment is contingent upon grant funding.*

The following checklists detail Application Requirements and Health Clearances for trainee candidates of the Hawai‘i MCH LEND Program. To apply for the MCH LEND Program, mail the completed forms and corresponding documents required in the Application Requirements section to:

**MCH LEND Program**  
*Department of Pediatrics*  
*Kapi‘olani Medical Center*  
*1319 Punahou Street, Room 745*  
*Honolulu, Hawai‘i 96826*

Applications received by May 13, 2016 will be given priority consideration. Once selected, Trainees will have until June 30, 2016 to submit the required immunization and health documentation. Trainees may be eligible for stipends, pending annual funding. If you have questions, contact the MCH LEND Program Office at (808) 369-1240 or mchlend@hawaii.edu.

**APPLICATION REQUIREMENTS**

For priority consideration as a candidate for the MCH LEND Program you must meet or exceed the following criteria and submit the required documentation by May 13, 2016:

**Minimum criteria:**
- US citizen or permanent resident visa status
- Advanced graduate student standing (Academic trainee)
- Completion of basic clinical training as required in discipline
- Demonstration of excellence in foundation courses within discipline

**Desirable criteria:**
- Demonstrates experience with individuals with disabilities and/or children with special health care needs and family members
- Demonstration of career goals to work in the area of maternal and child health with individuals with disabilities and families

**Required Documentation:**
- Completed Application Form (page 3-4)
- Supervisor/Departmental Nomination Form (page 5)
- Reference Forms from three (3) supervisory persons and/or faculty (page 6-7)
- Resume
- Copy of recent applicable certifications, licenses, and transcripts
- Proof of malpractice insurance coverage
HEALTH CLEARANCE

Health clearance and personal liability coverage is required for trainees to participate in clinical components of the MCH LEND Program. Written documentation must be provided for vaccinations received or documentation of a positive titer is required. Photocopies of previous documentation are acceptable.

Upon acceptance into the program, trainees must submit the following documentation by June 30, 2016:

- ✔ Proof of current professional or student liability insurance coverage
- ✔ Immunization records or positive titer or medical record of disease for:
  - o Chickenpox (Varicella Zoster)
    - Medical record documentation of disease OR (2) Varivax vaccinations OR positive blood test (titer) for varicella zoster
  - o Measles (Rubeola)
    - Medical record documentation of disease OR (2) MMR/Rubeola vaccinations OR positive blood test (titer) for Rubeola
  - o German Measles (Rubella)
    - Medical record documentation of disease OR (1) MMR/Rubella vaccination OR positive blood test (titer) for Rubella
    - If titer is negative, documentation of 1 subsequent MMR is required.
  - o Hepatitis B
    - Medical record documentation of disease OR documentation of completed vaccination series (3 vaccines) OR positive blood test (titer) for Hepatitis B.
    - If titer is negative, documentation of at least 2 Hepatitis B immunization series is required OR medical contraindication from a Health Care Provider (HCP) must be provided.
  - o Influenza Seasonal Vaccination
    - Current season vaccination OR signed declaration form OR medical record documentation of contraindication from a HCP.
  - o Tuberculosis (TB)
    - 2-step TB skin testing within 1 year from application:
      - 1. Positive TB skin test result (TST) including dates placed/read & induration OR chest x-ray report stating “history of positive TST” OR licensed medical practitioner’s note stating history of positive TST, TB disease, or INH therapy
      - 2. Negative Chest x-ray completed within 12 months of your start date
      - 3. TB symptoms questionnaire
      - If you had a prior negative 2-step TB skin test (TST) (anytime time in your past) and no positive TST thereafter
        - 1. 2-step TST results including dates placed/read & induration amount
        - 2. 1 additional negative TST within 12 months of your start date
      - If you had 1 negative TB skin test (TST) within 12 months of your start date
        - 1. TST result including dates placed/read & induration amount
        - 2. 1 additional negative TST to meet 2-step TB requirement
**APPLICATION FORM**

**Appointment is contingent upon grant funding.**

**Instructions:**

1. Print the form and complete the information below.
2. Print and submit the completed form by mail to:
   
   MCH LEND Program  
   Kapi'olani Medical Center  
   1319 Punahou Street, Room 745  
   Honolulu, Hawai‘i 96826
3. Priority consideration will be given to applications received by May 13, 2016.

### Application Details

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
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<tbody>
<tr>
<td>LAST NAME</td>
<td>FAMILY/SURNAME</td>
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<td></td>
<td>LEGAL FIRST NAME</td>
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<td>LEGAL MIDDLE NAME</td>
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<tr>
<td>CURRENT MAILING ADDRESS – NUMBER AND STREET</td>
<td>CITY</td>
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<td>STATE</td>
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<td>HOME PHONE</td>
<td>CELL PHONE</td>
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<td>PAGER</td>
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<tr>
<td>PERMANENT MAILING ADDRESS – NUMBER AND STREET</td>
<td>CITY</td>
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<td></td>
<td>STATE</td>
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<tr>
<td>EMAIL ADDRESS</td>
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</tbody>
</table>

The MCH LEND Program must report to several federal agencies summary data on the gender and ethnic background of its applicants. Therefore, it is required that each person applying for admission to the MCH LEND Program indicates his or her gender and ethnic background on the application form. This information does not affect determination of admission.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Birthdate</th>
<th>Ethnicity (List All)</th>
<th>Citizenship</th>
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</thead>
<tbody>
<tr>
<td>Female</td>
<td>MM/DD/YYYY</td>
<td>(List All)</td>
<td>USA</td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td>OTHER (Specify)</td>
</tr>
</tbody>
</table>

**Academic Trainee** (matriculated student) or **Post-Doctoral Fellow applicants only**: 

Indicate your student status: Degree sought and expected year of completion.

| Your Current Position/Job Title: |
| Your current employing agency: |
| List your education history |

<table>
<thead>
<tr>
<th>Institution</th>
<th>Years Attended</th>
<th>Degree Conferred</th>
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</thead>
</table>

**Complete this section if you are currently enrolled in a college or university**

<table>
<thead>
<tr>
<th>Name of institution currently attending</th>
<th>Location (City/State)</th>
<th>Term/year currently enrolled in</th>
<th>Major</th>
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</table>
Please briefly answer the following questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tr>
<td>Briefly summarize your background in terms of maternal and child health experiences.</td>
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<tr>
<td>Briefly summarize your background related to children with special health care needs and individuals with disabilities.</td>
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<tr>
<td>What are your goals for participation in the MCH LEND Program?</td>
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<tr>
<td>What are your career goals related to children with or at risk of disabilities, family members and community health services?</td>
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</tbody>
</table>

**APPLICANT’S CERTIFICATION**

I certify that the responses provided on the MCH LEND Application Form are complete and true to the best of my knowledge and belief. I understand that providing incomplete, incorrect, or false information may result in the recession or denial of my admission. Further, I understand that the MCH LEND Program shares a common database with the Association of University Centers on Disability and summary data pertaining to students in the MCH LEND training Program may be accessed.

**APPLICANT’S SIGNATURE**

**DATE**

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**HAWAI‘I MCH LEND OFFICE USE ONLY**

<table>
<thead>
<tr>
<th>Nomination Form</th>
<th>Resume</th>
<th>Reference 1</th>
<th>Reference 2</th>
<th>Reference 3</th>
<th>Certifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Application received</td>
<td>Faculty Mentor</td>
<td>Acceptance status</td>
<td>Stipend amount</td>
<td>Clinical Requirements</td>
<td></td>
</tr>
</tbody>
</table>
SUPERVISOR/DEPARTMENTAL NOMINATION FORM

Appointment is contingent upon grant funding.

Academic Trainees and Fellows must be nominated by a supervising faculty. Community Trainees must be nominated by their supervisor. Final decisions regarding acceptance, funding levels for trainees, and training activities will be conducted with the faculty representatives from the MCH LEND Program.

1. Submit the completed form by mail to:
   MCH LEND Program
   Kapi‘olani Medical Center
   1319 Punahou Street, Rm 745
   Honolulu, Hawai‘i 96826

2. If you have questions, contact the MCH LEND Program office at (808) 369-1240 or mchlend@hawaii.edu

Name of Applicant: ___________________________ Date: ___________________________

Supervising faculty to supply the following information for ACADEMIC TRAINEES

Name of Faculty Sponsor: ___________________________

Department: ___________________________

Address: ___________________________

City: ___________________________ State: ___________________________ Zip: ___________________________

Email Address: ___________________________

Work Phone: ___________________________ Fax: ___________________________ Other: ___________________________

Faculty’s Signature: ___________________________ Date: ___________________________

Direct Supervisor to supply the following information for COMMUNITY TRAINEES

Name of Supervisor: ___________________________

Organization: ___________________________

Address: ___________________________

City: ___________________________ State: ___________________________ Zip: ___________________________

Email Address: ___________________________

Work Phone: ___________________________ Fax: ___________________________ Other: ___________________________

Supervisor’s Signature: ___________________________ Date: ___________________________
REFERENCE FORM

Appointment is contingent upon grant funding.

Section A
(TO BE COMPLETED BY THE APPLICANT)

Applicant’s Instructions:
1. Print three (3) copies of this Form.
2. Fill-in all the information for Section A and check the appropriate line for authorization and waiver.
3. Sign at the line for applicant.
4. Give a copy of the ENTIRE Reference Form (Sections A and B) to three (3) reviewers.

Name of Applicant: ____________________________

Name of Reviewer: ____________________________

Reviewer’s Title: ____________________________
Reviewer’s Position: ____________________________

Reviewer’s Department or Organization: ____________________________

Select one of the following:

I understand that the completed form will be held in confidence from me and the public by the University of Hawai’i at Mānoa.

I do not waive my rights to access to this recommendation but I authorize the reference to provide a candid evaluation and all relevant information to the University of Hawai’i at Mānoa.

Applicant’s Signature: ____________________________  Date: ____________________________

Give one copy of this entire Reference Form (Sections A and B) to each reviewer.
REFERENCE FORM
Appointment is contingent upon grant funding.

Section B
(TO BE COMPLETED BY THE REVIEWER)

Reviewer’s Instructions:
1. Provide your estimate of the applicant’s ability to pursue and to complete a leadership training curriculum in Maternal and Child Health. Submit the completed form by mail to:
   MCH LEND Program
   Kapi’olani Medical Center
   1319 Punahou Street, Room 745
   Honolulu, Hawai‘i 96826

2. If you have questions, contact the MCH LEND Program office at (808) 369-1240 or mchlend@hawaii.edu

Name of Applicant:

Name of Reviewer: Reviewer’s Position:

Please rate the applicant on the following achievements and characteristics (check only one from each criterion):

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Above Average</th>
<th>Average</th>
<th>Below Average</th>
<th>Unable to Judge</th>
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<tr>
<td>Ability to express himself/herself in speech and writing</td>
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<td>Self-reliance and independence</td>
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<td>Maturity</td>
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<td>Flexibility</td>
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<td>Social Sensitivity</td>
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<td>Ability to work with others who have different viewpoints</td>
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<td>Growth during total period of observation</td>
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<td>Reliability and follow-through</td>
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Comments:

In what capacity do you know the Applicant?

Reviewer’s Signature: Phone: Date: