Please contact
OSH Volunteer Services
before completing this packet.

Email: OSHVolunteer.Services@dhsoha.state.or.us
Call: 503-945-2892

Volunteer Registration

Contact Information

Name:______________________________ Home Phone: ______________________

Address:____________________________ Cell Phone: ______________________

City, State, Zip: _____________________ DOB: ___________________________

Email: _____________________________(email address required to inform you of your background check status)

Emergency Contact Information

Emergency Contact: ___________________________________

Emergency Contact Phone: ______________________________

References

Name:______________________________ Phone: __________________________

Name:______________________________ Phone: __________________________

Assignment

Desired Start Date:_____________________ Desired End Date: __________________

What would you like to do? _______________ Department:_______________________

How many hours/week? ____

Why do you want to volunteer at Oregon State Hospital? _________________________

____

As a volunteer working in a State of Oregon agency, you are covered by State of Oregon insurance for liability and personal injury or illness. Worker's Compensation coverage through SAIF Corporation is provided to the Oregon State Hospital approved volunteers for injuries incurred while performing authorized duties. Volunteers are protected from civil liability for injuries or damage to the person or property of others subject to the following conditions: You are working on a state agency task assigned by an authorized agency supervisor; you limit your actions to the assigned duties; and you perform your assigned tasks in a good faith and do not act in a manner that is reckless or with intent to unlawfully inflict harm to others. OSH and/or OSH Volunteer Services reserve the right to terminate this volunteer assignment at any time.

If you use a personally owned vehicle in the course of your duties, you are required to have automobile liability insurance to provide your primary coverage for any accidents involving that vehicle. State provided auto insurance would apply on a limited basis only after your primary coverage limits have been used. Use of a private vehicle for Oregon State Hospital business requires written approval from the Superintendent.

I have read and understand the above conditions of service:

____

Signature

____

Date

Oregon State Hospital

Confidentiality Agreement

I understand that Oregon State Hospital has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health information. Additionally, Oregon State Hospital must assure the confidentiality of its human resources, payroll, fiscal, research, computer systems, and management information (collectively "Confidential Information").

In the course of my employment/assignment at Oregon State Hospital, I realize that I may come into possession of Confidential Information.

I further understand that I must sign and comply with this agreement in order to get authorization for access to any of Oregon State Hospital's Confidential Information.

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not need to know it. In addition, I understand that my personal user code, user ID(s), and password(s) used to access computer systems are also an integral aspect of this confidential information.

2. I will not access or view confidential Information, or utilize equipment, other than what is required to do my job.

3. I will not discuss Confidential Information where others can overhear the conversation (for example, in hallways, on elevators, at restaurants, etc.). It is not acceptable to discuss Confidential Information in public areas, even if the patient's name is not used. Such a discussion may raise doubts among patients and visitors about our respect for their privacy.

4. I will not make inquiries about Confidential Information for other personnel who do not have proper authorization to access such Confidential Information.

5. I will not knowingly inform another person of my computer password or knowingly use another person's computer password unless authorized to do so in writing.

6. I will not make any unauthorized transmissions, inquires, modifications, or purgings of Confidential Information in Oregon State Hospital's computer system. Such unauthorized transmissions include, but are not limited to removing and/or transferring Confidential Information form Oregon State Hospital's computer system to unauthorized locations (for instance, home).

7. I will log off any computer terminal prior to leaving it unattended.

8. I will comply with any security or privacy policy promulgated by Oregon State Hospital to protect the security and privacy of Confidential Information.

9. I will immediately report to my supervisor any activities, by any person, including myself, that is a violation of this Agreement or of any Oregon State Hospital information security or privacy policy.

10. Upon termination of my employment, I will immediately return any documents or other media containing Confidential Information to Oregon State Hospital.

11. I agree that my obligations under the Agreement will continue after the termination of my employment.

12. I understand that violation of this agreement may result in disciplinary action, up to and including termination of employment and/or suspension in accordance with Oregon State Hospital's Confidentiality and Security of Patient Information Policy as well as legal liability.

13. I further understand that all computer access is subject to audit.

By signing this document I understand and agree to the following: I have read the above agreement and agree to comply with all its terms.

Signature of employee/contractor/student - faculty/volunteer____

Print Name____ Date__________________

TO BE FILED IN STUDENT/FACULTY RECORD AT OSH

OREGON STATE HOSPITAL Infection Prevention and Employee Health TB RISK FACTOR FORM

(If you have documentation please provide, if not OSH will provide)

Name ______________________________ Unit/Dept. __________

Date of last chest x-ray ______

In order to determine your current TB status please answer the following questions:

Once you have had a chest x-ray, as long as you do not exhibit symptoms indicative of active disease, you do not need to have the chest x-ray repeated. You may, however, have the chest x-ray repeated upon request at any time. If you do not have a chest x-ray on file within the last 10 years, you may want to consider updating your baseline chest x-ray for future comparison.

	NO	YES	DATE
1. Close exposure to a person with known communicable pulmonary tuberculosis within the previous two (2) years. (Neither you, nor the person, were wearing a mask.)	____	____	______
Subjective symptoms during past year			
2. Cough of more than three (3) weeks duration	____	____	
3. Bring up sputum every day for one or more weeks	____	____	
4. Spitting up blood (hemoptysis)	____	____	
5. Tires easily	____	____	
6. Loss of appetite	____	____	
7. Unexplained weight loss (8 pounds or more)	____	____	
8. Night sweats	____	____	
9. Fever/chills (more than one week duration)	____	____	

Date ______________ Signature of Employee ________________________________

Reason for review: ☐ New Employee ☐ Risk Assessment ☐ TB Exposure

Chest x-ray: ☐ Ordered ☐ Not ordered

Date ________________ ________________________________

Signature Infection Control/Employee Health Practitioner

OREGON STATE HOSPITAL

Infection Prevention and Employee Health

Tuberculosis Status Requirements for Volunteers/Students/Interns

(If you have documentation please provide, if not OSH will provide)

You must show proof of a TB test within 1 year prior to work. The dates must be legible on your documents. History of a "positive" TB is acceptable. All positive TB tests require proof of a chest x-ray and a copy of the final report must be provided to OSH.

Oregon State Hospital (OSH) requires a Tuberculosis (TB) Screening of all employees, patients, volunteers, students and interns within the hospital. You may accomplish this through your personal Healthcare Provider, the County Health Department or through your School's Health Service Department.

A TB Screening needs to be completed before you start working and is repeated yearly if you have a history of a positive TB test.

Part I: Volunteer/Student/Intern INFORMATION

Name (Last-**PLEASE PRINT**)			(First-**PLEASE PRINT**)		(middle initial)
Birthdate	Gender	Primary Telephone:	Message Telephone:		
Address			City	ST	ZIP

I authorize the release of my TB Test information and CXR report (if applicable) to the Oregon State Hospital.

______________________________ ______________

Signature of Applicant Date

Check All that Apply: (copies of original documents must be attached. This form will NOT be ACCEPTED without documentation unless signed by a Healthcare Provider)

PART 2

Type of TB Test: ☐ **Skin Test** (Tine not accepted) ☐ **Blood Test** (skip to **PART 3**)

For skin test only: Date test placed: ____________
Date test read: ____________

Result in millimeters________mm
("negative" is not acceptable)

Date of last chest x-ray: __________Results: __________TB Symptoms Screening form attached ☐
Forms and documentation sent to IPEH ☐

For Positive Tests ONLY

PART 3

For Blood Test Only:

Date of result: ___________ Result (check one) ☐ Positive ☐ Negative ☐ Indeterminate

Date of last chest x-ray: ___________Results: _________TB Symptoms Screening form attached ☐
Forms and documentation sent to IPEH ☐

For Positive Tests ONLY

______________________________ ______________________________

PLEASE PRINT Name of Person Completing this form Signature of Person Completing this form

______________________________ ______________________________

Name of Institution (If Healthcare Professional) Office phone

2016-2017 DECLINATION OF INFLUENZA (FLU) VACCINATION FORM

VOLUNTEERS/INTERNS/STUDENTS/CONTRACTORS ONLY

(If you have documentation please provide, if not OSH will provide)

Volunteer/Intern/Student Acknowledgment

I have received information about the influenza vaccine, including the efficacy, safety, and benefits. I have had the opportunity to ask questions regarding the vaccine. I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands of people in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to protect this facility's patients from influenza, its complications, and death.
- The vaccine is provided to me free of cost.
- If I am infected with influenza, I can shed the virus for 24 hours before influenza symptoms appear; my shedding the virus can spread influenza to patients in this facility who may be at risk of complications.
- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't change, my immunity declines over time; this is why vaccination against influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including:
    - All patients in this healthcare facility
    - My coworkers
    - My family
    - My community

Despite these facts, I am choosing to decline influenza vaccination right now for the following reason:

☐ I received immunization at another site. Provide documentation to Infection Prevention.
Fax to: 503-945-2825, Scan to: OSH.InfectionControl@dhsoha.state.or.us , or Mail to: Infection Prevention, Kirkbride B01-224, 2600 Center St. NE, Salem, OR 97301

☐ I decline this vaccine due to an active medical condition that contraindicates administration of the flu vaccine

☐ I decline this vaccine for non-medical reasons

☐ Out of Season (Flu Season runs from October 1st – March 31st)

I understand that I can change my mind at any time and accept the influenza vaccination if vaccine is still available. I have read and fully understand the information on this declination form.

Printed Name: ______________________________ ID number (or DOB): ______________________

Signature: ______________________________ Date: ______________________________

Centers for Disease Control & Prevention. Prevention and Control of Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices.

i:\infection ctrl\forms\immunization forms\Influenza_declination_V_I_S_C_form_2016-2017.doc

DHS Oregon Department of Human Services

SHARED SERVICES
Background Check Unit

Oregon Health Authority

Background Check Request

301 HR

Use for current Department of Human Services (DHS) or Oregon Health Authority (OHA) employees, volunteers and individuals offered employment or volunteer placement at DHS or OHA.

Section 1 — To be completed by the interview coordinator or local volunteer coordinator.
Please give instruction sheets separately so the subject individual can keep them.

Name of subject individual: ______ *(Last)* ______ *(First)* ______ *(Middle)*

Title of position: Student - District: Marion

☐ DHS Program: ☐ CW ☐ SSP ☐ OVRS ☐ APD ☐ DO ☐ Shared Services ☐ Central Services

X OHA Program: ☐ AMH ☐ DMAP ☐ DO ☐ OCCS ☐ OPHP X OSH ☐ PEBB/OEBB ☐ PH ☐ Shared Services ☐ Central Services

Subject individual is: ☐ New to agency ☐ Current employee ☐ Current volunteer

Position is: ☐ Permanent employment ☐ Temp/LD employment ☐ JOBS Plus client ☐ Volunteer position X Student intern ☐ Rotation

Requires direct contact with: ☐ Children X Adults X Elderly X Confidential information X Secure facilities ☐ Finances/financial records X Information technology systems

Requires driving to conduct state business? ☐ Yes ☐ No

Hiring manager or volunteer coordinator: Jeff Jessel/ Phone: 503.945.2892

Manager's worksite: Volunteer Services, Kirkbride B01-221
(Office) *(City)* *(District number)*

I have verified the identity of the subject individual.

☐ Current/valid goverment-issued photo ID checked: ☐ Name ☐ Date of birth ☐ Address ☐ Photo

☐ ID not available/current/valid. Explain: ______

______ *(Signature of interview coordinator or volunteer coordinator)* ______ *(Date)*

Date position offered:

Date 301HR sent to BCU:

BCU/HR Use Only

(For volunteers only)
Abuse fitness determination: ☐ Denied ☐ Closed ☐ Approved (*return to BCU* for *records check)*

Completed by HR analyst: ______ Date: ______

Start date may be set: ☐ Yes ☐ No If no: ☐ Preliminary FD needed ☐ Fingerprints pending File to HR: ______ ______ *(BCU staff initials) (date)*

Date prints requested: ______ By: ______ Date to OSP: ______
☐ Residency ☐ Identity ☐ Disclosed OOS DL ☐ Disclosed OOS criminal history ☐ MSO

Results
Potentially disqualifying abuse? ☐ Yes ☐ No Potentially disqualifying crimes? ☐ Yes ☐ No
ODL: ☐ Valid ☐ Suspended ☐ ID only ☐ None ☐ Concealed handgun license

Final fitness determination: ☐ Approved ☐ Restricted approval ☐ Denied ☐ Closed

Final FD made by: ☐ BCU ☐ HR : ______ ______
(Signature) *(Date)*

Notice of fitness determination (MSC 300 HR) must be issued to SI and a copy maintained.

Background Check Unit – Serving the Department of Human Services and the Oregon Health Authority

Section 2: To be completed by the subject individual. **Please read instructions first.**

Name: ______________________________ Date of birth: __________
(Last) *(First)* *(Middle)* *(Month/day/year)*

All other names used: __________________ SSN or INS number (*voluntary)*: __________

Sex: ☐ Male ☐ Female Driver's license ID number: __________________ State: __________

Street/mailing address: ______________________________ City: __________

State: __________ ZIP: __________ Daytime or message phone: __________

If additional space is needed for any of the following questions, attach additional pages.
If you disclose criminal or abuse history, attach your responses to "Questions to Answer." *(See instructions)*

During the last five years, have you been outside of Oregon for 60 days or more in a row? ☐ Yes ☐ No
If yes, list the locations and dates.

City/state/country:	**From *(month/year)*:**	**To *(month/year)*:**

Have you ever been involved with an abuse or protective services investigation as an accused person, reported perpetrator or alleged perpetrator, resulting in a founded or substantiated outcome? ☐ Yes ☐ No
If yes, complete the information requested below and attach your responses to "Questions to Answer." *(See instructions)*

Date *(or estimate)*:	**Allegation:**	**County:**	**State:**

Have you ever been charged, arrested and/or convicted of a crime? ☐ Yes ☐ No
If yes, complete information requested below and attach your responses to "Questions to Answer." *(See instructions)*

Date *(or estimate)*:	**Charge, arrest or conviction:**	**County:**	**State:**	**Outcome:**

I have read and understand the instructions for completing this form. I understand that an abuse check and a criminal records check will be completed on me and the information will be shared with the DHS or OHA Office of Human Resources, resulting in a fitness determination. My signature authorizes DHS or OHA to request and receive any police or investigation reports needed to complete this background check. I certify the information I have provided is correct and complete. I understand that if I provide false or incomplete information, I may be denied the position. I understand the check may be repeated during the time I hold this position. If a new check is requested. I will be required to be complete a new background check request form in order for a fitness determination to be completed.

______________________________ ______________________
(Signature of subject individual) *(Date)*

DHS Oregon Department of Human Services

SHARED SERVICES
Background Check Unit

Oregon Health Authority

301 HR

Background Check Request

Instructions for subject individual

Read all the instructions before completing the form.

Subject individual: The **"subject individual"** is the person whose history is being checked. **You, the subject individual, must complete page 2**.

Listing your social security number (SSN) is optional. If you do not provide your SSN, fingerprints may be required. If you do not have an SSN but do have an INS number, write in your INS number. The department requests the SSN or INS number solely for the purpose of positively identifying you during the criminal records check process.

Disclose all criminal history: You must accurately and completely disclose **all** history requested. This includes **all** criminal history *(felonies, misdemeanors, probation violations and failures to appear).* If you fail to list any part of your criminal history, you may be denied. Serious traffic offenses, such as Reckless Driving, Driving Under the Influence of Intoxicants (DUII) and Driving While Suspended (DWS) **must** be listed. Failure to Appear, even for a minor traffic violation, **must** be listed. If you are not sure if something should be listed, you should list it. For each arrest, charge or conviction, include the date, location and the outcome. Minor traffic, moving and non-moving violations are **not** required to be listed.

Abuse/protective service history: The department shall conduct an abuse check, reviewing any available child protective services or adult protective services investigations and reports. You must accurately and completely disclose all known abuse history in which you were accused person, reported perpetrator, or alleged perpetrator that resulted in a founded or substantiated outcome.

Questions to answer: If you have criminal or abuse history which is potentially disqualifying, the department will determine whether you are fit for the position for which you are applying by conducting a weighing test.

If you have any criminal or abuse history, you should provide the following information:

- What happened leading up to the arrest, charge, conviction or abuse investigation?
- List any requirements resulting from each arrest, charge conviction or founded/substantiated abuse.
- Describe any treatment, education and training specifically related to criminal or abuse history.
- How is your criminal or abuse history relevant to your job or position?
- How has your life changed since the criminal or abuse history?
- Explain why your history does not pose a risk for the department, its clients or vulnerable individuals.
- List any other information you believe would be helpful for the department in its weighing test.
- Attach documentation to support the information provided.

Outcome of background check *(you will be given a notice of fitness determination)*	**Denial:** Denials may occur for some convictions, unresolved arrests, probation violations, warrants, sex offender status, false statement about criminal history or founded/substantiated abuse. The department will conduct a weighing test. If you are denied you may not hold the position or job and must be terminated immediately. This decision may be appealed for DHS or OHA employment or JOBS Plus positions; for other positions, see your notice of fitness determination. **Approved:** You will be approved if you have no criminal history or abuse history or after a weighing test the department determines that more likely than not you pose no risk to the department, its clients or vulnerable individuals. An approved fitness determination does not guarantee employment or volunteer placement. **Restricted approval:** If you have potentially disqualifying criminal history, you might be approved to work or volunteer with restrictions to a specific client, specific work site or set of duties. This decision may be appealed for DHS or OHA employment or JOBS Plus positions, for other positions, see notice of fitness determination. **Case closed:** If you do not cooperate with this background check process, your application may be closed without a fitness determination. There are no appeal rights.

Instructions for subject individuals continued.

Authority: The Department of Human Services (DHS) and Oregon Health Authority (OHA) are authorized by state law (ORS 181.534, 181.537) to complete criminal records checks for DHS and OHA program administration. These checks are to determine whether or not you, the subject individual, more likely than not pose a risk to the department, its clients or vulnerable individuals. For complete information, including potentially disqualifying crimes and conditions, how fitness determinations are conducted and the appeals process, see Oregon administrative rules
407-007-0000 to 407-009-0100, 407-007-0400 to 407-007-0460 and 943-007-0000 to 943-007-0500. Checks are processed by the Background Check Unit (BCU).

Results: Results from this request shall be returned to the Office of Human Resources.

Sources checked: In doing this check, DHS or OHA may use information from the Driver and Motor Vehicle Services Division; Department of Corrections; Oregon State Police; Federal Bureau of Investigation; local, state and federal courts. DHS may use information from other criminal justice, corrections and law-enforcement agencies and other state and local government agencies. Fingerprints may be requested by DHS or OHA. In addition, DHS or OHA may check current and previous employers.

Challenging criminal information: If you want to obtain a copy of the criminal record or challenge information in it, the subject individual must contact the Oregon State Police, 503-378-3070, extension 330 *(for Oregon criminal history);* or local courts or the Federal Bureau of Investigation, 304-625-3878 *(for national criminal history).* You may request a copy of the national FBI report from the Background Check Unit. Depending on your previous contacts with law enforcement and courts, you may need to contact several sources to find your complete criminal history.

Challenging abuse information: If you want to review child protective services or adult protective services information, determine the origin of the investigation and then contact the local branch or the Office of Investigations and Training for further information.

Rechecks: This background check process may be repeated by DHS or OHA at any time while you work or otherwise continue in this position. If a new check is requested, you will be required to complete a new background check request form.

If you are employed by or volunteer for the department or have been offered employment or volunteer placement with the department, you must notify the Office of Human Resources within 5 days if you are arrested, charged or convicted for any misdemeanor or felony or if you are formally notified about being an accused person, reported perpetrator or alleged perpetrator in an abuse investigation.

This document can be provided upon request in alternate formats for individuals with disabilities or in a language other than English for people with limited English skills. To request this form in another format or language, contact the Background Check Unit *(toll free)* 1-888-272-5545 or 503-378-5470 or 711 for TTY.