Community Partner Registration

Contact Information

Name:_____ Work Cell Phone: _____

Cell Phone: _____ Company Name: _____

Working Title: _____

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

As a community partner for Oregon State Hospital (OSH), it is important to understand and remember that OSH is a secure psychiatric facility subject to many federal and state laws. OSH strives to keep all patients and visitors safe. Ensuring that you work within the scope outlined in your service contract will help OSH continue to focus on safety, treatment and recovery for the people we serve. You will be asked to wear an identification badge while you are on our campus.

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 visit to Oregon State Hospital, I understand that I may inadvertently become aware of Confidential Information

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it.

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 make inquiries about Confidential Information for or from people who do not have proper authorization to access such Confidential Information.

6. I will not make any unauthorized transmissions, inquiries, modifications, or purging of Confidential Information in Oregon State Hospital's computer system.

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

Signature: _____

Print Name: _____

Date: _____

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.

DHS Oregon Department of Human Services

SHARED SERVICES
Background Check Unit

Oregon Health Authority

301 HRC

Background Check Request

Use for department contractors

Section 1 — To be completed by the hiring unit.
Please give instruction sheets separately so the subject individual can keep them.

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

Title of position: _____ Work site: _____

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

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

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

Employee mgt. coach for division/program: Phone:

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

Requires driving to conduct state business? ☐ Yes ☐ No

Point of contact: _____ Phone: _____

Point of contact worksite: _____
(Office) *(City)* *(District)*

Interview coordinator: _____ Phone: _____

I have verified the identity of the subject individual.

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

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

_____ _____
(Signature of interview coordinator) *(Date)*

Date position offered:

Date 301 HR sent to BCU:

BCU/HR use only

Preliminary hire allowed? ☐ Yes ☐ No
By: _____ Date: _____

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

Results
Potentially disqualifying crimes? ☐ Yes ☐ No
ODL: ☐ Valid ☐ Suspended ☐ ID only ☐ None ☐ Concealed handgun license
Completed by BCU staff: _____ Date: _____

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.

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 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 charged, arrested and/or convicted of a crime? ☐ Yes ☐ No
If yes, complete the information requested below and attach answers 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 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 reports needed to complete this criminal records 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. I understand the check may be repeated during the time I contract for this service. If a new check is requested, I will be required to 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

Background Check Request

301 HRC

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.

Questions to answer: If you have criminal 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 history, you should provide the following information:

- What happened leading up to the arrest, charge or conviction?
- List any requirements resulting from each arrest, charge or conviction.
- Describe any treatment, education and training specifically related to criminal history.
- How is your criminal history relevant to your job or position?
- Explain why your history does not pose a risk to the department, its clients or vulnerable individuals?
- How has your life changed since the criminal history?
- 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. A weighing test will be conducted. If you are denied you may not provide the service for which you are contracting and your work must end 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 determined that more likely than not you pose no risk to the agency, 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 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 request 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.

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

You must notify DHS or OHA within 5 days if you are arrested or convicted for any misdemeanor or felony.

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 Background Check Unit *(toll free)* 1-888-272-5545 or
503-378-5470 or 711 for TTY.