OREGON STATE HOSPITAL
Volunteer Services
Tina Kotek, Governor

Oregon Health Authority

Kirkbride Building, B01-221
2600 Center Street NE
Salem, OR 97301
503-945-2892
Fax: 503-947-2471

Dear Prospective Volunteer:

Thank you for your interest in volunteering at Oregon State Hospital (OSH). This packet contains all the paperwork and instructions you will need to begin the process of becoming a volunteer. Volunteer assignments are subject to application screening results, available placements, and hosting department's approval.

1. Infection Prevention Requirements:

Covid Vaccination: Please note at this time, all OSH Staff, Contractors, Students/Interns and Volunteers are required to be Covid Vaccinated. This must be verified by the OSH Infection Prevention Office. You will need to provide a copy of your Covid Vaccination card to them. You may contact the Infection Prevention office at 503-945-2827 or via email at OSH.InfectionControl@odhsoha.Oregon.gov

Tuberculosis Assessment: OSH requires ***two-step*** tuberculin skin testing for anyone working at OSH. The TB skin tests are provided free of charge at OSH, to schedule an appointment with the Infection Prevention office please call 503-945-2827. ***Please note this will be four separate visits.*** The first visit the test is placed; on the second visit the health care provider reads the test. This process is then repeated. If you have completed a TB skin test within the last 12 months, you can provide a copy of the test to count as one of the required TB skin tests. These results must be sent to our Infection Prevention office via mail 2600 Center Street NE, Salem Oregon 97301, faxed to 503-945-2825 or via scan and send in a secure email to OSH.InfectionControl@odhsoha.Oregon.gov Your clinician can also complete the ***two-step*** TB Assessments or order a one-time blood draw. If you choose to go to your private clinic, the hospital cannot cover this expense. Results will need to be sent to the OSH Infection Prevention office. Please contact the Infection Prevention office if you have any questions regarding this information.

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Influenza Vaccination Declination: During flu season (October 1st through March 31st), OSH requires documentation of receipt of the influenza vaccination or declination of receiving this. If you have received an Influenza Vaccination for this flu season, please provide them with a copy of your vaccination confirmation provided to you by your prescriber (either private Practitioner's office or pharmacy). If you are not planning to get this vaccination, please complete and return the Influenza Vaccination Declination form (enclosed). Any questions regarding the influenza vaccination may be directed to our Infection Prevention office at 503-945-2827. You can fax your influenza vaccination proof directly to the Infection Prevention office at 503-945-2825.

2. Volunteer Registration – Complete, sign and return to our Volunteer Services office.

3. Confidentiality Agreement -- Read, sign, and return to our Volunteer Services office.

4. ORCHARDS Background Check Request – Complete, sign, ***attach a clear photocopy of your government issued drivers license or identification card (front and back),*** and return either via email or regular US mail to Volunteer Services Coordinator at the address listed on page 1 of this letter. Please note the screening might require fingerprints to be received through the ORCHARDS Background Check Unit. If you are requested to do so, an email with directions will be sent requesting you promptly complete this task.

You will be expected to attend an OSH Safety orientation scheduled after your application has been approved. Please return all materials by US mail, dropping them off to the Salem or Junction City Campus Reception Center clearly marked "Volunteer Services", or via scan and email to OSHVolunteer.Services@odhsoha.Oregon.gov

Thank you for your interest in volunteering with our agency. If you have any questions regarding this information, please call 503-945-2892 or email.

Sincerely,

Lenette McClellan, Volunteer Coordinator
Volunteer Services Department

LM24/enclosure

OREGON STATE HOSPITAL

Volunteer Services Department

Volunteer Background Screening Application / Authorization for Submission to ORCHARDS (Oregon Criminal History Abuse Record Database System)

QUALIFIED ENTITY: Lenette McClellan, Volunteer Coordinator
Oregon State Hospital, Salem – Marion County

Title of Position: _____ Type of Position: _____

Program/Department Manager: _____

Direct Contact: ☐ Adults, ☐ Seniors (65yrs and older), ☐ Confidential Information,
☐ Secure Facility, ☐ Information Technology, ☐ Finances / Financial Records

SUBJECT INDIVIDUAL (SI) PLEASE PRINT LEDGIBLY

(Last Name)	**(First Name)**	**(Middle Name)**
All other names used:		
Phone(include area code)	**Type of Phone (Home, Mobile, etc.)**	
Phone(include area code)	**Type of Phone (Home, Mobile, etc.)**	
Residence street address:		
City	**State**	**Zip code**
Have you lived outside of Oregon within the last 5 years? ☐ Yes ☐ No		
If Yes: City/State	**From: (MM/YYYY)**	**To: (MM/YYYY)**
Email Address:		
Gender: ☐ Male ☐ Female ☐ Unknown/Not Specified		
Date of Birth (MM/DD/YYYY)	**SSN or INS (voluntary)**	**Drivers License/ID State Issued:** _____ **Number:** _____ **Expiration Date:** _____

All fields on this form is required to be completed except for the SSN or INS field which is a voluntary field.

By signing this form, I am authorizing the Oregon State Hospital's Volunteer Services Department to submit the above information to ORCHARDS background check system as part of my volunteer application with the Oregon State Hospital.

Enclosed with this form I have provided a clear copy (front and back) of my government issued identification.

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").

During my 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 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 purging 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 from Oregon State Hospital's computer system to unauthorized locations (for instance, home).

7. If appropriate, 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 Confidentiality Agreement or of any Oregon State Hospital information security or privacy policy.

10. Upon termination of my assignment, 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 assignment.

12. I understand that violation of this agreement may result in disciplinary action, up to and including termination of assignment 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.

_____ _____

PRINT NAME OF VOLUNTEER *Signature of Volunteer:*

Date: _____

TO BE FILED IN VOLUNTEER INFORMATION RECORD
Original: Volunteer Information File
Copy (if requested): Volunteer
Confidentiality Agreement 2022

DECLINATION OF INFLUENZA (FLU) VACCINATION FORM

Volunteers/Interns/Students/Contractors & Other Service Providers

Volunteer/Intern/Student/Contractor or Other Service Provider 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.
- My refusal 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@odhsoha.oregon.gov 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: _____