Notice of and Consent to Background Investigation

Notice: Covenant Health and/or its affiliates intends to conduct an investigation, and/or obtain from consumer reporting agency information concerning your character, general reputation (including criminal records), personal characteristics, and mode of living for the purpose of determining your eligibility for volunteer service. By your signature below, you are affirmatively authorizing Covenant Health and/or its affiliates to request and use your report for volunteering purposes.

Consent: I hereby authorize Covenant Health and/or its affiliates to request and obtain a report on me as described above for purposes of evaluating my qualification for volunteering. I also understand that if a report from a consumer reporting agency is the basis for an adverse volunteer action, I can be furnished a copy of the report, and such additional information as may be required by the law. This authorization shall remain valid until I furnish Covenant Health a written notice of revocation.

Observer/Volunteer Signature **Date**

_____ _____

Print First Name: _____

Print Middle: _____

Print Last Name: _____

***Social Security Number:** _____-_____-_____ ***DOB:** _____

Address: _____

City: _____ **State:** _____ **Zip code:** _____

CONFIDENTIALITY AGREEMENT: I understand and agree that in the performance of my duties as a volunteer of Covenant Health, I may have access to confidential information regarding patient records, personal records, and hospital records. It is one of my most important responsibilities to protect the privacy and confidence of patients, employees, and the hospital. Any confidential information should be used only in the performance of duties. I understand that my failure to comply will result in disciplinary action, which may include discharge.

Observer/Volunteer Signature **Date**

_____ _____

CovenantHealth

SUPERVISING PROFESSIONAL AGREEMENT FOR OBSERVERS

I agree that the Observer's presence with me shall be for the purpose of observation only, and that he/she may not perform any procedures, either in assistance with me or individually. Observer agrees that he/she shall respect the wishes of any patient who objects to his/her presence and that he/she shall abide by the policies and procedures of all Covenant Health entities and comply with the provisions of the Health Insurance Portability and Accountability Act.

I agree that I shall be responsible for all the Observer's acts and omissions while he/she is with me at Covenant. I hereby release and hold harmless Covenant Health and all their related and/or affiliated entities along with their respective directors, officers, representatives, agents, licensees, and/or employees, of all liability, damages, causes of action, suits, claims, or judgments relating to Observer's participation with me at Covenant. This release and hold harmless shall be binding upon the Observers and my heirs, executors, administrators, and assigns.

1.) _____ _____

Signature of Supervising Professional **Inclusive Dates of Rotation**

_____ **Specialty: ☐ Medicine ☐ Surgery**

Printed Name

☐ Other: _____

Observer will rotate with me at: ☐ CMC ☐CCH ☐ CMG Clinic ☐ Hobbs ☐ Cath Lab

☐ Plaza ☐CSH ☐Grace Clinic ☐Grace Hospital ☐Covenant Plainview

☐Covenant Levelland ☐ Other - _____

2.) _____ _____

Signature of Supervising Professional **Inclusive Dates of Rotation**

_____ **Specialty: ☐ Medicine ☐ Surgery**

Printed Name

☐ Other: _____

Observer will rotate with me at: ☐ CMC ☐CCH ☐ CMG Clinic ☐ Hobbs ☐ Cath Lab

☐ Plaza ☐CSH ☐Grace Clinic ☐Grace Hospital ☐Covenant Plainview

☐Covenant Levelland ☐ Other - _____

_____ _____

Student - Print Name **Date**

_____

Student Signature

Providence

Providence SWEDISH | PROVIDENCE Health & Services | CovenantHealth | KADLEC | pacific medical centers

Student Health Requirements

In supporting and creating healthier caregiver communities and to promote our vision of Health for a Better World, our student/agency/vendor/contractor partners must have the following health requirements assessed before starting their regular work assignment /rotation/shadow/visitation in any Providence St. Joseph Health facility or affiliate building where patients are treated, or caregivers perform work.

Please provide documentation to your administrator to keep on file:

Health Requirement	Check
Annual Health Screen -CA HCC Caregivers Only Indicate free of infectious disease, able to work with or without accommodation (specify any accommodations needed) and signed by MD, DO, NP or PA	
Tuberculosis Testing -- Tuberculosis testing; IGRA or Q-Gold blood test or two-step tuberculin skin test current within the last 12 months, and annual as per ministry requirements. If history of positive please provide copies of chest x-ray results after positive TB test and medical clearance note from your provider.	
Measles, Mumps, Rubella (MMR) – Documentation of 2 MMR's at least four weeks apart after the age of one and/or positive laboratory titer. If laboratory titers are negative, one of the below actions must be completed: **1.** Written vaccination declination **2.** Acceptance of vaccine *(Rubella vaccination is required in Alaska in some ministries)*	
Varicella (Chicken pox) – Documentation of 2 doses of varicella at least four weeks apart and/or positive laboratory titer. If laboratory titers are negative, one of the below actions must be completed: 1. Written vaccination declination 2. Acceptance of vaccine	
Hepatitis B (Hep B) - Documentation of Hepatitis B vaccinations (series of 3 Engerix or Recombivax or 2 Heplisav) and positive laboratory titer. If laboratory titers are negative, one of the below actions must be completed: 1. Written vaccination declination 2. Acceptance of vaccine (*Hep B vaccination is required in Alaska in some ministries*)	
Tetanus, Diphtheria & Pertussis (**Tdap) –** Documentation of vaccination/booster or signed declination	
Annual influenza vaccine -- Documentation of vaccination or signed declination, including reason for declining. Must follow masking requirements of setting.	
COVID vaccination- Documentation of updated (most current) COVID-19 vaccine or a written declination for medical or religious purposes. Please refer to local policy for masking requirements.	
Respirator Training: Respiratory Protection (PAPR or N95 Fit Mask Testing), if required by setting or functions performed. If prior training is not for device provided by PH&S, PH&S will provide training/testing as appropriate.	

I understand the declination of some vaccines may limit the locations where I am able to work. I hereby attest that I provided my administrator all the necessary medical documentation as outlined above in order to meet the health requirements of Providence St Joseph Health. I have done this to protect myself, our patients, colleagues, and the community.

Signature	Printed Name	Date

Administrator Signature	Printed Name	Date

Ideas on where to obtain your childhood and adult immunization immunity records:

- Previous health care employers or any schools you have attended
- Your family Physician or the Health Department where you grew up, which may take a couple weeks.
- Call your state **Immunization Registry Help Desk** as they may have record of your immunizations and can send them to you.

Ideas in where to receive vaccinations:

- Your Primary Care Provider or other walk-in clinics
- Local and national pharmacy stores/chains, some located in grocery stores chains.
- Family Practice Residency programs
- Low income or sliding scale clinics
- Local Health Department

Providence

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CAREGIVER HEALTH SERVICES

PLEASE RETURN COMPLETED FORM TO CAREGIVER (EMPLOYEE) HEALTH SERVICES

COVID-19 Declination Form 2024-2025

Providence St. Joseph Health and its family of organizations requests caregivers participate in the COVID-19 vaccination process by either being vaccinated or completing a written declination.

LEGAL NAME:_____ DOB: _____ EMPLOYEE ID#_____

CAMPUS/SITE:_____DEPT:_____PHONE:_____

IF NOT EMPLOYED BY PROVIDENCE, CHECK ONE:

☐ Medical Provider ☐ Volunteer ☐ Agency/Contractor ☐ Student ☐ Other

I AM DECLINING A COVID-19 VACCINE. I ACKNOWLEDGE THAT I AM AWARE OF THE FOLLOWING FACTS:

- *COVID-19 can cause severe illness or death and you can continue to have long-term health issues after COVID-19 infection. The level of protection people get from a COVID-19 infection may vary depending on how mild or severe their illness was, the time since their infection, and their age.*
- *Getting a COVID-19 vaccine can provide added protection for people who have already had COVID-19.*
- *Getting a COVID-19 vaccine is a safer and more dependable way to build immunity than getting sick with COVID-19, as vaccination causes a more predictable immune response than an infection with the virus that causes COVID-19.*
- *COVID-19 vaccines are recommended for healthcare workers because of the potential for workplace exposure and because of the vulnerability of the patients and residents they care for.*
- *COVID-19 vaccines help prevent severe illness, hospitalization, and death. Unvaccinated people are more likely to get COVID-19 and much more likely to be hospitalized and die from COVID-19, compared to people who are up to date with their COVID-19 vaccinations.*
- *COVID-19 vaccination is recommended for people who are pregnant, breastfeeding, or trying to get pregnant, as well as people who might become pregnant in the future. COVID-19 vaccination during pregnancy helps prevent severe illness and death and helps protect babies younger than 6 months old from hospitalization.*
- *Persons infected with COVID-19 virus, including those who are pre-symptomatic, can transmit the virus to coworkers and patients, some of whom may be at higher risk for complications from COVID-19.*
- *Some people are more likely than others to get very sick if they get COVID-19. This includes people who are older, are immunocompromised, have certain disabilities, or have underlying health conditions.*
- *Side effects after a COVID-19 vaccination tend to be mild, temporary, and like those experienced after routine vaccinations. Serious side effects are rare but may occur.*
- *I understand I must follow all current infection prevention policies and procedures for my location, such as masking, to limit the possibility of transmission of the virus.*
- *I understand that I can change my mind and agree to provide my vaccination record if I receive the vaccine in the future.*

Resources for future reference:

COVID-19 Vaccine Frequently Asked Questions | COVID-19 | CDC

Myths & Facts About COVID-19 Vaccines | COVID-19 | CDC

Healthcare Worker Vaccination is Important for Respiratory Virus Season | Blogs | CDC

I am declining the COVID-19 vaccine because of:

☐ My Licensed independent practitioner-documented allergy or medical contraindication to the components of the vaccine

☐ My religious beliefs, including my sincerely held ethical or moral beliefs

ELECTRONIC SIGNATURE ACKNOWLEDGEMENT AND CONSENT FORM

I, _____, agree and understand that by signing the Electronic Signature Acknowledgment and Consent Form, that all electronic signatures are the **legal equivalent** of my manual/handwritten signature and I consent to be legally bound to this agreement.

Signature:_____ **Date:**_____

Caregiver Health Services

Seasonal Influenza Declination Form 2025-2026

Providence and its family of organizations offers the influenza vaccine free of charge to caregivers, volunteers, students, employed & non-employed providers, and contracted employees in accordance with the annual CDC recommendations. By being vaccinated, you are protecting yourself, your patients, your family, and the community.

NAME: _____ **DOB:** _____ **EMPLOYEE ID#** _____

CAMPUS/SITE: _____ **DEPT:** _____ **PHONE:** _____

IF NOT EMPLOYED BY PROVIDENCE (Check one):

☐ Licensed Practitioner ☐ Volunteer ☐ Contractor ☐ Student ☐ Other

I AM DECLINING THE INFLUENZA VACCINE (FLU SHOT). I ACKNOWLEDGE THAT I HAVE BEEN PROVIDED THE FOLLOWING INFORMATION:

- Influenza is a serious respiratory disease that millions of people get every year. Hundreds of thousands are hospitalized, and thousands to tens of thousands die from flu-related causes. (2)
- Influenza vaccination is recommended for me and all healthcare workers to protect our patients from influenza disease, its complications, and death. (3)
- People infected with influenza virus, including those who are pre-symptomatic, can transmit the virus to coworkers, family members, and patients, some of whom may be at higher risk for complications from influenza. (3)
- Influenza vaccination is the most important measure to prevent seasonal influenza infection and the resulting potential complications for staff, their families, our patients and co-workers. (3)
- Influenza vaccination is recommended every year because immune protection declines over time and the virus is constantly changing. (4)
- The influenza vaccine contains inactivated virus or virus proteins which means it is not infectious therefore you cannot get influenza (the Flu) from the vaccine. (1)
- Side effects of the vaccine are usually mild and of short duration. (1)

- I understand the vaccine offered to me through Caregiver Health Services is preservative and latex free. An egg-free version of the vaccine may also be available, check with your local Caregiver Health office.
- I understand that I can change my mind and accept the vaccination at any time during the campaign, usually September through March, and through June if supplies are available.
- I understand I must follow any masking requirements in my ministry or region and commit to doing so.

I AM DECLINING THE INFLUENZA VACCINE (FLU SHOT) BECAUSE OF:

☐ As an accommodation for my documented medical condition.

☐ My religious or my sincerely held ethical or moral beliefs.

I, _____ , agree and understand that by signing the Electronic Signature Acknowledgment and Consent Form, that all electronic signatures are the **legal equivalent** of my manual/handwritten signature and I consent to be legally bound to this agreement.

Signature: _____ **Date:** _____

References:

1. https://www.cdc.gov/flu/vaccine-safety/index.html
2. https://www.cdc.gov/flu-burden/php/data-vis/2024-2025.html
3. https://www.cdc.gov/flu/hcp/infection-control/healthcare-settings.html
4. https://www.cdc.gov/flu/vaccines/keyfacts.html#cdc_generic_section_5-vaccine-match

Caregiver Health Services

Seasonal Influenza Attestation Form 2025-2026

Providence and its family of organizations offers the influenza vaccine free of charge to caregivers, volunteers, students, employed & non-employed providers, and contracted employees in accordance with the annual CDC recommendations. By being vaccinated, you are protecting yourself, your patients, your family, and the community.

NAME: _____ **DOB:** _____ **EMPLOYEE ID#** _____

CAMPUS/SITE: _____ **DEPT:** _____ **PHONE:** _____

IF NOT EMPLOYED BY PROVIDENCE (Check one):

☐ Licensed Practitioner ☐ Volunteer ☐ Contractor ☐ Student ☐ Other

ATTESTATION: I attest I have received my influenza vaccine elsewhere for the 2025-2026 season.

Where was it received? _____

Who provided it? _____

Vaccine Type?

☐ Influenza ☐ Influenza - Egg Free ☐ Influenza – High Dose ☐ Influenza - FluMist

Date of Vaccination: _____

By typing your name on the line below, you certify that (i) you are the individual completing the form; (ii) all information entered on this form is true and accurate to the best of your knowledge; (iii) you agree with all terms and conditions as listed on this form; and (iv) you consent to typing your name as the means of providing your signature electronically and that such electronic signature is valid.

Vaccination must have taken place between August 1st 2025, and March 31st, 2026. Any misrepresentation in providing vaccination information in the Influenza Attestation of Vaccination Received Elsewhere may result in disciplinary action including and up to termination of employment. The information provided in support of my Influenza Vaccination Received Elsewhere is truthful and accurate. Providence St. Joseph Health reserves the right to request appropriate and/or legal documentation reflecting the proof of my Influenza Vaccination Received Elsewhere.

Signature: _____ **Date:** _____