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