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. OBSERVERS MUST WEAR A SHIELD AND MASK UNLESS THEY PROVIDE PROOF OF RECEIPT OF THE COVID-19 VACCINE PRIOR TO THEIR ROTATION, AND MUST NEVER BE IN COVID UNITS. 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

Consent and Release of Medical Information

Name:_____ Date of Birth: _____
Last First Middle

I authorize the Providence Health & Services designee(s) to administer immunization(s), TB skin testing/TB blood testing, and other preventative, or diagnostic treatments for illness or injury sustained during the course of my work. This Authorization also includes treatment for minor non-industrial injuries/illnesses.

This authorization does not prevent me refusing treatment at a later date. It remains in effect during my volunteer assignment at any Providence Health & Services and Kadlec facility. Commonly administered injections include TB skin test, tetanus & diphtheria, tetanus, diphtheria & pertussis, MMR (measles, mumps & rubella), varicella and influenza. Additional testing may be ordered, such as chest x-rays or lab testing. This is to rule out Tuberculosis and test for immunity status.

All individually identifiable information in the Caregiver Health Service (CHS) record is maintained in said department in accordance with state and federal statutes and regulations. Information will be disclosed if that information is deemed relative regarding suitability for volunteering, ability to perform essential volunteer functions.

In the event of a work-related injury/illness sustained while volunteering at Providence Health & Services and Kadlec, information may be provided to those involved in the administration of my Workers Compensation Claim.

- **Work related incidents/injuries need be reported to your Volunteer Coordinator.**
- **Communicable disease related illnesses/exposures should be reported to Caregiver Health.**

Findings of initial health screen and any other examinations will be reviewed by the CHS nurse or designee. I have read this document and I have been given an opportunity to ask questions.

Volunteer Signature:_____ Date: _____

CHS Representative:_____ Date:_____

Parental Consent

_____#_____
(PRINT Parent/Legal Guardian Name) **Phone number**

I give Providence Caregiver Health Services permission to draw blood for Tuberculosis Testing and titers.

X_____ Date: _____
Signed by parent or legal guardian for volunteer/student under 18 years of age

New Volunteer, Intern and Observer Health Screening

Welcome to Providence!

To protect you and our vulnerable patients, certain health requirements must be met before you start volunteering. Please complete this packet and bring it to your health screen appointment, along with your photo ID and immunization records.

Immunization and Titer records

Please bring as much documentation as possible regarding the tests and immunizations listed below. This will prevent the duplication of testing and/or vaccinations.

- **Measles, mumps, and rubella (MMR) –** Documentation of two MMR vaccines at least 4-weeks apart and/or positive titers
- **Chickenpox (varicella) –** Documentation of two varicella vaccines at least 4-weeks apart and/or positive titer
- **Tetanus, diphtheria, and pertussis (Tdap)** – Documentation of vaccination
- **Annual influenza vaccine –** Documentation of acceptance or declination of the vaccine
- **COVID Vaccines** – Documentation of vaccination

If you need help obtaining your immunization records, check with your physician, previous employers, schools or contact the health department where you grew up.

We strongly encourage you to gather your records as soon as possible.

It may take several weeks to obtain your records.

Please bring all your records to your health screening appointment.

Thank you

Volunteer Screening Form

Name:_____ Date of Birth:_____ Gender: _____
Last First Middle

Address:_____ City:_____ State: _____ Zip: _____

Email address: _____

Phone number:_____ Alternate phone number: _____

Best time to call:_____ Supervisor: _____

Region:_____ Facility/Department:_____ Position: _____

Start date: _____

Please complete the following to the best of your knowledge. This will become a part of your Caregiver Health Services (CHS) file. All medical information is confidential.

I understand the following:

☐ **Yes** I understand, if applicable, I am willing and able to wear required safety equipment such as gloves or a surgical mask, on the job.
If no, please explain:_____

☐ **Yes** I understand, if I have ever had any reaction to any latex product (e.g., rash, swelling, anaphylaxis, burning after contact) that I would inform my Caregiver Health Services professional.

☐ **Yes** I understand that titers will be drawn, and I will be notified of my immune status and if I am not immune, I may be vaccinated Caregiver Health Services.

☐ **Yes** ☐**NA** I am under age 18 and understand that I must being in my immunization records from by my primary care provider. I must have my parent's signature before any procedures can be done.

Applicant signature:_____ Date: _____

Caregiver Health signature:_____ Date: _____

Providence St. Joseph Health

TUBERCULOSIS SCREENING QUESTIONNAIRE

Name:_____ **Date of Birth:**_____ **Caregiver ID #:**_____
Last First Middle

Dept:_____ **Home/Cell Phone #:** _____

☐**Caregiver/Applicant** ☐**Volunteer** ☐**Other:** _____

DO YOU CURRENTLY HAVE SYMPTOMS OF:		**If yes, please explain**
1. Persistent and/or productive cough for more than three weeks?	☐Yes ☐No	
2. Cough for more than one week following confirmed TB exposure?	☐Yes ☐No	☐N/A
3. Prolonged low grade fever associated with cough for more than 1 week?	☐Yes ☐No	
4. Blood present in sputum?	☐Yes ☐No	
5. Unexplained night sweats (unrelated to menopause)?	☐Yes ☐No	
6. Unusual fatigue for more than two weeks?	☐Yes ☐No	
7. Loss of appetite for more than two weeks?	☐Yes ☐No	
8. Unexplained weight loss of five pounds or more?	☐Yes ☐No	
CURRENT HEALTH STATUS:		**If yes, please explain**
9. Do you have an acute viral infection or febrile illness?	☐Yes ☐No	
10. Have you had a live-virus vaccine in the past four weeks?	☐Yes ☐No	
11. Are you on or planning to begin immunosuppressive therapy or treatment for: diabetes, human immunodeficiency virus (HIV) infection, organ transplant recipient, undergoing radiation therapy, chemotherapy, treatment with a TNF-alpha antagonist (e.g., Infliximab, etanercept, or other), chronic steroids (equivalent of prednisone >15 mg/day for >1 month) or other immunosuppression medication? (*)	☐Yes ☐No	
HISTORY:		**If yes, please explain**
12. Have you lived or visited (more than one month) in a country with a high TB rate? (Any country other than the United States, Canada, Australia, New Zealand and those in northern Europe or Western Europe). (*)	☐Yes ☐No	
13. Have you had unprotected close contact with someone who has had infectious TB disease in the past 12 months or since your last TB test? (*)	☐Yes ☐No	Relationship:
14. Have you received the BCG vaccination?	☐Yes ☐No	
15. Have you ever had a positive TB skin or blood test?	☐Yes ☐No	Date:
16. Have you had a chest x-ray related to TB?	☐Yes ☐No	Date:
17. Have you ever been treated with TB medications?	☐Yes ☐No	

Please note: HIV infection and other medical conditions may cause a TB test to be negative even when TB infection is present. Persons with HIV infection and certain other medical conditions that may suppress the immune system are at significant risk of progressing to TB disease if they have TB infection. If you have HIV infection or other medical conditions that may suppress the immune system, discuss your risk of TB with your primary care provider.

To my knowledge, the above information is correct. I consent for an IGRA (TB) blood test, and/or chest x-ray, if applicable.

Applicant/Caregiver Signature:_____ **Date:** _____

For Clinic Use Only

(*) Risks: if any one question is marked yes, refer back to TB algorithm.

***(!)* Any questions 1-8 marked positive refer to TBQ Scoring Grid Standard Work.**

Caregiver Health Nurse Review: Based on current TB algorithm, I have reviewed the above and recommend:
☐IGRA ☐TST ☐Symptom review only

Caregiver Health Nurse Name (print):_____ Signature:_____ Date: _____

IGRA: Draw Date:_____ Review Date:_____ IGRA Results: ☐Negative ☐ Positive

IGRA: Draw Date:_____ Review Date:_____ IGRA Results: ☐Negative ☐ Positive

Follow-up Action: ☐ No further follow up needed CHN Name:_____

CXR ordered; Date:_____ Results: ☐Negative ☐ Positive CHN Name:_____

For known history of positive TB test: TST on file? ☐Yes ☐No Date:_____ If yes, IGRA drawn? ☐Yes ☐ No

IGRA on file? ☐Yes ☐ No Date:_____ CXR on file? ☐Yes ☐ No Date:_____ Results: ☐ Neg ☐ Pos