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**

____

Printed Name

Specialty: ☐ Medicine ☐ Surgery

☐ 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**

____

Printed Name

Specialty: ☐ Medicine ☐ Surgery

☐ 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

New Volunteer 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.

- **Tuberculosis testing –** Interferon Gamma Release Assay (IGRA), which is a blood test for TB, that is current within the last 30 days. Quantiferon Gold or T-spot is acceptable. If there is a history of positive TST (TB skin test) or IGRA, please bring copies of chest x-rays, medical provider documentation, and previous positive test results.
- **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.

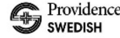
We strongly encourage you to gather your records as soon as possible.

It may take several weeks to obtain your records.

Please bring all your records to your health screening appointment.

Thank you

Providence



Caregiver Screening Form

Name: ______________________________ Preferred Name: ___________________ Date of Birth: __________
Last First Middle

Address: _____________________________________ City: _______________ State: ______ Zip: ____________

Email Address: ____ Preferred Pronoun: ___________________

Phone number: ________________________________ Alternate phone number: _________________________

Best time to call: __________ Supervisor: ______________________________ Region: ____________________

Facility/Department: ______________________________ Position: ____________________________________

Please complete the following to the best of your knowledge. This will become a part of your caregiver health file. All medical information is confidential. If you have any questions, please call Caregiver Health Services (CHS).

❑ **Yes** ❑ **No**	If applicable, are you willing and able to wear required safety equipment such as gloves, glasses, respirators, masks, or ear protection on the job? If no, please explain:____
❑ **Yes** ❑ **No**	I understand the primary job duties for the position for which I am being hired and am mentally and physically capable of performing them.
❑ **Yes** ❑ **No** ❑ **N/A**	Are any reasonable accommodation(s) needed for you to perform the primary job duties of the position for which you are being hired? If yes, please specify accommodations required:______________________________
❑ **Yes** ❑ **No**	Are you taking medications which may impact your ability to safely perform the functions of your position or otherwise pose a safety concern?
❑ **Yes** ❑ **No** ❑ **N/A**	If you are being hired in Oregon or Washington, have you been placed in the Preferred Worker Program under workers' compensation laws?
❑ **Yes** ❑ **No**	Have you ever had an allergic or adverse reaction to any latex product? Which product(s)? ❑latex gloves ❑balloons ❑poinsettia plant ❑condoms ❑clothing with elastic or stretchy fabrics ❑elastic bandages ❑dental dams ❑other If other, please describe__________________________________ What type of reaction to latex products do you have (please check all that apply)? ***Skin reaction***: ❑itchy ❑red ❑inflamed ❑scaly ❑dry and cracked ❑blistered ***Respiratory***: ❑allergic rhinitis ❑asthma ***General***: ❑allergic general urticaria (itchiness and/or rash all over) ❑hives in area of contact ***Anaphylaxis*** ❑
❑ **Yes** ❑ **No** ❑ **N/A**	Have you been evaluated for these symptoms and diagnosed with a latex sensitivity/allergy? If yes, what restrictions or accommodations were recommended by your provider? ____
❑ **Yes** ❑ **No**	Do you have any communicable condition that may be potentially transmitted to others in the hospital or health care setting?

ELECTRONIC SIGNATURE ACKNOWLEDGMENT 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.

Applicant signature: ____ Date: ____________________________

Reviewed by: ____ Date: ____________________________

Providence

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

TB RISK ASSESSMENT AND SYMPTOM SCREENING QUESTIONNAIRE

Name: ______________________________ Preferred Name: ______________________________
Last First Middle
Date of Birth: ____________________ Caregiver ID #:____________________
Dept: ______________________________ Home/Cell Phone #: ______________________________
☐Caregiver/Applicant ☐Volunteer ☐Other: ______________________________

DO YOU HAVE SYMPTOMS OF		If yes, please explain
1. Persistent and/or productive cough for more than three weeks? (Exceptions: Cough due to asthma, allergies, COPD, or residual cough from recent Covid-19 infection)	☐Yes ☐ No	
2. Cough for more than one week following confirmed TB exposure?	☐Yes ☐ No	☐N/A
3. Prolonged low-grade fever (98.9) 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	
9. Do you have unexplained shortness of breath lasting more than two weeks?	☐Yes ☐ No	
10. Do you have unexplained pain in your chest lasting more than two weeks?	☐Yes ☐ No	
11. Do you have unexplained hoarseness lasting more than two weeks?	☐Yes ☐ No	
CURRENT HEALTH STATUS		**If yes, please explain**
12. Do you have an acute viral infection or febrile illness?	☐Yes ☐ No	
13. Have you had a live-virus vaccine in the past four weeks?	☐Yes ☐ No	
14. 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**
15. 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	
16. Have you had unprotected close contact with someone who has had infectious TB disease during your lifetime or since your last TB test? (*) (Exception: Not including any close exposure in the last 8 weeks)	☐Yes ☐ No	Relationship:
17. Have you received the BCG vaccination?	☐Yes ☐ No	
18. Have you ever had a positive TB skin or blood test?	☐Yes ☐ No	Date:
19. Have you had a chest x-ray related to TB?	☐Yes ☐ No	Date:
20. 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.

ELECTRONIC SIGNATURE ACKNOWLEDGMENT 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.

Applicant/Caregiver Signature: ______________________________ **Date:** ____________________

For Clinic Use Only
(*) Risks: if any one question is marked yes, refer back to TB algorithm.   *(!)* **Any questions 1-11 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 (Printed): ____________________ Signature: ____________________ Date: ____________________

Providence

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

Consent and Release of Medical Information

Name:____ Date of Birth: ____________________

Last First Middle

Preferred Name: ____________________________________

I authorize designees of the Providence family of organizations 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 employment at any facility that is part of the Providence family of organizations. Commonly administered injections may include Tuberculosis skin test, Tetanus & Diphtheria, Tetanus, Diphtheria & Pertussis, Hepatitis B, Hepatitis A, MMR (Measles, Mumps & Rubella), Varicella, Meningococcal, Covid-19, and Influenza. Additional testing may be ordered, such as chest x-rays or lab testing.

For your continuity of care, all of your laboratory and diagnostic imaging reports ordered by Caregiver Health will become a part of your electronic Caregiver Health record.

All individually identifiable information in the employee health record is maintained in the Caregiver Health Services (CHS) department in accordance with state and federal statutes and regulations. Information will be disclosed if that information is deemed relative regarding suitability for employment, ability to perform essential job functions or significant job change or transfer.

In the event of a work-related injury/illness sustained during employment at any facility that is part of the Providence family of organizations, information may be provided to those involved in the administration of your Workers' Compensation Claim.

I hereby certify that the above statements are true to the best of my knowledge and that intentional misstatements may result in the withdrawal of my conditional offer or the immediate termination of my employment. I consent to post-offer health screening and test by a physician or other qualified health professional appointed by any facility that is part of the Providence family of organizations, if necessary. I understand that any information disclosed during this pre- employment health screen and the results of this health screen will be provided to the facility that is part of the Providence family of organizations where I am employed. By my signature below, I am expressly authorizing disclosure of this information with my ministry, affiliate and/or clinic employer.

ELECTRONIC SIGNATURE ACKNOWLEDGMENT 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.

Applicant Signature: ____Date: _________________

CHS Representative: ____Date: _________________