Job Shadow Registration

Student Contact Information

Name:_____ Home Phone: _____

Address:_____ Cell Phone: _____

City, State, Zip: _____ Email: _____

DOB: _____

Emergency Contact Information

Emergency Contact: _____

Emergency Contact Phone: _____

College Information

School:_____ Hours Required Per Week: _____

Advisor/Faculty: _____ Advisor/Faculty Phone: _____

OSH Rotation Start Date: _____ OSH Rotation End Date: _____

Assignment

Study/Program :_____ Hours Required Per Week: _____

OSH Supervisor: _____ Unit Assignment if Applicable: _____

Does your school provide Workman's Compensation during your placement? _____

Do you have any health restrictions? (Describe if applicable): _____

_____

As a person participating in a Job Shadow, your role is to observe the work of the staff person you are shadowing. Oregon State Hospital (OSH) expects everyone visiting the hospital to respect the patients and follow hospital policies. You will be asked to wear an identification badge and will be escorted by a staff person the entire time you are on campus. OSH is a place for people to work towards safety, obtain treatment, and find recovery. OSH strives to maintain a place of autonomy for the people we serve.

I have read and understand the above conditions of service: _____

Signature

_____

Date

OREGON STATE HOSPITAL
HOPE • SAFETY • RECOVERY

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").

In the course of my visit to Oregon State Hospital, I understand that I may inadvertently become aware of Confidential Information

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it.

2. I will not access or view any Confidential Information, or utilize any Oregon State Hospital equipment.

3. I will not make inquiries about Confidential Information for or from people who do not have proper authorization to access such Confidential Information.

4. I will not make any unauthorized transmissions, inquiries, modifications, or purging of Confidential Information in Oregon State Hospital's computer system.

5. I understand that violation of this Agreement may result in legal liability.

By signing this document I understand and agree to the following: I have read this entire agreement and agree to comply with all its terms.

Signature: _____

Print Name: _____

Date: _____

OREGON STATE HOSPITAL Infection Prevention and Employee Health TB RISK FACTOR FORM

(If you have documentation please provide, if not OSH will provide)

Name _____ Unit/Dept. _____

Date of last chest x-ray _____

In order to determine your current TB status please answer the following questions:

Once you have had a chest x-ray, as long as you do not exhibit symptoms indicative of active disease, you do not need to have the chest x-ray repeated. You may, however, have the chest x-ray repeated upon request at any time. If you do not have a chest x-ray on file within the last 10 years, you may want to consider updating your baseline chest x-ray for future comparison.

	NO	YES	DATE
1. Close exposure to a person with known communicable pulmonary tuberculosis within the previous two (2) years. (Neither you, nor the person, were wearing a mask.)	____	____	_____
Subjective symptoms during past year			
2. Cough of more than three (3) weeks duration	_____	____	
3. Bring up sputum every day for one or more weeks	____	____	
4. Spitting up blood (hemoptysis)	_____	____	
5. Tires easily	_____	____	
6. Loss of appetite	_____		
7. Unexplained weight loss (8 pounds or more)	_____	____	
8. Night sweats	_____	____	
9. Fever/chills (more than one week duration)	____	____	

Date _____ Signature of Employee_____

Reason for review: ☐ New Employee ☐ Risk Assessment ☐ TB Exposure

Chest x-ray: ☐ Ordered ☐ Not ordered

Date _____ _____

Signature Infection Control/Employee Health Practitioner

OREGON STATE HOSPITAL

Infection Prevention and Employee Health

Tuberculosis Status Requirements

for

Volunteers/Students/Interns

(If you have documentation please provide, if not OSH will provide)

You must show proof of a TB test within 1 year prior to work. The dates must be legible on your documents. History of a "positive" TB is acceptable. All positive TB tests require proof of a chest x-ray and a copy of the final report must be provided to OSH.

Oregon State Hospital (OSH) requires a Tuberculosis (TB) Screening of all employees, patients, volunteers, students and interns within the hospital. You may accomplish this through your personal Healthcare Provider, the County Health Department or through your School's Health Service Department.

A TB Screening needs to be completed before you start working and is repeated yearly if you have a history of a positive TB test.

Part I: Volunteer/Student/Intern INFORMATION

Name (Last-**PLEASE PRINT**)	(First-**PLEASE PRINT**)	(middle initial)

Birthdate	Gender	Primary Telephone:	Message Telephone:

Address	City	ST	ZIP

I authorize the release of my TB Test information and CXR report (if applicable) to the Oregon State Hospital.

_____ _____

Signature of Applicant Date

Check All that Apply: (copies of original documents must be attached. This form will NOT be ACCEPTED without documentation unless signed by a Healthcare Provider)

PART 2

Type of TB Test: ☐ **Skin Test** (Tine not accepted) ☐ **Blood Test** (skip to **PART 3**)

For skin test only: Date test placed: _____

Date test read: _____ Result in millimeters_____mm

("negative" is not acceptable)

Date of last chest x-ray: _____ Results: _____ TB Symptoms Screening form attached ☐

Forms and documentation sent to IPEH ☐

For Positive Tests ONLY

PART 3

For Blood Test Only:

Date of result: _____ Result (check one) ☐ Positive ☐ Negative ☐ Indeterminate

Date of last chest x-ray: _____ Results: _____ TB Symptoms Screening form attached ☐

Forms and documentation sent to IPEH ☐

For Positive Tests ONLY

_____ _____

PLEASE PRINT Name of Person Completing this form Signature of Person Completing this form

_____ _____

Name of Institution (If Healthcare Professional) Office phone

2016-2017 DECLINATION OF INFLUENZA (FLU) VACCINATION FORM

VOLUNTEERS/INTERNS/STUDENTS/CONTRACTORS ONLY

(If you have documentation please provide, if not OSH will provide)

Volunteer/Intern/Student 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.
- The consequences of my refusing 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@dhsoha.state.or.us , 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: _____

Centers for Disease Control & Prevention. Prevention and Control of Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices.