Salem Health
Hospitals & Clinics

Student Health Services/Volunteer Form Packet
Volunteer Services

GUIDELINES
This sheet must be completed and submitted as part of your student form packet.
Initial on each blank line to verify you have read and agree to each item.

_____ I understand that I must be at least 14 years old to participate.
_____ I have read the documents in this form packet and have signed each one.
_____ I understand that a parent or guardian must sign on each form with me as indicated if I am under 18.
_____ I understand I must turn in this completed form packet to my Health Services teacher.
_____ I understand that I may not be allowed to participate in the Health Services program if my form packet does not meet the program's minimum standards.
_____ I understand that being a Health Services 2 student I will be required to fill out the TB (Tuberculosis) History and Screening form and will be required to get a TB test.
_____I understand that I may be required to wear a mask and other PPE while volunteering at the hospital, and despite diligent hygiene measures and compliance with the regulations, the hospital cannot guarantee that infectious transmissions (i.e. COVID-19) will not occur.

Printed Name: _____

Signature: _____

Date: _____

FORM PACKET INSTRUCTIONS
1. Print this packet. Read all the forms included and sign off on everything you can to complete them.
2. If you have any questions regarding this Form Packet, please connect with your teacher or Volunteer Services 503-814-1793
4. This form packet must be completed and turned in to be considered to visit Salem Health.
5. Health OC 1 students do not need to fill out the last form: TB History & Screening.

Salem Health
Hospitals & Clinics

Personal Appearance Standards
Volunteer Services

The personal appearance of participants of Volunteer Services & Career Exploration programs at Salem Health is important to the impression that our patients, their families, visitors and other customers have about each of us and of Salem Health. Our program participants will dress with taste and discretion to convey a clean, well-groomed, professional appearance.

Dress Element	Expectations
ID Badge	• Worn at all times. • Easily readable. • Worn above the waist.
Hair & Personal Hygiene	•Volunteers must maintain clean personal hygiene. Considerations should be used in the application of personal care products to be unscented or fragrance-free whenever possible. Perfumes, colognes, after shaves, and other heavily scented/fragranced personal care products are not permitted. •Grooming is essential for the overall professional appearance of all workforce members. In a healthcare environment, including all clinical and non-clinical areas, it is important for workforce members to be clean and well groomed. •Hair must be clean, neatly trimmed, and contained in such a manner that it does not come in contact with patients. Hairstyles, hair color, and cosmetics should project a professional image.
Jewelry	•Jewelry should be small and simple.
Fingernails	• Clean, trimmed to a length that will not interfere with participation. • Nail polish un-chipped and freshly applied. • Adornments limited.
Fragrance	• All personal care products must be unscented or fragrance-free.
Tattoos	•Any visible tattoo that includes the following is unacceptable: gang-related images or language; prison/crime/drug-related tattoos; offensive/profane language; images depicting any type of nudity or sexual images; images showing any type of intolerance, racism, hate, or bigotry; tattoos with “dark” images related to death or pain (e.g., skulls or demons); or anything that, in the judgment of management, is considered to be offensive to others.
Clothing	•Clothing and attire must be clean, neat, and in good condition. Tops should not be overly tight, revealing, or contain any large logos. Bottoms (slacks, jeans, leggings, etc.) must be past the level of your knee, free of rips/holes or obvious stains, and opaque. Scrubs, sweatpants/shirts, shorts, and pajamas are not permitted. •Uniforms will be maintained neatly and cleanly. Volunteers will wear the uniform appropriate for their role at all times: a black vest for adult volunteers, a yellow vest for Pet Therapy volunteers, and a red polo shirt for students.
Face Mask	•A hospital-issued face mask must be worn securely over the mouth and nose at all times while on campus.
Shoes	• Shoes must be closed-toe.

By signing below, I agree to follow the above dress code and understand that arriving for scheduled program events wearing clothes that do not meet the dress code may result in my being sent home. If I have any questions or clarifications about the dress code, I will discuss them with the Volunteer Services staff so I can fulfill my commitment to following these dress code standards.

Printed Name: _____

Signature: _____

Parent/Guardian Signature: _____
(If participant is under 18 years old)
Date: _____

Salem Health Non-Employee Confidentiality Statement
Volunteer Services

EMPLOYEE, AGENCY, VOLUNTEER OR OTHER NON-EMPLOYEE PERSONNEL
CONFIDENTIALITY STATEMENT

Confidentiality means protecting a patient's privacy and sharing hospital business only with those who have a need to know. The "need to know" is defined as the need to have information to perform one's job. Confidential patient information includes, but is not limited to, a patient's presence, medical, financial, quality assurance/ quality improvement/performance improvement, and risk management data. I agree to maintain absolute confidentiality of all Salem Health information, unless disclosure is required for legal compliance. This expectation pertains to patient, physician and employee information, as well as my own personal medical records and those of my family members, (including children, parents, spouses, siblings), and other non-workforce or business arrangement information.

I understand that this means that I will not discuss confidential patient information with others or access information, including on-line, unless it is required in the performance of my job duties or for legal compliance, is the minimum necessary, and is as identified in the level indicator that is associated with my job.

I further agree that if I require computer access, the user ID and password that are issued to me are my means of accessing the computer system. It is to be used solely in connection with the performance of my authorized job functions. I will take all necessary steps to prevent anyone from gaining knowledge of my login ID and password, and I will not use anyone else's login ID and password. The use of these unique codes by anyone other than the person to whom they have been assigned is prohibited, and will be reported to my supervisor if detected. I will sign off each time I leave the terminal, to ensure the security of my password and the information. I agree that when it is necessary, as part of my job duties or work assignment, for me to discuss patient information with other employees, I will be certain the conversation is in a private area. I understand that I may not access my personal lab results, physician-dictated reports, x-ray reports; in short, anything in my personal medical record is considered Protected Health Information (PHI). If I desire access to my medical record, I will sign an authorization form available in the HIM department and get such records from them. I further under-stand that I may not access my family members', (including children, parents, spouses, siblings), medical records, and that these are also considered PHI.

I agree to not use my Salem Health email for matters not associated with Salem Health or in any matters representing my personal, political, social, spiritual or moral views.

Any breach of confidentiality is grounds for immediate withdrawal of onsite privileges, termination of my service and/or indemnification afforded me by Salem Health, or corrective action, up to and including termination of my employment/services.

I attest that I am not on the Office of Inspector General (OIG) Excluded Individuals/Entities (LEIE) list. Should I ever appear on the OIG exclusion list, I will immediately notify my direct supervisor and the Corporate Integrity Department.

I have read the above confidentiality statement of policy. I understand it, and I agree to comply. Type of Affiliation (Non-Hospital Employee Only)

Printed Name of Student: _____

Signature of Student: _____ Date: _____

Signature of Parent/Guardian: _____
(if student is under 18 years old)

Salem Health
Hospitals & Clinics

Consent Form
Volunteer Services

If you are 18 or older, please sign & date this form, writing "self" on the relationship line

My son/daughter, _____, has my permission to participate in Salem Health's Career Exploration and Volunteer Services Programs. As the parent/guardian of the above-named student, I will read the literature that is provided to my child so that I know what will be expected of him/her. If the above-named participant is over 18, he or she may complete this form for him/herself, in lieu of a parent or guardian.

I understand my child may be required to have a Tuberculin skin test prior to beginning his or her hospital experience and I give my permission for my child to have this test performed by Salem Health's Occupational Medicine Department. I understand that my child may be required to wear a masks and other PPE while volunteering at the hospital, and despite diligent hygiene measures and compliance with the regulations, the hospital cannot guarantee that infectious transmissions (i.e. COVID-19) will not occur.

Participation in these programs will include observing patients and healthcare professionals in a hospital setting and observing medical, laboratory, and/or business procedures. I do hereby release Salem Health and its staff and sponsors from any responsibilities of injury or accident as a result of the Career Exploration and Volunteer Services Programs. Any medical expenses incurred as a result of injury or accident will be my responsibility.

I understand that, in case of a medical emergency, every attempt will be made to contact the emergency contact person for the above-named participant. However, this document is my consent as parent, guardian, or participant for emergency treatment and/or procedures necessary for my son/daughter/myself by the professional staff at Salem Health.

I also understand that it is my responsibility to find or provide transportation for my child to and from his or her assignment if my child is unable to drive him or herself. I understand that my child is expected to notify the appropriate person, in advance, if they are unable to report at the prearranged time and that any absences or failure to comply with program standards may disqualify them from participating in Career Exploration and Volunteer Services programs with Salem Health in the future.

_____ _____
Printed Name of Parent/Guardian (if participant is under 18) or Self Relationship*

_____ _____
Signature of Parent/Guardian (if participant is under 18) or Self Date*

_____
Street Address of Parent/Guardian Daytime Phone # □ Home □ Work

_____
City, State, Zip Code Evening Phone # □ Home □ Work

Emergency Contact: (only complete to list someone other than parent/guardian as emergency contact)

_____ _____
Name of Emergency Contact (If other than contact above) Relationship

_____
Phone Number

Salem Health
Hospitals & Clinics

Volunteer Agreement/Photo Consent
Volunteer Services

Volunteer Agreement

I certify that the information contained in this application is true, correct, and complete to the best of my knowledge. I understand that continuation of any subsequent volunteer placement depends upon true and accurate representation of the facts stated or implied herein. In addition, I hereby authorize Salem Health to make inquiries regarding my education, work experience and references, unless otherwise stated. I hereby release all parties and persons associated with any such inquiries from all claims, liabilities, and damages for whatever reason in connection with information they give.

I acknowledge and agree that I am not obligated if called upon to perform the volunteer services herein applied for, and that Salem Health is not obligated to assign or actively seek to assign me to a placement.

I understand that failure to adhere to the attendance policy may result in dismissal from the program.

I understand this application is not a contract of employment. If I am accepted as a volunteer, I agree to abide by and conform to all policies and procedures of Salem Health and Volunteer Services.

I understand that my services are donated to the hospital without contemplation of compensation or future employment, and are given with humanitarian reasons. I also understand that becoming a volunteer does not ensure that I will become a paid hospital employee in the future.

_____ _____
Applicant's Signature Date

_____
Applicant's Name – Printed

_____ _____
Parent/Guardian's Signature – **If Applicant is UNDER 18 Years Old** Date

Student Consent to Photograph or Interview

As requested by Salem Health or a member of the media, I consent to and authorize photographs or videotape recordings to be taken.
I also consent to be interviewed by a representative of the media or Salem Health for purposes of publication.
I further authorize and consent to the use of the still or video images by the media and/or Salem Health in print publications, hospital or media Web sites, or broadcast productions.

Applicant's printed name: _____ Applicant's signature: _____

Date: _____

_____ _____
Printed Name of Parent/Guardian (if student is under 18) **Relationship**

_____ _____
Signature of Parent/Guardian (if student is under 18) **Date**

Salem Health
Hospitals & Clinics

Confidentiality & Social Media
Volunteer Services

It is the responsibility of all student volunteers at Salem Health to preserve and protect confidential patient, employee and business information. I understand and acknowledge that I will respect and maintain the confidentiality of all discussions, deliberations, patient care records and any other information connected with individual patient care.

I will not post or share information or photos about patients, discussions, activities, online in any form (including but not limited to: email, websites, message boards, blogs, or social networking websites and apps). It is my responsibility to protect patient confidentiality as a student volunteer.

I acknowledge that I have read and understand the foregoing information and that my signature below signifies my agreement to comply with the above terms.
In the event of a breach or threatened breach of this Social Media/ Confidentiality Agreement, I acknowledge that Volunteer Services Department may, as applicable and as it deems appropriate, pursue disciplinary action up to and including early dismissal from the Student Volunteer Program.

I will not post before, DURING, or after my shift any photos or statements that contain any (or potential) patient information or patients.

Printed Name: _____

Signature: _____

Parent/Guardian Signature: _____
(If participant is under 18 years old)

Date: _____

Salem Health
Hospitals & Clinics

Volunteer Services Tuberculosis (TB) History and Screening Form
Salem Health Employee Health Department

Name: _____ **DOB:** _____ **ID #:**___**ON FILE**_____

Completion of this form is the screening method for Tuberculosis (TB) for workers with a previous history of positive TB tests. If you have any questions, or to report any change in symptoms (see list below) please contact Occupational Medicine at (503) 814-5352.

History	**YES**	**NO**	**Comments**
Have you ever had an adverse reaction to a TB skin test?	_____	_____	_____
Were you born outside the United States?	_____	_____	_____
Have you spent more than 1 month in a country with a high TB rate? (i.e., any country other than the US, Australia, Canada, New Zealand, and western or northern Europe)	_____	_____	_____
Current or planned immunosuppression such as organ transplant recipient, HIV infection, chronic steroids, or other immunosuppressive medication?	_____	_____	_____
Have you ever had a positive TB skin test?	_____	_____	_____
Have you ever had the BCG vaccine? (given outside the US)	_____	_____	_____
Have you been in close contact with someone who has active TB since your last TB test?	_____	_____	_____
Have you had Quantiferon Gold blood test? (if yes was it positive?)	_____	_____	_____
Have you had previous treatment for **active** or **latent** TB? Date(s) of treatment: _____	_____	_____	_____
Have you had a chest x-ray for **latent** TB? Date of last x-ray: _____	_____	_____	_____

Do you have any of the following symptoms:	**YES**	**NO**	**Comments**
Coughing lasting greater than 3 weeks duration	_____	_____	_____
Weakness or fatigue	_____	_____	_____
Unexplained weight loss or loss of appetite	_____	_____	_____
Night sweats	_____	_____	_____
Fever and /or chills	_____	_____	_____
Coughing up blood (hemoptysis)	_____	_____	_____
Chest Pain	_____	_____	_____

Other: _____

Signature: _____ Date: _____

Parent/Guardian Signature (if under 18)_____ Date:_____

I hereby certify that the medical history recorded herein is true and complete to the best of my knowledge. I further understand that any false statement, misrepresentation, or omission of pertinent data would be sufficient cause for immediate discharge. I agree to notify my supervisor or Occupational Medicine regarding any changes in my health status affecting my ability to perform my job safely or posing a threat to patients or other employees.

Clinical use only:

Name of clinician reviewing: _____

Reason for review: _____ New Employee/ Volunteer _____ TB Exposure _____Annual Review _____ Previous Positive

Findings: ____ Normal findings no action needed _____ Abnormal findings, action needed: _____

Signature of clinician reviewing: _____ Date: _____ (v.8/27/2019)