Please Indicate Volunteer Location:

_____	St. Charles Bend 2500 NE Neff Rd Bend, OR 97701	_____	St. Charles Madras 470 NE A St Madras, OR 97741
_____	St. Charles Redmond 1253 NW Canal Blvd Redmond, OR 97756	_____	St. Charles Prineville 384 SE Combs Flat Rd Prineville, OR 97754

VOLUNTEER SERVICES APPLICATION *(Must be 16 years of age or older.)*

Legal Name _____
First Middle Initial Last

Address _____ City & State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ Name to Appear on Badge _____

Work & Volunteer Experience:

Current Employer _____ Dates Employed _____

Supervisor Name _____ Phone Number _____

Volunteer Experience #1 _____ Dates _____ Duties _____

Volunteer Experience #2 _____ Dates _____ Duties _____

Personal Reference: Name _____ Phone Number _____

High School Attended _____ City _____ State ___ Graduated? _____

College Attended _____ City _____ State ___ Graduated _____

School Currently Attending _____ City _____ State _____

Where are you interested in volunteering? _____

How did you learn about Volunteer Services at St. Charles?

___ Website	___ Hospital Volunteer	___ Leaflet/Display at Hospital
___ Social Media	___ Newspaper	___ Religious Group
___ Community Event	___ Local Business	___ Volunteer Website(s)

Skills/Experience/Interests: (Please circle all categories that may be of interest to you in the future.)

Cancer Center	Family Birthing Center	Pediatrics	Other (Please Specify):
Clerical & Office Duties	Gift Shop	Pet Therapy	_____
Entrance Greeter / Runner	Music	Special Events	_____
ER/ICU Family Liaison	Patient Visitor	Supply Stocking	_____

Do you speak any languages in addition to English? Yes No If yes, which? _____

Availability: (Circle.) Mon Tues Wed Thurs Fri Sat Sun Hours: _____

Does your schedule change? Yes No Can we put you on call? Yes No

Legal Status:

Have you ever been convicted of a felony or misdemeanor? Yes No

If yes, what charge and what state? _____

Can you perform the essential functions of the position you are applying for with or without reasonable accommodation, including the attendance requirements? Yes No

The above information is accurate and correct to the best of my knowledge.

I understand this information may be used to determine my eligibility to volunteer for St. Charles Health System.

_____ _____

Signature Date

Brad Ruder

Brad Ruder
Volunteer Services Supervisor
bmruder@stcharleshealthcare.org
(541) 706-2924

Kara Magee

Kara Magee
Volunteer Coordinator – Bend/Redmond
kamagee@stcharleshealthcare.org
(541) 706-2657

(Please read and sign Volunteer Agreement on the next page.)

3436 v.2

VOLUNTEER AGREEMENT

If accepted as a volunteer for St. Charles Health System, I agree to the following:

1. I will hold all information that I may obtain directly or indirectly concerning patients, doctors or staff, as **absolutely confidential** and will not seek to obtain information from patients. In addition, I will not solicit my political or religious beliefs to patients, their families and/or staff.

2. My services are donated to the hospital without contemplation of compensation or promise of future employment.

3. I will submit to medical screening which may include: TB skin test and/or immunizations that may be necessary as part of my volunteer assignment.

4. I understand that a criminal background check will be required prior to beginning volunteer service.

5. I agree to commit to my volunteer position for a minimum of three months.

6. I will be punctual and conscientious; conduct myself with dignity, courtesy and consideration of others; and endeavor to make my work professional in quality.

7. I will make every effort to resolve any problems related to my volunteer assignment with my supervisor and the volunteer coordinator.

8. I will make my best effort to fulfill my commitment to St. Charles Health System by completing all volunteer assignments that I accept.

9. I understand that the Volunteer Services Department reserves the right to terminate my volunteer status as a result of failure to comply with hospital policy; absences without prior notification; unsatisfactory attitude, work or appearance; or any other circumstance which in the judgment of the volunteer coordinator, would make my continued service as a volunteer contrary to the best interests of the hospital.

10. I understand that it is a violation of the health system's policy to solicit business or act as an agent for outside business or to solicit business from patients or staff.

11. I will not sell or attempt to sell goods or services, request contributions, or solicit persons to sign or distribute political petitions on hospital property, unless I receive the express authorization of the volunteer coordinator.

I agree to the above conditions and consent to and authorize St. Charles Health System to complete a criminal background check.

_____ _____

Volunteer Signature Date

_____ _____

Parent/guardian signature if volunteer is under 18 years of age Date

CONSENT TO PERFORM CRIMINAL HISTORY BACKGROUND CHECK IN COMPLIANCE WITH THE FCRA (FAIR CREDIT REPORTING ACT)

Date:	Driver License #:	Driver License State of Issue:
Last Name:	First Name:	Middle Initial:
Maiden and/or Other Last Names		
Address (No PO Boxes):	City, State, & Zip Code:*	County of Residence:*
Date of Birth:**	Social Security Number:**	Male [ ] Female [ ]

I consent to and authorize the organization to complete a pre-employment check, including employment, compliance, criminal background, degree verification, and consumer credit report. I release and hold employers, from all claims, liability, and damages for whatever reason, related to my background, and my suitability for employment either now or in the harmless all parties and persons, including my present/prior employers, from all claims, liability, and damages for whatever reason, related to providing information regarding my application and my employment. I also release and hold harmless all parties and persons, including my present/prior future. I understand that the organization may, and hereby authorize the organization to, solicit information regarding my character, felony record, driving record, credit history, previous employment and similar background information. I authorize my current and former employers and references to disclose such information to the organization.

I understand that according to the Federal Fair Credit Reporting Act, I am entitled to know whether employment was denied based upon the information obtained and to receive, upon written request, a disclosure of the background report. I also understand that I may request a copy of the report from **Trak-1 Technology PO Box 52028, Tulsa, OK 74152** at telephone number (800) 6008999. After reading this document, I fully understand its contents and authorize the background verification.

*** AS SHOWN ON THE ORIGINAL APPLICATION**
**** TO BE USED ONLY FOR CRIMINAL HISTORY SEARCHES, AND NOT A PART OF THE PERSONNEL FILE**.

As of the date of this authorization, do you have any pending criminal charges against you? [ ] YES [ ] NO

If YES, Please provide an explanation below:

THIS SECTION IS TO BE USED TO LIST ALL COUNTIES AND STATES OF RESIDENCE SINCE AGE 18 OR HIGH SCHOOL GRADUATION. YOU MUST BE SPECIFIC ABOUT DATES OF RESIDENCE.

CITY/TOWN	COUNTY	STATE	DATES FROM	TO

I HEREBY CERTIFY THAT ALL INFORMATION PROVIDED IN THIS AUTHORIZATION IS TRUE, CORRECT AND COMPLETE. I UNDERSTAND THAT IF ANY INFORMATION PROVES TO BE INCORRECT OR INCOMPLETE THAT GROUNDS FOR THE CANCELING OF ANY AND ALL OFFERS WILL EXIST AND MAY BE USED AT THE DISCRETION OF THE ORGANIZATION.

By signing below, I also acknowledge that the organization has provided me a summary of my rights under the federal Fair Credit Reporting Act.

Signature of Applicant Date

Caregiver Health Immunization/Titer/TB Requirements

St Charles Health System screens all new caregivers for Tuberculosis, Measles, Mumps, Rubella and Varicella immunity status, as recommended by the Center for Disease Control and Prevention. Caregivers with positions that are fully remote and located outside of the Central Oregon area are exempt from this screening unless otherwise noted.

Hepatitis B verification is performed for positions that have an increased risk for bloodborne pathogen exposure.

Vaccine records should be sent to caregiverhealth@stcharleshealthcare.org for review. If you are unable to provide documentation of these requirements, these services will be provided to you as a vaccine administration and/or titer blood draw.

Covid-19 Vaccine
Provide documentation indicating fully vaccinated status, **caregiver can not start unless fully vaccinated**

- 2 weeks must pass after second dose of 2-dose series (Pfizer or Moderna)
- 2 weeks must pass after single dose vaccine (Johnson & Johnson)

Measles, Mumps and Rubella Immunity
Please provide one of the following:

- Medical documentation of 2 MMR vaccinations at least 28 days apart **OR**
- Laboratory blood titers indicating immunity to Measles, Mumps and Rubella

Varicella Immunity
Please provide one of the following:

- Medical documentation of 2 Varicella vaccinations at least 28 days apart **OR**
- Laboratory blood titers indicating immunity to Varicella

Tuberculosis Screening
If history of a positive TB screening test, provide the following:

- Documentation of positive QuantiFERON Gold or T Spot blood test
- Negative chest x-ray report indicating no active tuberculosis **OR**
- Medical documentation of INH treatment including dates

If history of a negative TB screening, provide the following:

- Documentation of a negative QuantiFERON Gold or T Spot blood test completed with in the last 12 months

Hepatitis B Immunity
If your position places you at increased risk for bloodborne pathogen exposure, provide the following

- Documentation of 3 Hepatitis B or 2 Heplisav-B vaccines **AND**
- Laboratory blood titer indicating immunity to Hepatitis B

Tetanus, Diphtheria, Pertussis Vaccine (Tdap)
Provide documentation of 1 vaccine given after the age of 19

Flu Vaccination
Seasonal October 1 – March 31

- Documentation of seasonal flu vaccine. Caregivers who decline flu immunization must wear a mask during active flu season with guidance from infection prevention

Email/Submit

Caregiver Health History Form

Name: _____ Date of Birth: _____

Phone Number: _____ Email Address: _____

Campus: _____ Department: _____ Job Title: _____

Tuberculosis Screening

	YES	NO
Have you ever been screened for Tuberculosis? *Date of most recent test*: _____ *Result*:_____	☐	☐
Have you ever had a **positive** TB screen? *Date* : _____ *Last chest xray*: _____	☐	☐
Have you ever taken medication for TB? *Medication*: _____ *Dates*: _____	☐	☐
Have you had temporary or permanent residence greater than 1 year in a country with high TB rate? *Any country other than US, Canada, Australia, Northern or Western Europe*	☐	☐
Did you receive the BCG vaccine?	☐	☐
Do you have any of the follow symptoms of TB which cannot be attributed to a different disease: ☐ Coughing ☐ Fever/chills ☐ Unexplained weight loss ☐ Chest pains ☐ Coughing up blood ☐ Night sweats ☐ Increased fatigue ☐ Loss of appetite	☐	☐
Do you have any conditions or take medication that will increase your risk for TB disease? ☐ Organ transplant ☐ HIV/AIDS ☐ Rheumatoid arthritis ☐ Chronic malabsorption syndromes ☐ Recent TB infection ☐ Diabetes ☐ End stage renal disease ☐ Immunosuppressed	☐	☐
Have you had close contact with someone infected with TB or worked/lived in an area with high incidence of TB? *Correctional institute, homeless shelter, IV drug users, nursing homes*	☐	☐

Please explain any **YES** statements:

Are you allergic to latex? YES ☐ NO ☐ Any other allergies: _____

Do you have any skin conditions of the hand(s) that interfere with glove use or hand hygiene? ☐ ☐

Are you enrolled in a Workers' Compensation Preferred Worker Program? ☐ ☐

IMMUNIZATION HISTORY

Check the box if you have documentation of the following and email records to caregiverhealth@scmc.org

- ☐ Covid 19
- ☐ Hepatitis B immunization and Titer
- ☐ Measles Mumps Rubella immunization or titer
- ☐ Varicella immunization or titer
- ☐ Tdap immunization after age 19
- ☐ TB CXR, documentation of treatment if past positive
- ☐ Influenza (October – March)

Caregiver Signature: _____ Date: _____

St. Charles HEALTH SYSTEM

NOTE: Complete Section 1 & sign and date Section 9

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1 Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

2 Purpose for requesting information: ☐ Legal ☐ Insurance ☐ Personal ☐ Continuation of Care ☑ Other See Below

Please complete the following section, using a separate form for each sender or recipient of the medical records.
This form can be used for records of St. Charles Health System or records of other health care providers.

3 Check one: ☑ From ☐ To

☑ **St. Charles Health Systems (all locations) or;**
- ☐ St. Charles Bend hospital
- ☐ St. Charles Redmond hospital
- ☐ St. Charles Madras hospital
- ☐ St. Charles Prineville hospital
- ☐ St. Charles Sage View
- ☐ St. Charles Medical Group: write in clinic name(s).

_____
_____
_____

4 Check one: ☐ From ☑ To

☐ **Same name and address as listed above** ☐ Other

Sender / Recipient Name:
SCHS Operations and Human Resources in the capacity as my employer

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Note: Faxes are only sent to other healthcare providers offices.

5 Date Range of Services: All as defined under Other - section 6 to All as defined under Other - section 6

I authorize the following information to be released from the medical record(s):

Note: Standard copy fees will apply subject to federal and state regulations.

6 ☐ Any & All Records (complete legal Health Record) or select from below:
- ☐ Visit Summary *(Includes: Provider Notes, History & Physical, Operative Report, Discharge Summary, Diagnostics - ie: Radiology, Lab, Cardiac tests)*
- ☐ Emergency Room Record
- ☐ Lab Report(s)
- ☐ Radiology Report(s)
- ☐ Cardiac Tests
- ☐ Itemized Billing Records
- ☑ Other: I give St. Charles Health System permission to share my State, CDC, and / or OSHA recommended vaccination, immunization record, and diagnostic screenings (including but not limited to titers & TB, etc) with SCHS Operations and Human Resources in the capacity as my employer.

~~☐ By Checking this box, I authorize release of **Radiology films, imaging / tracings** for the above dates by either of the following:~~
~~1) **Central Oregon Radiology Associates**~~
~~1460 NE Medical Ctr Dr Bend, OR 97701~~
~~Phone: 541-383-6977 Fax: 541-390-9786~~
~~**or**~~
~~2) **St. Charles Health System**~~

Instructions:

1. Enter the name, date of birth, address, and phone number of the patient whose records you would like to send or receive.
2. Select the purpose of your request: legal, insurance, personal, continuation of care, or other (please specify).
3. Check with the 'From' or 'To' box, then identify and provide the contact information for the sender or recipient of the medical records, as applicable.
4. Check with the 'From' or 'To' box, then identify and provide the contact information for the sender or recipient of the medical records, as applicable.
5. Enter the date range of services for which you are requesting records.
6. This is the basic information that health care providers commonly request. Check the box / boxes stating what types of records you are requesting. If requesting other that what is stated, check "other" and write the information you would like.

St. Charles
HEALTH SYSTEM

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that the medical records may contain sensitive or specially-protected information.
Please initial those types of sensitive information that you would like to have released.

In some situations, state and federal law protect the following information. If this information applies to you, please indicate whether you would like this information to be released.

7

Alcohol, Drug or Substance Abuse Records	n/a	Initial Required
HIV Testing Records	n/a	Initial Required
Mental Health Records	n/a	Initial Required
Genetic Records	n/a	Initial Required

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal and state regulations.
- I have the right to revoke (take back or change my mind about) this authorization at any time. To do this, a request must be made in writing and provided or mailed to the St. Charles Health System Manager of Health Information Management
- If I ask to revoke an authorization that was signed by me on a previous date, the request to revoke will not apply to records that were already copied and released as a result of the original and authorized request.
- No determination about treatment, payment, enrollment, or eligibility for benefits will be based on whether or not I sign this authorization form.
- I understand that federal confidentiality rules will not protect the medical information that I have authorized to be released, if it is released again by the organization or person that receives it.
- This authorization will expire one year from the date it is signed.

8 **Records Format** (paper is the default if not marked):
☐ Paper ☐ CD ☑ n/a

Delivery Options (Please note: Standard copy fees may apply subject to federal and state regulations):
☐ U.S. Mail ☐ Pick up ☑ n/a

9

Patient or Authorized Representative Signature	Date
Print Name	Caregiver ID #

(For Office Use Only)

10

Name of Caregiver Accepting Authorization	Department

☐ Photo ID checked

Note: This form is a permanent part of the medical record

St. Charles Health Information Management | 2500 NE Neff Road, Bend, OR 97701 | Phone: 541-382-4321 ext. 7784

Instructions cont:

7. In some cases, a health care provider may be prohibited from releasing those types of records that are not initialed.
8. Check the box indicating the format in which you would like to have the records sent or received. Note: Faxes are only sent to other healthcare provider's offices.
9. The person authorizing the release must sign, date, print his or her name, and indicate his or her relationship to the patient. No drug and alcohol treatment records of a minor who is 14 years old or older, nor medical records of any type of a minor who is 15 years old or older, may be released without the minor's written authorization if the minor is self-consented to the treatment associated with the records. St. Charles reserves the right to reject this authorization form if the legal authority of the representative cannot be validated.
10. St. Charles staff accepting the release must sign and document department.