AFFILIATION AGREEMENT FOR NON-EMPLOYEES

INSTRUCTIONS:

Prior to granting access and a badge to Medical Staff/Students in Approved Programs with Contracts on File/Contractors and Job Shadows the following information must be completed and submitted to Human Resources at ***least three days prior*** to the candidates arrival.

Section 1 is to be completed by the Manager/Supervisor/Medical Staff
Section 2 is to be completed by the Medical Staff Member/Job Shadow/Student/Contractor

Medical Staff Member/Students in Approved Programs/Contractors

please complete the following documents:

- ☐ Island Hospital Non-Employee Confidentiality Agreement
- ☐ Island Hospital Disclosure Statement for Background Check
- ☐ Washington State Patrol Background Check
- ☐ Safety Training Manual

***Medical offices, student programs, and contractors are responsible for ensuring that individuals have proof of current (< 12 months) Quantiferon Gold test screening, two step tuberculosis (TB) skin test or chest x-ray and physician clearance if known positive TB test history, proof of MMR vaccine x 2 doses or positive titers, current TdaP (tetanus, diphtheria, pertussis) vaccine; one dose in adulthood (>18) or declination, completion or initiation of a Hepatitis B vaccine series, and/or positive lab titer for students and contract employees performing work in high risk positions, and current seasonal influenza (flu) vaccination (Sept-May).**

All health requirement records will be reviewed by Employee Health prior to on site participation.

****Physician documented medical waiver(s) must be available/provided if MMR and flu vaccinations are medically contraindicated, or are otherwise required. TdaP vaccine may be declined, but is encouraged.**

Job Shadows (example: High School Student projects), must first complete a *Job Shadow/Student application* for approval from the requesting department. IF that department is able to accommodate your request the following forms must be submitted:

- ☐ Island Hospital Non-Employee Confidentiality Agreement
- ☐ Island Hospital Disclosure Statement for Background Check
- ☐ Safety Training Attestation Form
- ☐ Occupational Health History Questionnaire
- ☐ Vaccination Consent Waiver
- ☐ Must provide proof of current (< 12 months) Quantiferon Gold test results, 2 step tuberculosis (TB) skin test or chest x-ray and physician clearance if known positive TB test history, proof of MMR vaccine x 2 doses or positive titers, tetanus, diphtheria, pertussis (TdaP) vaccine; one dose in adulthood (>18) and current seasonal influenza (flu) vaccination (Sept-May).

****Physician documented medical waiver(s) must be provided if MMR and flu vaccinations are medically contraindicated, or are otherwise required. TdaP vaccine may be declined, but is encouraged.**

Please contact Human Resources at 299-4285 if you have questions regarding this agreement.

SECTION 1: TO BE COMPLETED BY AUTHORIZING MANAGER/ SUPERVISOR / MEDICAL STAFF MEMBER

NAME: ______________________ DEPARTMENT/CLINIC: ______________________

ACCESS: ☐ Medical Office Staff ☐ Contract ☐ Student ☐ Job Shadow ☐ Meditech Access Only

EMPLOYEE HEALTH: ☐Complete Date: ________ ☐ MISSING: Notes______________ Date:________

PROJECTED START DATE______________________PROJECTED END DATE: ______________________

Please grant the incumbent below access to:

☐ IH Badge with proximity card ☐ Identification Badge Only ☐ IH Meditech Copy ____________profile

☐ IH Outlook Account ☐ Other (please specify): ______________________________

I authorize the following person to have access to Island Hospital and the systems checked above. I will be responsible for letting Island Hospital's Human Resources Department know if and when access needs to be changed or terminated.

______________________________ ______________________________

PRINT NAME Authorizing Mgr /Supv / Med Staff Member SIGNATURE – Authorizing Mgr / Supv / Med Staff Member

SECTION 2: - TO BE COMPLETED BY MEDICAL STAFF MEMBER/JOB SHADOW/STUDENT/CONTRACTOR

NAME____ DATE ____________________

Last First Middle

OTHER NAMES KNOWN BY:____

DATE OF BIRTH____

HOME ADDRESS____ PHONE (____)______________

____ EMAIL ______________________

EMERGENCY CONTACT __________________________________ PHONE (___)______________

RELATIONSHIP ____

COMPANY / CLINIC / SCHOOL AFFILIATION

NAME of COMPANY / CLINIC / SCHOOL ____

ADDRESS ____ PHONE (___)______________

____

IF ENROLLED IN SCHOOL, LIST MAJOR COURSE OF STUDY ____

If your observation is for a school project, please list Instructors' Name: _____________________________________

EDUCATION: (include any job related education or training in military service)

College/Schools (after High School) Name Location	Academic Major, Skill or Trade	Dates Attended	Did you Graduate?	Degree Level AS,BA,MA,PhD/Cert

LICENSURE (if applicable). Please attach copies.

____ _________________________________

Washington State License / Certification Expiration Date

Have you ever had a professional registration/license revoked, suspended or restricted? ☐ Yes ☐ No

If yes, explain fully ____

Have you ever been sanctioned and/or excluded from participation in Medicare, Medicaid, or other Federal health care programs? ☐ Yes ☐ No

If yes, explain fully ____

BACKGROUND CHECK

Have you been convicted of a criminal offense or been released from prison within the past ten (10) years?

☐ Yes ☐ No (*A "yes" answer to this question will not necessarily bar you from employment.)*

If yes, explain fully____

Have you lived outside Washington State in the last ten (10) years? ☐ Yes ☐ No

JOB SHADOW/OBSERVER ONLY: If under 18 years of age, the following information must be completed.

Permission is granted for ____________________________to participate in job shadowing or observing at Island Hospital. In the event I cannot be reached, I give permission for any necessary treatment to be given in case of illness or injury.

________________________________ ______________________

Parent/Guardian's Name Date

ACKNOWLEDGMENT AND CONSENT

PLEASE READ AND SIGN THE FOLLOWING:

I ACKNOWLEDGE THAT I HAVE BEEN DIRECTED TO THE LOCATION OF ISLAND HOSPITAL'S POLICY MANUAL AND UNDERSTAND AND I AGREE TO BE BOUND BY THE TERMS THEREOF IN ALL MATTERS RELATING TO MY AFFILIATION WITH ISLAND HOSPITAL.

I certify the information set forth in this Application is true and complete to the best of my knowledge. I understand that, falsified statements on this application or failure to furnish all requested information shall be considered cause for my dismissal or loss of privileges.

Unless subject to an individual contract, affiliation with Island Hospital is voluntary and may be terminated, with or without cause and with or without notice at any time by you or Island Hospital. No Hospital representative has the authority to enter into any agreement either verbal or in writing to the contrary except for written collective bargaining agreements or individual contracts signed by the Hospital's Administrator.

I understand my affiliation shall be contingent upon proof of identity. I further understand that I will be required to complete a disclosure statement and a Washington State Patrol form under the Washington State Child/Adult Abuse Information Act of 1988 (if a contracted employee this may be completed by source agency).

I consent to and authorize Island Hospital and its personnel to conduct an investigation into educational history and licensure as applicable. I release all parties and persons connected with any requests for information from all claims, liabilities and damages for whatever reason arising out of the furnishing of such information. If I am employed by Island Hospital, I release it from any liability for future references it may provide regarding my work history with Island Hospital.

If I am affiliated with Island Hospital and I lose, damage, or fail to return any Island Hospital property, I am responsible to repay any damages or expenses incurred by the hospital. I understand any expenses the hospital incurs in effort to collect this repayment will be my responsibility to pay.

______________________________________ __________________

Signature **Date**

DISCLOSURE STATEMENT

Pursuant to the requirements of R.C.W. 43.43.830 and .842, we must ask you to complete the following disclosure statement. This information will be kept confidential.

Have you ever been convicted of any of the following crimes against children or other persons?

YES	NO	
[ ]	[ ]	Aggravated murder
[ ]	[ ]	First or Second degree murder
[ ]	[ ]	First or Second degree kidnapping
[ ]	[ ]	First, Second, or Third degree assault
[ ]	[ ]	First, Second, or Third degree assault of a child
[ ]	[ ]	First, Second, or Third degree rape
[ ]	[ ]	First, Second, or Third degree rape of a child
[ ]	[ ]	First or Second degree robbery
[ ]	[ ]	First or Second degree manslaughter
[ ]	[ ]	First or Second degree extortion
[ ]	[ ]	First or Second degree criminal mistreatment
[ ]	[ ]	Child abuse or neglect as defined in RCW 26.44.020
[ ]	[ ]	Selling or distributing erotic material to a minor
[ ]	[ ]	Custodial assault
[ ]	[ ]	Child buying or selling
[ ]	[ ]	Child abandonment
[ ]	[ ]	Violation of child abuse restraining order

YES	NO	
[ ]	[ ]	First degree promoting prostitution
[ ]	[ ]	Communication with a minor
[ ]	[ ]	First degree arson
[ ]	[ ]	First degree burglary
[ ]	[ ]	Indecent liberties
[ ]	[ ]	Incest
[ ]	[ ]	Vehicular homicide
[ ]	[ ]	Unlawful imprisonment
[ ]	[ ]	Sexual exploitation of minors
[ ]	[ ]	First or Second Degree custodial interference
[ ]	[ ]	Malicious harassment
[ ]	[ ]	First, Second, and Third degree child molestation
[ ]	[ ]	First or Second degree sexual misconduct with a minor
[ ]	[ ]	Patronizing a juvenile prostitute
[ ]	[ ]	Promoting pornography
[ ]	[ ]	Felony indecent exposure
[ ]	[ ]	Or any of these crimes as they may have been renamed

Have you, within fewer than 3 years preceding the date of this application, been convicted of any of the following crimes against children or other persons:

[ ]	[ ]	Simple assault
[ ]	[ ]	Prostitution
[ ]	[ ]	Assault in the Fourth degree
[ ]	[ ]	Or any of these crimes as they may have have been renamed

If your answer is "yes" to any of the above, please describe and provide the date(s) of the conviction(s) and the sentences(s) imposed:

____

____

Have you ever been convicted of any of the following crimes relating to financial exploitation of a person 60 years of age or older, who has a functional, mental, or physical inability to care for himself or herself or is a patient in a state hospital:

YES	NO		YES	NO	
[ ]	[ ]	First, Second, or Third degree extortion	[ ]	[ ]	First or Second degree robbery
[ ]	[ ]	First degree theft	[ ]	[ ]	Or any of these crimes as they may have been renamed

Have you, within fewer than 5 years preceding the date of this application, been convicted of any of the following crimes relating to financial exploitation of a person 60 years of age or older, who has a functional, mental or physical inability to care for himself or herself or is a patient in a state hospital.

YES	NO		YES	NO	
[ ]	[ ]	Theft in the Second degree	[ ]	[ ]	Forgery
[ ]	[ ]	Or any of these crimes as they may have been renamed			

If your answer is 'yes' to any of the above, please describe and provide the date(s) of the convictions and the sentence(s) imposed.

____

____

____

1. Have you ever been found in any dependency action to have sexually abused or exploited any minor or to have physically abused any minor?

   Yes [ ] No [ ]

2. Have you ever been found in a court in domestic relations proceeding to have sexually abused or exploited any minor or to have physically abused any minor?

   Yes [ ] No [ ]

3. Have you ever been found in any disciplinary board final decision to have sexually or physically abused or exploited any minor or developmentally disabled person?

   Yes [ ] No [ ]

4. Have you ever been found in any disciplinary board final decision to have abused or financially exploited a person 60 years of age or older who has a functional, mental, or physical inability to care for himself or herself or who is a patient in a state hospital

   Yes [ ] No [ ]

5. Have you ever been found by a court in a protection proceeding under Chapter 74.34 RCW to have abused or financially exploited a person 60 years of age or older who has a functional, mental, or physical inability to care for himself or herself or who is a patient in a state hospital?

   Yes [ ] No [ ]

If your answer is "yes" to any of questions 1 through 5 above, please describe and provide the date(s) of the finding(s) and the penalty(ies) imposed.

____

____

____

Have you ever been convicted of any crime related to the manufacture, delivery, or possession with intent to manufacture or deliver a controlled substance? Yes [ ] No [ ]

If your answer is 'yes' to the above, please describe and provide the date(s) of the conviction________________________

____

____

UNDER PENALTY OF PERJURY, I certify that the above information is true, correct, and complete. I understand that if I am hired, I can be discharged for any misrepresentation or omission in the above statement. I also understand that you [may/will] request a criminal background check from the Washington State Patrol to verify the accuracy of the information I have provided. I also understand that if I am hired, my employment is conditioned on your receipt of a satisfactory report from the Washington State Patrol.

Signature:_______________________________________

Name (print):____________________________________

Date:____

We may request your fingerprints to obtain from the Washington State Patrol criminal identification system a report of your record of criminal convictions for offenses against persons, civil adjudications of child abuse, and disciplinary board final decisions. If you are granted access to Island Hospital before that report is available, YOUR HOSPITAL ACCESS WILL BE CONDITIONED UPON THE RECEIPT OF A SATISFACTORY REPORT.

You will be notified of the State Patrol's response within ten days after we receive the report. We will make a copy of the report available to you upon your request.

ISLAND HOSPITAL

Island Hospital
Non-Employee Confidentiality Agreement

Maintaining confidentiality for patients is of the utmost importance to Island Hospital. Unauthorized disclosure of protected health information (PHI) is a violation of the respect for the privacy of our patients and a violation of the ***Health Insurance Portability and Accountability Act of 1996*** (HIPAA). I understand that I may have access to PHI and Island Hospital wishes to insure that I maintain the confidentiality of all PHI to which I may gain access in accordance with all applicable state and federal laws, including without limitation the HIPAA Privacy Rules.

I understand that I may be given an Island Hospital computer access password, User ID(s) or other authorization which will allow me to access the Island Hospital computer network upon signing this Agreement and agree to comply with its terms. I understand and agree that I must hold PHI, my Island Hospital computer access password and any other information of a private or sensitive nature, in the strictest confidence and in accordance with HIPAA regulations and agree as follows:

1. I understand that computer access passwords used to access computer systems are the equivalent of my signature and should not be shared with anyone, including other office staff.

2. I will use PHI only as needed by me to perform my legitimate duties relating to and for the benefit of Island hospital and its patients. This means that:

    a. I will not access or view PHI or utilize equipment containing such information other than what I have a legitimate need to know or utilize;
    b. I will not in any way divulge copy, transmit, release sell, revise, alter, or destroy any PHI except as properly authorized within the scope of my activities relating to Island Hospital. This includes, but is not limited to,removing and/or transferring PHI from Island Hospital's computer systems to unauthorized locations (e.g. home).
    c. I will not make inquiries about PHI for other individuals that do not have the proper authorization to access such information.

3. I will not misuse or carelessly fail to safeguard PHI. This means that:

    a. I will not disclose my access code, user ID(s), and password(s) or any other authorization I have that allows me access to confidential information. I accept responsibility for all activities undertaken using my access code, user ID(s), and/or password(s).
    b. I will log out of the computer system after accessing confidential files.
    c. I will not leave unattended a computer terminal to which I have logged on.
    d. I will not discuss confidential information where others can overhear the conversation.

4. If I have reason to believe that PHI or the confidentiality of my access code, user ID(s), and/or password(s) have been compromised, I will immediately report any known or suspected breach of confidentiality to the Privacy Officer even if such actions were made by another due to my intentional or negligent act.

5. I understand that I will be unauthorized to access PHI and that my access code, user ID(s), and Password(s) will be inactivated upon notification that I no longer have a legitimate need for access to the information.

6. I will return any documents or other media containing confidential information upon request or termination.

7. A periodic audit of patient access will be reviewed by Island Hospital administration and physicians.

I understand that violating this agreement may result in computer access denial and/or termination of my relationship with Island Hospital and that I am responsible for any legal action resulting from my misuse of PHI.

The undersigned hereby acknowledges reviewing this Agreement and agrees to comply with its terms.

____

Name (Last, First, Middle Initial)

____

Signature

____

Date

As indicated above (Acknowledgement & Consent), all Job Shadow participants must undergo a WA STATE PATROL Background Check to be performed by Island Hospital. Please complete the following form in Sections C & D only.

ISLAND HOSPITAL

WASHINGTON STATE PATROL

Identification and Criminal History Section
PO Box 42633, Olympia WA 98504-2633

REQUEST FOR CRIMINAL HISTORY INFORMATION CHILD/ADULT ABUSE INFORMATION ACT RCW 43.43.830 THROUGH 43.43.845

(A) REQUESTING AGENCY/ADDRESS

Island Hospital
Agency

Human Resources
Attn

1211 24th St
Address

Anacortes, WA 98221
City/State/Zip

I certify this request is made pursuant to and for the purpose indicated.

Authorized Signature ______ Date ______

HR Coordinator — Title
(360) 299-4286 — Area Code/Phone Number

(B) PURPOSE

Check appropriate box

- ☐ Educational School District (ESD)/School District Volunteer – no fee
- ☑ Non-Profit Business/Organization – no fee (Excluding Schools & ESD's)
- ☐ Profit Business/Organization - $17
- ☐ Adoptive Parent - $17
- ☐ Receive background results electronically

Email address ______

Password ______ (must be at least 8 characters)

Fees: Make payable to **Washington State Patrol** by check, money order, or business account.

Notary letters certifying the results are available upon request. There is an additional $10.00 processing fee per notary seal.

______ **Notarized Letter(s)**

(C) APPLICANT OF INQUIRY (Please provide as much information as possible; name and date of birth are mandatory.)

Applicant's Name: ______ Last ______ First ______ Middle

Alias/Maiden Name(s): ______

Date of Birth: ______ Month/Day/Year Sex: ______ Race: ______

Secondary dissemination of this criminal history record information response is prohibited unless in compliance with statute.

(D) WASHINGTON STATE PATROL IDENTIFICATION & CRIMINAL HISTORY SECTION

As of this date, the applicant named below has no record pursuant to RCW 43.43.830 through 43.43.845.

______
Requesting Agency

______
Applicant's Signature

______
Applicant's Name

______
Address

______
City/State/Zip