SHORT-TERM OBSERVER VOLUNTEERS

An Observer/Practicum Volunteer is one who is doing a special assignment—not something that Volunteer Services can recruit for and place for more than 2 weeks. The Observer/Practicum does not sign his/her hours in Volunteer Services or use Volunteer Services parking.

1. Fill out observer application form.

2. If proof of current PPD within this calendar year is provided please fax health history forms to the Observer Supervisor at that time. Otherwise the individual can go to his/her physician/clinic and then send/fax forms to the Observer Supervisor when completed. The fax number is 832-825-0128. Employee Health will notify the supervisor by e-mail when the individual has been cleared.

3. All forms will be retained by the supervisor at Texas Children's Hospital.
Observer Application

NAME: Mr. Ms., Mrs. _______________________________________________________________________
(circle one) (last) (first) (m.i.)

Driver’s license number including state___________________ Social Security number_______________________

ADDRESS__________________________________________CITY___________________ST____ZIP___________

PHONES: (home)___________________(work)__________________(cell)______________________________

E-MAIL ADDRESS:__________________________________________________________________________

CURRENT EMPLOYER/SCHOOL________________________________________________________________________

IN EMERGENCY NOTIFY:

Name____________________________________ Relationship________________________________________

Phone (work)________________________ (home)______________________________________________

Physician’s Name_________________________________________Phone________________________________

Department sponsoring your experience__________________________________________________________

TCH staff member or physician sponsoring you_________________________Phone______________________

Prior volunteer experience?_____________________________________________________________________

PLEASE LIST RELATIVES OR FRIENDS ASSOCIATED WITH TEXAS CHILDREN’S HOSPITAL (Medical Staff,
Employees, Board of Trustees, patients or volunteers and indicate relationship)
____________________________________________________________________________________________________
____________________________________________________________________________________________________

For office use

Health screen sent/faxed____________________________________

Health screen cleared____________________________________
IF ACCEPTED AS A TEXAS CHILDREN'S HOSPITAL VOLUNTEER, I AGREE THAT:

1. I shall hold as ABSOLUTELY CONFIDENTIAL ALL information that I may obtain directly or indirectly concerning patients, doctors or personnel, and not seek to obtain confidential information from a patient.

2. I spend my time at the hospital without contemplation of compensation or future employment.

3. I understand that it is a crime to solicit business for attorneys. I shall not solicit any business for attorneys or insurance companies, either on or off of hospital property, or act as a runner or capper for an attorney in the solicitation of business. I shall report all known occurrences of solicitation for attorneys to the person sponsoring my experience.

4. I shall not sell or attempt to sell or influence others (including patients, and their families, staff, volunteers and others) to buy goods or services, request contributions, or solicit persons to sign or distribute any petitions on hospital premises or through any other means (e.g. telephone, mail, e-mail or internet) while not on the premises.

5. If needed, I shall submit to examinations, which may include chest x-rays, skin tests, appropriate laboratory test and/or immunizations, as part of my volunteer service. I hereby authorize my doctor(s) to furnish to the Hospital information concerning my health. I also authorize the person(s) making tests or x-ray films to report the results to the Hospital.

6. I shall 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 comply with the Hospital policies and procedures as outlined in the orientation process, including the Corporate Compliance Program/Standards of Ethical Behavior and all security issues including electronic media, Hospital property and patients’ physical well being.

8. I understand that the host department reserves the right to terminate my experience as a result of (a) failure to comply with hospital policies, rules and regulations; (b) unsatisfactory attitude, work or appearance; (c) any other circumstances which, in the judgement of the sponsoring department director, would make my continued presence at the Hospital contrary to the best interests of the Hospital.

9. I understand that my name, address, phone number and other information as shown on this application will be maintained in the records of the sponsoring department.

10. I authorize a Texas Children's Hospital employee/volunteer to take photographs, audiotapes, videotapes or films of myself and/or my child. I understand and agree that these photographs, tapes and/or films may be used by Texas Children's Hospital, or persons authorized by Texas Children's Hospital, for education, publicity, advertising, or any other purpose, at the sole discretion of Texas Children's Hospital, without compensation to me or my child of any kind. I understand and agree that my and/or my child's identity may or may not be released. I agree to hold Texas Children's Hospital harmless from any and all liability arising from these activities.

Observer signature

Date

Parent/Legal Guardian's Signature (if minor)
Texas Children's Hospital has a legal and ethical responsibility to protect the confidentiality of information it obtains and/or uses to conduct its business. Please read this form carefully.

I, ________________________________, (print name) understand that it is likely that I will come into contact with Confidential and/or Proprietary information, as these terms are defined below, during my relationship with Texas Children’s Hospital and/or its affiliated entities.

**Confidential information** refers to the most sensitive business information intended strictly for use within and between TCH entities, Medical Staff and authorized third parties, including employee personnel files, payroll information, business strategies, and trade secrets. Confidential information also includes protected health information that identifies a patient by any of the following: patient name, address, telephone number, medical record number, diagnosis, treatment information, billing information and any other information that could be used to identify an individual patient.

**Proprietary information** refers to information that is not considered confidential, but is intended for use within TCH unless otherwise authorized for distribution. This includes any of the following: TCH policies and procedures, financial information, business plans, supplier information, information systems, internal correspondence and any other information that relates to TCH operations.

Please review and initial the following statements to indicate your agreement:

______ I will only use Confidential and/or Proprietary Information as necessary to complete my assigned duties at TCH.

_____ Upon completion of my TCH experience, I will continue to keep this information confidential. Furthermore, I agree to return to TCH any items that may contain Confidential and/or Proprietary Information, including documents, notes, manuals, and any copies of such materials.

_____ I will not disclose Confidential and/or Proprietary Information to any other person or entity, unless it is in accordance with TCH policies and procedures or I have received approval from my TCH supervisor/instructor or the TCH Privacy Office at (832) 824-2085.

_____ I will notify my TCH supervisor/instructor or the TCH Privacy Office if I cannot comply with these guidelines or if I have any questions about Confidential and/or Proprietary Information.

_____ I will immediately notify my TCH supervisor/instructor or the TCH Privacy Office if I discover any violation of these confidentiality guidelines.

_____ I understand that all Confidential and/or Proprietary Information is the exclusive property of TCH, whether or not I participated in whole or in part in the preparation of the information.

_____ I understand that if I violate any of the statements in this Confidentiality Agreement I may be prosecuted to the fullest extent of the law.

_____ I have read this Agreement and I understand I am required to protect all Confidential and/or Proprietary information.

___________________________________________  ___________________________________
Signature                                  Date
OBSERVER HEALTH HISTORY QUESTIONNAIRE

TCH supervisor: ____________________________

Phone Number: ____________________________

NAME_______________________________

SOCIAL SECURITY #_______-_______-_______

AGE_______ MALE_____ FEMALE____

HOME PHONE #__________________________

DOB________________________________

PERSONAL PHYSICIAN’S NAME______________________________________________________

PHYSICIAN’S PHONE_________________________________________________________________

IN EMERGENCY, NOTIFY_________________________ PHONE#__________________________

PLEASE CHECK IF YOU HAVE HAD THE FOLLOWING IMMUNIZATIONS (dates if available) OR THE DISEASE:

[  ] Chicken Pox___________________

[  ] Rubella (German Measles)________

[  ] Rubeola (Red Measles)___________

[  ] Mumps__________________

[  ] or MMR_______

[  ] Tetanus/Diphtheria Booster (within last 10 years)____________________

[  ] Date of last PPD____________________

PPD (Mantoux Tuberculin Skin Test)

Hospital policy requires a Mantoux Tuberculin Skin Test in the current calendar year. The test must be read between 48 and 72 hours. The following information must be recorded:

Date Placed__________________________ Date Read__________________________

Negative_________________________________ Positive/mm of induration______________

Signature & Title of Doctor or Registered Nurse reading the PPD Skin Test:

Name__________________________________ Title______________________________

(Signature only, no stamp) (R.N. or M.D. only)

ARE YOU CURRENTLY PREGNANT? YES_______ NO_______

PLEASE LIST ALL PRESCRIPTION MEDICATIONS THAT YOU ARE CURRENTLY TAKING: ____________________________

Do you have any health concerns which might limit your ability to perform certain volunteer responsibilities:

Yes_______________ No_______________

If yes, please explain: ________________________________________________________________

FOR EMPLOYEE HEALTH USE ONLY:

MD NOTE REQUESTED ☐ CXR PENDING ☐
Have you ever had or do you now have any of the listed conditions? Explain when and where a treatment was received for all “YES” answers in the space provided.

<table>
<thead>
<tr>
<th>Condition</th>
<th>NO</th>
<th>YES</th>
<th>EXPLANATION OF ANSWER</th>
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</thead>
<tbody>
<tr>
<td>Alcoholism</td>
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<tr>
<td>Arthritis</td>
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<td>Asthma/Emphysema</td>
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<td>Back Trouble</td>
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<tr>
<td>Breathing Difficulty</td>
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<td>Cancer</td>
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<td>Chest Pains</td>
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<td>Diabetes</td>
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<tr>
<td>Drug Abuse</td>
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<tr>
<td>Epilepsy/Seizure</td>
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<tr>
<td>Fainting/Dizziness</td>
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<td>Hernia</td>
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<tr>
<td>Hearing Problem</td>
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<td>Heart Problem</td>
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<td>Hepatitis</td>
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<td>High Blood Pressure</td>
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<td>High Cholesterol</td>
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<td>Knee, Foot or Ankle Problem</td>
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<td>Liver Disease</td>
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<tr>
<td>Nervous Breakdown/</td>
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<td>Psychiatric Illness or Treatment</td>
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<td>Obesity (overweight)</td>
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<tr>
<td>Stroke</td>
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<td>Surgery</td>
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<td>Ulcers</td>
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<td>Vision Problem</td>
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<td>Other</td>
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</table>

I hereby declare that my answers to the above questions are complete and true. I agree that any false statement shall be sufficient cause for dismissal. I hereby grant permission to Texas Children's Hospital to investigate any information included in this form, and to contact my personal physician (listed on page 1 of form) with regard to the information given. I understand that any information given to Texas Children's Hospital by either myself or my physician will remain confidential.

Signature of Observer_________________________   Date ____________________
Orientation Review

You should be able to answer the following questions before beginning your experience at Texas Children’s. Please refer to the observer handbook to answer the questions below.

1. ALL soiled linens are placed in what color bags?
   Blue
   Green
   Red

2. Standard Precautions are best demonstrated by:
   a. Treating only known infectious materials as hazardous.
   b. Washing hands only if you handle blood/body fluids
   c. Treating all patients’ blood and body fluids as potentially hazardous

3. One action that you would NOT take when responding to a hospital fire emergency is:
   a. Alert other staff on the unit
   b. Pull the fire alarm
   c. Call out “fire”

4. In the Hospital’s fire response program, what does R.A.C.E. stand for?
   a. Run, Alarm, Condense, Evacuate
   b. Rescue, Alert, Confine or Contain, Extinguish
   c. Remove All Children Early

5. The number for reporting a hospital emergency or possible child abduction is?
   a. 41111
   b. 44444
   c. *9999
   d. 45400

6. What is the phone extension for the Security Department?
   a. 42525
   b. 46330
   c. 45400
   d. 41111

7. What is the easiest and one of the most effective ways to prevent the spread of infection?
   a. Observe isolation precautions
   b. Wash hands
   c. Put trash in garbage containers

8. During a hospital stay children may
   a. Regress developmentally
   b. May be more anxious and shy than usual
   c. Express feelings of anger or sadness without adult disapproval
   d. All of the above