Cape Cod Healthcare, Inc.

Occupational Health Services

Hyannis Office: 26 Gleason St., Hyannis, MA 02601 Phone: (774) 552-6100 Fax: (508) 771-6445
Falmouth Office: 67A Ter Heun Dr., Falmouth, MA 02540 Phone: (508) 457-3950 X73950 Fax: (508) 457-3793

Please print clearly

Name:_____ **DOB:**_____ SS #:_____ED:_____

Academic Facility:_____ **Program:**_____**Start:**_____**End:**_____

Facility Location:_____ **Unit/Dept:**_____ Preceptor Name:_____

MMR-Measles, Mumps and Rubella MMR Comment:	**2 doses of vaccine or** positive titers indicating immunity **(report each individually)**	**MMR1:** **Measles Positive Titer:** **MMR2:** **Mumps Positive Titer:** **Rubella Positive Titer:**
Varicella (chicken pox) Vari Comment: **history of disease not accepted**	**2 doses of vaccine or** positive titer indicating immunity	**VAR1:** **Varicella Positive Titer:** **VAR2:**
Hepatitis B Hep B Comment:	**3 doses of vaccine AND positive titer** indicating immunity, **or** positive titer **or signed declination**	**HEP B1:** **Hep B Positive Titer:** **HEP B2:** **HEP B3:** Signed Declination: ☐ Yes Date_____
Tetanus, Diphtheria, Pertussis Tdap Comment:	**1 dose of Tdap** vaccine Within 10 years	**TDAP:**
Tuberculosis-TST (PPD) OR IGRA (t-spot, quantiferon)	**1 Negative TST** (tuberculosis skin test) **or IGA** (t-spot or quantiferon) **blood work within one year.** **If prior history of positive TST**, must provide: completed, reviewed TB Screening (Symptom) Questionnaire **and** record of written negative chest x-ray report **within 2 years**	**TST1:** ☐Neg ☐Positive Comments: Or **IGRA:** ☐Neg ☐Positive Comments: **Chest X-ray:** ☐Neg ☐Positive Comments: **TB Screening Questionnaire:** ☐ Yes Date_____ Comments:
Influenza Flu Comment:	**Influenza immunization within current flu season or** signed declination	**FLU:** **Signed Declination:** ☐ Yes Date _____ ☐Instructed re: wearing mask when vaccination is declined
Other **Have you traveled outside the country within the last 14 days?**	Completion of mandatory packet/orientation set up: Confidentiality signed: **No__ Yes___**	If yes, where?_____
Facility Signature:		Date:
OHS RN Signature:		**OHS Clearance Date:**

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OCCUPATIONAL HEALTH SERVICES

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Tuberculosis Screening Questionnaire

This form must be completed ANNUALLY by all employees with a positive TB Skin Test.

Name: _____ D/O/B: _____ SS#: _____

Telephone/Home: _____ Work #: _____

Facility: _____ Unit: _____ Position: _____

Our records indicate you have previously tested positive on the TB skin test (TST) or are sensitized to the TB solution. Positive TB skin tests indicate you have been exposed to TB, but do not necessarily indicate you have active TB disease.

☐ Pre-Placement ☐ Annual ☐ Post Exposure

	NO	YES
1. Have you had recent close contact with someone with infectious TB disease?		
2. Have you lived in or traveled in a TB endemic country (e.g. Africa, Asia, Central/ South America, Caribbean- not Puerto Rico, Eastern Europe, Middle East)?		
3. Have you had any of the following signs or symptoms with in the last year?		
▪ Unexplained fever		
▪ Unexplained cough for 3 weeks or more If yes, ☐ Productive ☐ Non-Productive - # of weeks		
▪ Night sweats		
▪ Unexplained weight loss		
▪ Chest pain		
▪ Unexplained fatigue/malaise		
▪ Blood-tinged sputum (Hemoptysis)		
4. Have you been informed that you have any condition that could depress your immune system, such as: cancer, immune deficiency disease, diabetes, silicosis, renal failure, cirrhosis, HIV infection, poor nutrition, substance abuse, major stomach/intestinal surgery, severe infectious disease, solid organ transplant?		
5. Are you presently being treated with any medication that could depress your immune system, such as: cortisone, methotrexate, Imuran, chemotherapy, HIV Meds?		
6. Is your treating physician aware that you have a positive PPD? (If not, we recommend that you advise him/her.)		

Employee Signature _____ Date: _____

OHS Reviewer Signature _____ Date: _____

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RELEASE FORM

Student Declination of Hepatitis B Vaccination Series

Student's Name: _____ Date: _____

Department student will be assigned: _____

❒ Exposure Prone work assignment ❒ Non-Exposure Prone Work Assignment

I understand that due to my possible exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. Because I have no proof of either receiving the Hepatitis B vaccination series or positive titer I continue to be at risk of acquiring hepatitis B, a serious disease. In spite of this knowledge I am willing to take this risk without protection.

Signature Date

Witness Title

MANDATORY ACCORDING TO OSHA

Cape Cod Healthcare
CONFIDENTIALITY AGREEMENT

Consistent with applicable state and federal laws, the Principles of Ethics of both the American Medical and Hospital Associations, and established Cape Cod Healthcare, Inc. ("CCHC") policies and procedures, individuals who are given access to CCHC records (whether medical, financial or other) as well as all users of the CCHC Information System (the "CCHCIS"), must acknowledge and agree that they will safeguard and protect all such records and information from inappropriate use or disclosure. You acknowledge that all such records are confidential and/or proprietary to CCHC, whether stored in hard copy, film or computerized/electronic form, and that the unauthorized access, use, disclosure or dissemination of such information is strictly prohibited.

CCHCIS user codes and passwords will be issued on a private, individualized basis. These codes and passwords are not to be shared with anyone else, and it is your responsibility to protect and safeguard those codes/passwords from unauthorized use. Your password is a unique code which identifies your identity for and within the CCHCIS. All activities, performed using this password, such as, inquiries, data entries and orders, are recorded and will be attributable to you. The CCHCIS can and will be monitored frequently and without advance notice for inappropriate access to individually identifiable health information ("PHI – Protected Health Information") and for other purposes.

All PHI and other data and information stored on the CCHCIS are the exclusive property of CCHC. Because virtually all of that information is or will become a part of a patient's legal medical record, all CCHC policies, legal restrictions and ethical guidelines applicable to patient medical records, PHI and other protected clinical, financial and administrative information also apply to the data stored at and within CCHC as well as on the CCHCIS.

By signing where indicated below, you acknowledge your legal obligation to maintain the confidentiality of PHI and other patient and CCHC records. You further acknowledge that accessing patient and/or CCHC system information which is not essential to the performance of your duties for and within CCHC, disclosing your system identifier and/or password to another, allowing access to the CCHCIS by unauthorized individuals and/or entities whether intentional or unintentional, or any other breach of patient record or health care system confidentiality policy will be investigated and the consequences could be severe for you, up to and including your termination as an employee of CCHC and/or the permanent loss of your ability to access CCHCIS.

Should a Medical Staff Member of a CCHC affiliated hospital or an employee of that Medical Staff Member, disclose PHI or other information obtained from CCHC or the CCHCIS in an unauthorized manner, in violation of applicable state and/or federal law or in violation of applicable CCHC policy and/or procedure (including those set forth in this Confidentiality Agreement), the Medical Staff Member, his/her employee as well as his/her employer shall remain obligated to indemnify and hold CCHC harmless from all claims, demands, suits and liabilities, including reasonable attorney's fees and costs that may be made or taken against CCHC for that breach.

Finally, by signing this Agreement you acknowledge your obligations with respect to those confidentiality obligations imposed upon CCHC and its affiliates pursuant to the Health Insurance Portability and Accountability Act of 1996, a law more commonly known as HIPAA. You agree to protect and safeguard PHI (as defined under HIPAA), and acknowledge your receipt of a copy of CCHC's Notice of Privacy Practices. You agree to abide by the provisions of that Notice. If at any time you have reason to believe that the confidentiality of CCHCIS or any other source of PHI may have been compromised at or within CCHC, you are required to notify your supervisor, manager, department head, or CCHC's Compliance Office immediately so that appropriate action can be taken.

I ACKNOWLEDGE THAT I HAVE READ THE FOREGOING CONFIDENTIALITY AGREEMENT AND AGREE TO ABIDE BY ITS TERMS. *****ALL FIELDS ARE REQUIRED!!*****

Last Name	First Name	MI	Birthdate (MMDDYYYY)	Last four SSN (xxxx)
Job/Title	**Department/Office**	**Company/Facility**		**Office Telephone**
Signature:		**Date:**		

CAPE COD HEALTHCARE

Student Placement Information:

Please be advised that each entity needs to be aware of your presence in the facility and enter you into a data base within the system for reference.

Please provide the below information by completing and returning via e-mail to studentclearance@capecodhealth.org ***at least 2 weeks*** prior to your arrival for clinical placement:

Clinical Placement Information

Start date for clinical rotation:

End date for clinical rotation:

Clinical site & department:

Preceptor:

Student Information

First Name, Middle Initial, & Last Name:

Date of Birth:

Last 4 of Social Security Number:

Mailing address:

Phone:

Email:

Gender:

Ethnicity:

Please email studentclearance@capecodhealth.org with any questions.

CCHC Active Shooter Policy and Procedures – Sign Off Page

Name _____ **DATE** _____

Department_____

I acknowledge I have read and understand the CCHC Active Shooter Policy and Procedures.

Signature _____

Please return your completed sign off page to the same location as your 2018 MAT Answer Sheet