Black River
MEMORIAL HOSPITAL

Alternative Orientation Response Sheet

Participant Name_____

Date:_____ Department:_____

Students only: Name of School _____

Tasks to Complete:

1. Answer all questions on this Orientation Response Sheet
2. Return all completed forms to the Organizational Development Department via e-mail: OrganizationalDevelopment@BlackRiverHospital.com
3. Printing off the response sheet, completing and mailing in is also acceptable.

- Describe one way you will be able to contribute to the mission, vision and values of BRMH.

  _____

  _____

True/False Questions

T___ F___ 1. The single most important measure for preventing the spread of infection is proper hand hygiene.

T___ F___ 2. Hands do not need to be washed before and after using gloves.

T___ F___ 3. Hazardous Waste refers to all wastes.

T___ F___ 4. Maintaining the confidentiality, privacy and security of patients' Protected Health Information (PHI) is not only a matter of organizational policies and procedures, but a right assured by federal HIPAA legislation and state laws.

T___ F___ 5. BRMH follows a no retaliation policy in regards to reporting harassment.

T___ F___ 6. Safety Data Sheets (SDS) are located "on-line" by clicking on the SDS link located on the right side of the "iAccess" homepage.

T___ F___ 7. Breaching patient confidentiality may be grounds for disciplinary actions up to and including discharge.

- **FIRE SAFETY**
  The RACE for fire safety stands for:

  R=_____

  A=_____

  C=_____

  E=_____

FIRE EXTINGUISHER
The PASS acronym stands for:

P=_____

A=_____

S=_____

S=_____

- Three of the Five Core Values recognized by BRMH include:
- a. _____

  b. _____

  c. _____

I have read the required orientation information as well as completing the Alternative Orientation Response Sheet. My signature below indicates my understanding of the core processes of BRMH as outlined in the handbook. My signature additionally validates my intention to comply with the stated elements. If I have questions regarding any information, I am to contact a staff member.

I acknowledge receiving information on the policies and procedures related to confidentiality and the Security of protected health information required by the federal HIPAA Security rule. I understand that my use or disclosure of PHI is limited to the extent that the information is necessary to perform my assigned tasks and that unauthorized use or disclosure may result in termination of my time at BRMH.

Date: _____ Name (Print) _____

Signature: _____

Reviewed by: _____

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TUBERCULOSIS (TB) RISK ASSESSMENT QUESTIONNAIRE

Name (Printed): _____ Date of Birth: _____

Review the screening criteria and select all that apply. Provide explanations as indicated.

Recent TB symptoms: ◯ Yes ◯ No

a. Persistent cough lasting three or more weeks AND
b. One or more of the following symptoms: coughing up blood, fever, night sweats, unexplained weight loss, or fatigue.

If answered Yes:
List the symptoms you are experiencing: _____

Have you ever been treated with TB medication(s)? ☐ Yes ☐ No
If answered Yes:
Med Name(s): _____
Duration of Medication(s): _____

Have you ever been in close contact with someone with TB during your lifetime? ☐ Yes ☐ No
If answered Yes:
Indicate the date(s): _____

Birth, travel or residence in a country with high TB rates ☐ Yes ☐ No

a. Includes any country other than the United States, Canada, Australia, New Zealand or a country in Western or Northern Europe

If answered Yes:
Indicate the date(s): _____

Current or former employee, volunteer or resident of a high-risk setting with an elevated TB rate
◯ Yes ◯ No

a. Includes Alaska, California, Florida, Hawaii, New Jersey, New York, Texas, or Washington DC
b. Includes correctional facilities, long-term residential care facilities, or shelter for the homeless

If answered Yes:
Indicate the date(s): _____

By signing, I agree that to the best of my knowledge, that I do not have any of the above symptoms.
I agree to notify the Infection Prevention Nurse if any symptoms of and/or exposures to Tuberculosis occur.

Signature: _____ Date:_____

RETURN DOCUMENT TO THE INFECTION PREVENTION NURSE AS SOON AS POSSIBLE

You will be contacted if further follow up is needed.

For Use by Infection Prevention Staff:

☐ A TB risk assessment was completed for individual named above. No risk factors for TB were identified.
☐ A TB risk assessment has been completed for the individual named above. Risk factors for TB have been Identified. Further testing recommended determining the presence or absence of tuberculosis in a communicable form.

Comments: _____
_____

IP RN or Designee Signature:_____ Date:_____

Student Program Parental Permission Form

Date: _____

I hereby give permission for my son/daughter _____ to participate in the Job Shadowing Experience at Black River Memorial Hospital. I certify that my son/daughter is _____ years of age and that his/her birth date is _____.

I also authorize any health screening that is required for participation in the Job Shadow experience.

_____

Name of Parent/Guardian

_____

Home Phone Work Phone Cell Phone

_____

Emergency Contact Information