Spokane Regional Health District

Volunteer/Internship Program

HUMAN RESOURCES
1101 West College Avenue
Spokane, WA 99201-2095

509.324.1461| *PHONE*
509.324.3604| *FAX*
509.324.1464| *TDD*

www.srhd.org

The following paperwork must be turned in to the Human Resource Office to start the volunteer/internship application process:

- Volunteer/Intern Registration/Participant Agreement Form
- Immunization Form and copies of Immunization Records
- Disclosure and Authorization for Background Inquiry
- Oath of Confidentiality
- Emergency Information Form
- Signed Drug Free Workplace Agreement
- Signed HIPPA Privacy Rule Acknowledgement
- Signed Agreement of Non-Tobacco Use for Volunteers/Interns
- Signed Class Participation Agreement for Non-SRHD Employees
- All Nursing Students require a current TB Test (within the last 6 weeks) and Proof of Hep B immunity. Students may sign a Declination Form.

To help us better serve you please answer the following questions:

- Which programs are you interested in?
  _____
- Have you been in contact with a program manager? If so, who?
  _____
- College Interns, are Competencies or an Affiliation Agreement required for your internship?
  _____
  - If yes, did you forward the information to the precepting manager?
    _____

Please return completed forms in person or mail to address above or fax to (509)324-3604.

Spokane Regional Health District Volunteer/Internship Registration Form

Participant Agreement

HUMAN RESOURCES
1101 West College Avenue
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Participants in the Spokane Regional Health District Volunteer/Internship Program must agree to the following requirements and sign below in acknowledgement.

VOLUNTEER/INTERN REQUIREMENTS

- Must complete Background Inquiry form and agree to a Washington State Patrol background check.
- Health care professionals must provide proof of licensure if needed for volunteer/intern activities.

Public Health Volunteers for Emergency Response must also agree to the following:

- Must have a valid motor vehicle driver's license and have access to a vehicle **OR** have another means of accessing multiple sites in a timely manner.
- Must be at least 18 years of age.

RISK ACKNOWLEDGEMENT

I understand that participation in the Spokane Regional Health District Volunteer/Internship Program may carry risks, including personal injury, from natural or man-made hazards, environmental conditions, diseases and other conditions that have the potential to cause injury. Being fully aware of the potential risks involved, I hereby waive any and all legal rights I have or may have in the future to bring any claim or lawsuit against SRHD or its employees, officers, or agents arising out of or connected with participating in the Spokane Regional Health District Volunteer/Internship Program.

BEHAVIORAL STANDARDS:

All volunteers/interns are required to be respectful and courteous to all co-volunteers/interns and leadership. Volunteers/Interns are further expected to represent the team in a positive manner at all times and be a team player who works toward meeting the objectives set forth. In order to maintain trust, volunteers/interns will be honest and adhere to ethical standards in all instances. Failure to adhere to respectful behavior standards may result in removal from the team.

RELEASE

My signature below confirms that I am at least 18 years of age and I agree to the terms and conditions outlined in this Participant Agreement. I further understand that as a matter of procedure, a background check will be conducted at the time that I volunteer/intern and periodically thereafter. I also agree to follow the behavioral standards set forth in this document and that if I fail to adhere to these standards, my association with the Spokane Regional Health District Volunteer/Internship Program may end without notice.

Print Name: _____

Signed: _____Date: _____

Spokane Regional Health District
Volunteer/Intern Registration Form

Becoming a Public Health Volunteer for emergency response could involve working in a mass prophylaxis or vaccination clinic, or assisting during a communicable disease outbreak. Please complete the following information and return this form to:

Spokane Regional Health District, Volunteer/Internship Program, 1101 W. College Avenue #345, Spokane, WA 99201

First **Name:**	MI	Last
Date of Birth:	**County of Residence:**	
Employer:	**Job Title:**	
E-Mail:	**SRHD Division/Program/Project:**	
Home Address:		
City, State, Zip:		
Previous Address (if lived outside WA State in last 24 months)**:**		
Primary Phone:	Is this: Home ☐ Work ☐ Cell ☐	
Secondary Phone:	Is this: Home ☐ Work ☐ Cell ☐	
Emergency Contact Name:		
Emergency Contact Phone #:	**Relationship to Volunteer/Intern:**	

Are you currently or have you ever been a Spokane Regional Health District Volunteer/Intern?	Yes ☐ No ☐ If yes, when?
Do you have the ability to stand continuously for a minimum of 4 hours?	Yes ☐ No ☐
Can we call upon you to assist in other public health emergencies in outlying counties?	Yes ☐ No ☐
Can we call upon you for other public health emergencies? (Assistance during a communicable disease outbreak.)	Yes ☐ No ☐

Are you a health care professional? ☐ Yes No ☐	**Licensed?** Yes ☐ No ☐	**Lic # & Exp:**

Experience & Skills (*Please check all that apply*)

Administration/Supervisor ☐	Customer Service ☐	Medical Diagnosis ☐	Other (please specify):
Purchasing/Logistics ☐	Phones/Switchboard ☐	Patient Care ☐	
Staffing/Scheduling ☐	Clerical ☐	Triage ☐	
Interviewing/Investigation ☐	Medical Records ☐	First Aid/CPR ☐	
Education/Teaching ☐	Commercial Driver's License ☐	Medication Distribution	
Advanced Computer Skills ☐	Bus Operator ☐	Providing Vaccination ☐	
	Security/Law Enforcement ☐	Mental Health ☐	

Do you speak a foreign language? Yes ☐ No ☐	**Please list language(s):**

Speak fluently? Yes ☐ No ☐ **Reading/Writing?** Yes ☐ No ☐ **Medical Translation?** Yes ☐ No ☐

VOLUNTEER and INTERN IMMUNIZATION FORM

Please indicate whether you have received any of the following vaccinations

Vaccination					Year(s) Received
MMR	Yes ☐	No ☐	Unknown ☐	Incomplete ☐	
Tdap	Yes ☐	No ☐	Unknown ☐	Incomplete ☐	
Varicella	Yes ☐	No ☐	Unknown ☐	Incomplete ☐	
Hepatitis B	Yes ☐	No ☐	Unknown ☐	Incomplete ☐	
Influenza	Yes ☐	No ☐	Unknown ☐	Incomplete ☐	

MMR=measles, mumps, rubella Tdap= Tetanus, diphtheria, pertussis Hep B=hepatitis B

Note: SRHD e-mail is not encrypted. Please do not e-mail immunization records.

Volunteers/Interns may submit Immunization records to:

ATTN: Volunteer Coordinator
Spokane Regional Health District
1101 W. College Ave., Suite 345
Spokane, WA 99201

OR via fax at 509-324-3604

CONFIDENTIAL

Volunteer/Intern Disclosure and Authorization for Background Inquiry

SPOKANE REGIONAL HEALTH DISTRICT

HUMAN RESOURCES
1101 West College Avenue
Spokane, WA 99201-2095

509.324.1461 | PHONE
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509.324.1464 | TDD

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Important Applicant Information:

You are applying for appointment to a volunteer/internship position that may be directly responsible for the care, supervision, or treatment of children or developmentally disabled persons. As provided by Washington State Law under RCW 43.43.830, applicants must provide a disclosure statement of certain civil adjudications, conviction records of crimes against persons, and disciplinary board final decisions prior to appointment to positions which are directly responsible for the care, supervision, or treatment of children or developmentally disabled persons.

The Spokane Regional Health District (SRHD) will make background inquiries of the above noted disclosures. Such inquiries may be made to State and/or Federal law agencies. Information obtained from the disclosure statement or from the background inquiries will not necessarily preclude appointment, but will be considered in determining the applicant's character, suitability, and competence for the volunteer/internship position applied for and may result in denial of appointment. The use of these inquiries will be restricted to decisions on possible SRHD appointment.

If you wish to be considered for appointment, you must complete and sign this *Applicant Disclosure and Authorization for Background Inquiry* form. Failure to complete and sign this form will disqualify you from SRHD appointment. The information provided on this form will only be considered if you are being appointed as a volunteer.

State background identification shall satisfy future record check requirements for the applicant for a two (2) year period. A copy of the background inquiry information from State or Federal law enforcement agencies will be available to you upon request. SRHD is not liable for defamation, invasion of privacy, negligence, or any other claim in connection with any lawful dissemination of information under RCW 43.43. SRHD will not disseminate this information to a second party in compliance with RCW 10.97.

The Spokane Regional Health District may require that a volunteer/intern provide the Federal Bureau of Investigation, United States Department of Justice with classifiable fingerprints to be used as a further inquiry of the volunteer's/intern's background, pursuant to and for the purpose set forth in Chapter 486, Laws of 1987.

State and Federal background checks and FBI fingerprinting will be completed at SRHD's expense.

Volunteer/Internship Disclosure and Authorization for Background Inquiry

Please type or print:

Last Name:	First Name:	M.I.:
Alias/Maiden Name:		
Date of Birth:	Race:	Sex: ☐ Male ☐ Female
Driver's License Number:		State:

Please answer Yes or No to each listed item below. If you answer Yes to any item, explain in the area provided or attach additional sheets indicating the charge or finding, date, court(s), and state involved.

1. Have you ever been convicted of any crimes against children or other persons as follows?

Aggravated murder;
First or second-degree murder;
First or second-degree kidnapping;
First, second, or third-degree assault; First, second, or third-degree rape;
First, second, or third-degree statutory rape (rape of a child),
First or second-degree robbery;
First-degree arson;
First-degree burglary;
First or second-degree manslaughter;
First or second-degree extortion;
Indecent liberties;
Incest;
Vehicular homicide;
First-degree promoting prostitution;
Communication with a minor;
Unlawful imprisonment;
Simple assault;
Sexual exploitation of minors;
First or second-degree criminal mistreatment;
Child abuse or neglect as defined in RCW 26.44.020;
First or second-degree custodial interference;
Malicious harassment;
First, second, or third-degree child molestation;
First or second-degree sexual misconduct with a minor;
Patronizing a juvenile prostitute;
Child abandonment;
Promoting pornography;
Selling or distributing erotic material to a minor;
Custodial assault;
Violation of a child abuse restraining order;
Child buying or selling; or prostitution

☐ No ☐ Yes If Yes, explain:

2. Have you ever been convicted of crimes related to the financial exploitation (First, second, or third degree extortion; First, second, or third degree theft; First or second degree robbery; Forgery) where the victim was a vulnerable adult?

☐ No ☐ Yes If Yes, explain:

3. Have you ever been found in any dependency action under RCW 13.34.030 (2)(b) to have sexually assaulted or exploited any minor, or to have physically abused any minor?

☐ No ☐ Yes If Yes, explain:

4. 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 or to have abused or financially exploited any vulnerable adult or found by a court in a protection proceeding under RCW 74.34, to have abused or financially exploited a vulnerable adult?

☐ No ☐ Yes If Yes, explain:

I swear, under penalty of perjury that the above information is correct:

Signature: _____ Date: _____

Oath of Confidentiality

(Revised Sept. 2013)

As a condition of my employment or service relationship with Spokane Regional Health District, I agree to the following:

I am bound by 42 Code of Federal Regulations (CFR), Part 2, federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR, Parts 160 and 164, and by Revised Code of Washington (RCW) 70.96A, Treatment of Alcoholism, Intoxication, and Drug Addiction and (RCW) 70.24.80 and 70.24.084, Control and Treatment of Sexually Transmitted Diseases.

I certify not to divulge to any unauthorized third party, any information concerning a client, other than to another Spokane Regional Health District staff member, following the agency's Minimum Information Necessary policy, except when:

a) I have written authorized consent for the release of such information from the client.
b) I am reporting child abuse or neglect per RCW 26.44.
c) I am reporting information concerning a crime, which is threatened to be committed either at the program, or against any person who works for the program.
d) The disclosure is a requirement of a court order, or of federal or state laws and regulations.
e) I am reporting a medical emergency that poses an immediate threat to the health of any individual and requires immediate medical attention.
f) I am ordered by a court order, which satisfies the requirements of 42 CFR, Part 2.
g) I am reporting a crime a patient has committed on the premises of/or against agency personnel.

I will consult with my Program Manager/Division Director/Privacy Officer for direction anytime I am unclear as to the interpretation of confidentiality regulations or the legality of requests made of me for information.

I agree to be bound by procedures for safeguarding client information, including:

a) All charts, notes, and other written materials will be stored in a secure room or locked up when not in use.
b) Discussions regarding clients will be held in staff offices or in other places providing assurance of privacy.
c) No privileged information will be shared with other agencies, professionals, friends, or family members without prior written authorization from the client.
d) I will deny acknowledgement of or requests for access to client files by anyone not employed by SRHD, and refer such requests to the Division Director or Agency Privacy Officer.

I understand that an unauthorized disclosure of client information or records may subject me to a civil action for damages of $1,000 or three times the amount of actual damages sustained by a willful release of confidential information under RCW 71.05.440, or state and federal criminal prosecution in accordance with 42 CFR, Part 2 and 45 CFR, Parts 160 and 164 as follows:

42 CFR, Part 2 Penalties

- Not more than $500 for the first offense and up to $5,000 for each subsequent offense.

45 CFR, Part 160 and 164 Penalties (as of September 2013)

Type of Violation	Range of Amounts of CMP for Each Violation	All Such Violations of an Identical Provision in a Calendar Year
Unknowing Violation did not know and by reasonable diligence would not have known of the violation.	$100 to $50, 000	$1,500,000
Reasonable Cause committed a violation due to reasonable cause not willful neglect.	$1,000 to $50,000	$1,500,000
Willful Neglect, Corrected committed a violation due to willful neglect but corrected in a timely manner.	$10,000 to $50,000	$1,500,000
Willful Neglect, Uncorrected committed a violation due to willful neglect and not corrected in a timely manner.	$50,000	$1,500,000

42 USC §1320 d.6.

- $1,000,000 maximum fine and 5 years imprisonment if offense is committed under false pretenses.
- $250,000 maximum fine and 10 years imprisonment if offense is committed with intent to sell, transfer, or use the protected information for commercial advantage, personal gain or malicious harm.

I understand all applicable federal and state statutes, regulations or laws pertaining to confidentiality must be followed. I also understand my Oath of Confidentiality and these requirements do not cease at the time I terminate my relationship with the Spokane Regional Health District. I agree to be permanently bound by this oath and by the regulations of confidentiality henceforth.

Signature: _____ Date: _____

Printed Name: _____

Statutes/Regulations

Act / Law / Topic	Number
General Release of Information	WAC 248-14-270
Federal Alcohol and Drug Abuse Act	42 CFR Part 2, August 1, 1987
Privacy Act of 1974	Public Law 93-579
Health Insurance Portability & Accountability Act 1996 - HIPAA	Public Law 104-191
Standards for Privacy of Individually Identifiable Health Information	45 CFR Parts 160 & 164
Public Disclosure Act	RCW 42.17.310
Washington AIDS Omnibus	Bill SB 6221, March 23, 1988 Amended SB 5886, April 20, 1989
Coroner/Medical Examiner	RCW 68.50
Third Payors	RCW 51.36.060
Mental Illness Act	RCW 71.05
WA State Public Disclosure Law	RCW 42.17.310
Labor and Industries	RCW 51.36.060
Alcohol and Drug Abuse Records	RCW 69.04.830 - 840 RCW 70.96A.150 RCW 71.05.390 WAC 275-19-170
Minor Authorization	RCW 26.16.125 RCW 70.24.110 RCW 26.33.350 RCW 71.34.030 RCW 26.44
Vital Statistics	RCW 70.58.030
Communicable Diseases	WAC 246-100
STD	RCW 70.24.105
Child/Elder Abuse	RCW 26.44 RCW 74.34
Subpoenas, Search Warrants, Court Orders	RCW 44.16.080 RCW 51.04.050 RCW 10.79.015 RCW 74.09.290 RCW 48.03.070 RCW 4.24.250 RCW 51.36.060

Volunteer/Intern Emergency Information Form

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Name: _____ Date: _____

Address: _____ Phone: _____

City, State, Zip: _____

Emergency Notification Information

Person to notify first: _____ Relationship: _____

Phone: _____ Alternate: _____

Person to notify second: _____ Relationship: _____

Phone: _____ Alternate: _____

Physician: _____ Phone: _____

Medical Insurance Carrier: _____

_____

Subscriber/Member ID #: _____

_____

Known Allergies: _____

_____

List any current medication/dosage: _____

_____

_____

Critical Medical Information: _____

_____

_____

Drug Free Workplace Statement

The Spokane Regional Health District is committed to providing a safe drug-free work environment and to fostering the well-being and health of its employees and volunteers/interns. That commitment is jeopardized when a Health District volunteer/intern illegally misuses drugs or uses alcohol on the job, comes to work under the influence, or possesses manufactures, distributes, or sells illegal drugs or alcohol in the workplace. All volunteers/interns must abide by the following terms as a condition of volunteering/internship or continued volunteer/internship opportunities with the Health District:

A. It is a violation of Health District policy for any volunteer/intern to unlawfully manufacture, distribute, dispense, possess, sell, trade, offer for sale or use controlled substances on the job or to otherwise engage in the illegal misuse of drugs or use of alcohol on the job.

B. It is a violation of Health District policy for anyone to report to work or work under the influence of illegal drugs or alcohol.

C. It is a violation of Health District policy for anyone to misuse prescription drugs.

The goal of this policy is to balance respect for individuals with the need to maintain a safe, productive, drug and alcohol free work environment. Everyone shares responsibility for maintaining a safe work environment, and volunteers/interns should encourage anyone who may have a drug or alcohol problem to seek help.

As a condition of volunteering/internship, volunteers/interns must abide by the terms of this policy and must notify their supervisor and the Volunteer/Internship Coordinator in writing of any conviction for violation of a criminal drug statute occurring in the workplace or during work hours no later than five calendar days after such conviction.

Drug Free Workplace Agreement

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I, _____, do hereby declare that I have read and understand the above mentioned conditions of volunteering/internship with the Spokane Regional Health District, and have read and understand the Drug Free Workplace Policy.

_____ _____

Volunteer/Intern Signature Date

*** Please return ONLY this form. Thank you**

Revised January 2016

HIPAA TRAINING HANDBOOK

(Revised Feb. 2011)

HIPAA: PRIVACY COMPLIANCE

The HIPAA Rule – finalized on August 14, 2002 – ensures that personal medical information you share with doctors, hospitals and others who provide and pay for healthcare is protected. It is part of the Health Insurance Portability and Accountability Act (HIPAA) enacted by Congress

Basically, the Privacy Rule does the following:

- Imposes new restrictions on the use and disclosure of personal health information
- Gives clients greater access to their medical records
- Gives clients greater protection of the medical records

WHO IS COVERED BY THE HIPAA PRIVACY RULE?

You're covered by the HIPAA Privacy Rule – and termed a covered entity – if you are a:

- Healthcare provider
- Health Plan
- Healthcare clearinghouse

HIPAA also indirectly affects business associates who have access to client records.

WHAT IS PROTECTED HEALTH INFORMATION?

When a client gives personal health information to a covered entity, that information becomes Protected Health Information – or PHI. PHI includes any information – oral, recorded, on paper, or sent electronically – about a person's physical or mental health, services rendered or payment for those services and that includes personal information connecting the client to the record.

Examples of information that might connect personal health information to the individual client include:

- The individual's name or address
- Social security or other identification numbers
- Physician's personal notes
- Billing information

WHAT ARE THE RULES FOR THE USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION?

HIPAA's Privacy Rule is all about the use and disclosure of Protected Health Information or PHI. With few exceptions, PHI can't be used or disclosed by anyone unless it is permitted or required by the Privacy Rule.

PHI is used when:

- Shared
- Examined
- Applied
- Analyzed

PHI is disclosed when:

- Released
- Transferred
- In any way made accessible to anyone outside the covered entity.

You are permitted to use or disclose PHI:

- For treatment, payment and healthcare operations
- With authorization or agreement from the individual client
- For disclosure to the individual client
- For incidental uses such as physicians talking to patients in a semi-private room

You are required to release PHI for use and disclosure:

- When requested or authorized by the individual – although some exceptions may apply
- When required by the Department of Health and Human Services (HHS) for compliance or investigation

WHEN IS AUTHORIZATION REQUIRED?

The final ruling makes consent for routine healthcare optional. But you are required to get a signed authorization from the patient if you use or disclose his or her Protected Health Information for purposes other than:

- Treatment
- Payment
- Healthcare operations

Generally, authorization is required to use PHI:

- For use or disclosure of psychotherapy notes
- For research purposes, unless a documented waiver is obtained from the Institutional Review Board (IRB) or privacy board
- For use and disclosure to third parties for marketing activities such as promoting services or selling lists of patients

However, covered entities may communicate freely with clients about treatment options and health-related information.

WHAT IS INCLUDED IN AN AUTHORIZATION FORM?

Each authorization form only covers the use/disclosure outlined in that form. The form must contain:

- A description of the PHI to be used/disclosed, in clear language
- Who will use/disclose PHI, and for what purpose
- Whether or not it will result in financial gain for the covered entity
- The client's right to revoke the authorization
- A signature of the client whose record are used/disclosed, and date of signing
- An expiration date

WHEN IS AUTHORIZATION NOT REQUIRED?

PHI can be used/disclosed without authorization, but with client agreement, for the following reasons:

- To maintain a facility's patient directory
- To inform family members or other identified persons involved in the patient's care, or notify them on patient location, condition or death
- To inform appropriate agencies during disaster relief efforts

Other permitted uses/disclosures that do not require patient authorization include:

- Public health activities related to disease prevention or control
- To report victims of abuse, neglect, or domestic violence
- Health oversight activities such as audits, legal investigations, government functions
- For coroners, medical examiners, funeral directors or tissue/organ donations
- To avert a serious threat to health and safety

WHAT IS MINIMUM NECESSARY?

In general, use/disclosure of PHI is limited to the minimum amount of health information necessary to get the job done right. That means:

- Covered entities must develop policies and practices to make sure the least amount of health information is shared
- Employees must be identified who regularly access PHI along with the types of PHI needed and the conditions for access.

The Minimum Necessary requirement does not apply to use/disclosure of medical records for treatment, since healthcare providers need the entire record to provide quality care. But it does apply in all other circumstances.

WHAT IS THE NOTICE OF PRIVACY PRACTICES?

Clients have the right to adequate notice concerning the use/disclosure of their PHI on the first date of service delivery, or as soon as possible after an emergency. And new notices must be issued when your facility's privacy practices change.

The Notice of Privacy Practices must:

- Contain patient's rights and the covered entities' legal duties

- Be made available to patients in print
- Be displayed at the site of service, and posted on a web site whenever appropriate

Once a patient has received notice of his or her rights, covered entities must make an effort to get written acknowledgement of receipt of notice from the patient, or document reasons why it was not obtained. And copies must be kept of all notices and acknowledgements.

WHAT ARE PATIENT PRIVACY RIGHTS?

The Privacy Rule grants patients new rights over their PHI. It's your job to make sure they can exercise their rights, including the following:

- Receive Notice of Privacy Practices at the time of first delivery of service
- Request restricted use and disclosure, although the covered entity is not required to agree
- Have PHI communicated to them by alternate means and at alternate locations to protect confidentiality
- Inspect and amend PHI, and obtain copies with some exceptions
- Request a history of disclosures for six years prior to the request, except for disclosures made for treatment, payment healthcare operations or with prior authorization
- Contact designated persons regarding any privacy concern or breach of privacy within the facility or at HHS.

WHAT ABOUT THE PRIVACY RIGHTS OF MINORS?

In general, parents have the right to access and control the PHI of their minor children – except when state law overrides parental control. Examples include:

- HIV testing of minors without parental permission
- Cases of abuse
- When parents have agreed to give up control over their minor child

WHAT MUST ADMINISTRATION DO TO COMPLY?

- Allow patients to see and copy their PHI
- Designate a full – or part-time privacy official responsible for implementing the programs
- Designate a contact person or office responsible for receiving complaints
- Develop a Notice of Privacy Practices document
- Develop policies and safeguards to protect PHI and limit incidental use or disclosure
- Institute employee – training programs, so everyone knows about the privacy policies and procedures for safeguarding PHI
- Institute a complaints process, and file and resolve formal complaints
- Make sure contracts with business associates comply with the Privacy Rule.

WHAT HAPPENS TO THOSE WHO DON'T COMPLY?

If you violate the Privacy Rule, HIPAA set civil and criminal penalties including:

- A $100.00 civil penalty up to a maximum of $50,000.00 per year for each standard violated occurring prior to 02/18/2009.
- For violations occurring on or after 02/18/09: $100 to $50,000 or more per violation
- A criminal penalty of $50,000 and up to one year imprisonment occurring prior to 02/18/2009. The criminal penalties increased to $100,000 and up to five years imprisonment if the wrongful conduct involves false pretenses, and to $250,000 and up to 10 years imprisonment if the wrongful conduct involves the intent to sell, transfer, or use identifiable health information for commercial advantage, personal gain or malicious harm. The Department of Justice is responsible for criminal prosecutions under the Privacy Rule.

But if you unknowingly make a mistake, remember: the Department of Health and Human Services is mandated to give you and your organization advice and technical assistance – and help you work out problems.

WHAT CAN YOU DO TO PROTECT PATIENT'S PRIVACY AND CONFIDENTIALITY?

HIPAA protects our fundamental right to privacy and confidentiality. And that means HIPAA's Privacy Rule is everyone's business – from the CEO to the healthcare professional to the maintenance staff. To do your part:

- Make sure you fully understand your facility's privacy practices
- Protect your patient's personal health information
- Encourage others to do the same

HIPAA PRIVACY RULE ACKNOWLEDGEMENT

I acknowledge I have read and understand the following HIPAA regulations:

- **HIPAA Privacy Compliance**
- **Who Is Covered By The HIPAA Privacy Rule**
- **What Is Protected Health Information**
- **What Is Minimum Necessary Information**
- **What Is The Notice Of Privacy Practices**
- **What Are Patient Privacy Rights**
- **What About The Privacy Rights of Minors**
- **What Must Administration Do To Comply**
- **What Happens To Those Who Don't Comply**
- **What Can You Do To Protect Patient's Privacy and Confidentiality**

_____ _____

Volunteer/Intern Signature Date

Please Print Name Clearly

*** Please return ONLY this form. Thank you**

Agreement of Non-Tobacco Use for Volunteers/Interns

I acknowledge that the Spokane Regional Health District (SRHD) is dedicated to providing a healthy, comfortable and tobacco-free work environment for all employees and volunteers/interns. The reasons are simple:

- Tobacco Prevention and Control is one of the Health District's primary objectives. It is important that we demonstrate healthy behaviors by our actions and through our policies that support the education and marketing of tobacco prevention efforts within the Spokane County community.
- Former U. S. Surgeon General, Dr. David Satcher, stated that "Tobacco use will remain the leading cause of preventable illness and death in the Nation…until tobacco prevention and control efforts are commensurate with the harm caused by tobacco use."

I understand that the Spokane Regional Health District serves the Spokane County community and that tobacco-use prevention is a primary objective. I acknowledge that as a volunteer/intern of the Health District, I will be expected to demonstrate tobacco-free behavior when representing SRHD. I agree not to use tobacco products during my volunteer/internship shift or activity. I understand that the College Avenue campus is 100% tobacco free including the surrounding area and parking lots, and I further agree that I will not use tobacco products at that facility. I acknowledge that by demonstrating such behaviors, I will be educating and promoting tobacco prevention efforts to our Spokane County community.

My signature below acknowledges the terms of this agreement.

_____ _____

Signature of Volunteer/Intern Date

_____

Print First and Last Name of Volunteer/Intern

March, 2013 Rev 8/17

Class Participation Agreement

For Non-SRHD Employees

In the event that I participate in any Spokane Regional Health District's (SRHD) classes and/or use exercise equipment located at SRHD facilities, I hereby certify, covenant, and agree as follows:

1. I fully recognize that I am responsible for knowledge of my own state of health at all times and participate in physical activities at my own risk. I acknowledge the potential risk and have independently sought any medical approvals as may be necessary.
2. I acknowledge that there is no expectation or requirement on behalf of SRHD to provide training or educational materials on any exercise equipment, or to make warranties about the condition of the equipment. I further acknowledge that I am responsible for checking and maintaining the safety and good operating condition of any equipment that I may use during my participation regardless of where or from whom I may have obtained such equipment.
3. I have an obligation and responsibility to myself and others to conduct myself in a safe and reasonable manner. I will not participate or take part in a class or activity while under the influence of drugs or alcohol or while suffering from or experiencing any condition (illness or injury) that might impair me.
4. In the event of an emergency, I authorize the SRHD to arrange for emergency assistance, and agree that I will be responsible for payment of any and all medical services rendered.
5. I understand that I am participating at my own risk, and hereby release and forever discharge SRHD, SRHD's agents, advisors, officials, officers or employees from any and all liability, harm and damage, and waive any and all claims whatsoever, for any injury, accident, loss of life, or loss in connection with my use of equipment and/or participation in SRHD wellness activities or classes.

_____	_____	_____
Name (please print)	Signature	Date