ARKANSAS DEPARTMENT OF HEALTH

State Employee Criminal Record Check (AR920200Z)

Section I: FBI RECORD CHECK REQUESTED ☐
State Check Completed Online ☐

Instructions:
Applicant/Employee completes Criminal Record Check Form.
Form is submitted to HR/Employee Relations Section, Slot 26.

If a FBI Record Check is required, attach the following document to this form:
- FBI Fingerprint Card

ADH CHARGE ACCOUNT

Purchase Order Number _____

AASIS Cost Center 609032

Position Number _____

Section II: Contact Information

Center/Branch/LHU _____ Address _____

Name of Supervisor _____ City/Zip _____ Telephone #, including area code _____

Section III: Person to be Checked (Enter Name and DOB as it currently appears on Driver's License or Identification.)

Last Name _____ First Name _____ Middle Name _____ Maiden Name _____ Aliases _____

Date of Birth (mm/dd/yy) _____ Social Security Number _____ Sex (M/F) _____ Race _____ Driver's License Number _____ State of Issuance _____

Address (Street, City, Zip) _____ Current or Last Place of Employment _____

Have you lived continuously in the State of Arkansas for the past five years? ☐ Yes ☐ No

NOTE: The name, address, and date of birth listed above must appear on a valid identification document issued by a government entity. Please list the identification document used, if not the person's driver's license. _____

The person listed above must list all past felony or misdemeanor charge(s) for which he/she was found guilty or pled nolo contendere to:

Date of Charge	Location	Description of Charge	Sentence/Disposition

Section IV: Notice: Your current or potential employer may receive copies of the criminal record report for determination of employment eligibility. Prior to completion of a criminal record check, the employer may choose to deny an employee unsupervised access to a person to whom the employer provides care.

STATE BACKGROUND:

ANY CHALLENGES TO THE ACCURACY OF THE RESULTS SHOULD BE DIRECTED FIRST TO THE ARKANSAS STATE POLICE; STATE IDENTIFICATION BUREAU (PHONE 501-618-8500), #1 STATE POLICE PLAZA DRIVE, LITTLE ROCK AR 72209.

FBI FINGERPRINT CARD:

If, after viewing his/her identification record, the subject thereof believes that it is incorrect or incomplete in any respect and wishes changes, corrections, or updating of the alleged deficiency, he/she should make application directly to the agency which contributed the questioned information. The subject of a record may also direct his/her challenge as to the accuracy or completeness of any entry on his/her record to the FBI, Criminal Justice Information Services (CJIS) Division. ATTN: SCU, Mod. D2, 1000 Custer Hollow Road, Clarksburg, WV 26306. The FBI will then forward the challenge to the agency which submitted the date requesting the agency to verify or correct the challenged entry.

Upon the receipt of an official communication directly from the agency which contributed the original information, the FBI CHIS Division will make any changes necessary in accordance with the information supplied by that agency. **Ensure that the correct finger printing reason code and agency ID are used.

I, the undersigned, hereby give my consent for the Arkansas State Police (ASP) to conduct the required criminal records check on myself and release any results to the Arkansas Department of Health, HR/Employee Relations, 4815 West Markham Street, Slot 26, Little Rock, AR 72205-3867. I also authorize the Arkansas State Police to give the above mentioned party access to my records through the Criminal Background Check System on an annual basis. I further authorize a national records check through the Federal Bureau of Investigation.

Providing false information on this form is a violation of Arkansas law and punishable as set forth in Arkansas Code 5-53-103.

Statement of Oath:

I state on oath that the representations made herein are true and correct.

_____ _____

Signature of Applicant/Employee Date

Section V: Notary (Required for all Criminal History Checks, both State and Federal)

State of Arkansas
County of _____

Subscribed and sworn to before me a notary public in and for the county and state aforesaid this the _____day of _____ 20_____.

_____ (Notary Seal)

Notary Public

My commission expires on _____.

FOR ARKANSAS STATE POLICE USE ONLY

☐ 80001 ☐ 80005 FBI Records Check @ $15.75

HR-56 (R 6/15)

ARKANSAS DEPARTMENT OF HEALTH
Confidentiality Agreement

As a volunteer/student/extra help employee with privileges at the Arkansas Department of Health (ADH), you may have access to Private Information (PI) which includes Protected Health Information (PHI) as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other confidential information protected by Arkansas and federal law. The purpose of this Agreement is to help you understand your duty regarding PI.

PI includes information not only about patients but also about members of the ADH workforce and other students and volunteers. You may learn of or have access to PI through a computer system or through your activities at ADH. You must receive training prior to having contact with PI.

As a volunteer/student/extra help employee, you are required to conduct yourself in strict conformance to applicable laws and ADH policies governing PI. Your principal obligations in this area are explained below. You are required to read and to abide by these duties. The violation of any of these duties will result in termination of your association with ADH and possible legal liabilities or fines. As a volunteer/student/extra help employee, you may have access to PI relating to:

- Patients (records, conversations, admittance information, financial information, etc.)
- Workforce/volunteers/students (salaries, employment records, disciplinary actions, etc.)

Accordingly, as a condition of and in consideration of your access to PI, you agree to the following:

1. You will use PI only in conformity with ADH policies as needed to perform your legitimate duties as a volunteer/student/extra help employee affiliated with ADH. This means, among other things, that:
   A. You will only access PHI for which you have a need to know, and
   B. You will not in any way divulge, copy, release, sell, loan, review, alter or destroy any PI except as properly authorized within the scope of your professional activities affiliated with ADH, and
   C. You will not misuse PI or wrongfully disclose PI.
2. You will safeguard and will not disclose any access code that allows you to access confidential information.
3. You will immediately report activities by any individual or entity that you suspect may compromise the confidentiality of PI to your supervisor or the ADH Privacy Officer at (501) 661-2000. Reports made in good faith about suspect activities will be held in confidence to the extent permitted by law.
4. You understand that obligations under this Agreement will continue when you are no longer a volunteer or assigned to an ADH work unit.
5. You will be responsible for your misuse or wrongful disclosure of PI and for your failure to safeguard your access code or other authorized access to PI.

I have read, understand and agree to abide by the terms of the above Confidentiality Agreement.

_____ _____

Volunteer/Student/Extra Help Employee Signature **Date**

_____ _____

Printed Name **Date of Last Service**

ARKANSAS DEPARTMENT OF HEALTH
STUDENT AND VOLUNTEER HIPAA TRAINING

Facts ADH Students and Volunteers Should Know About HIPAA

WHAT IS HIPAA?
Health Insurance Portability and Accountability Act (HIPAA) is a federal law that sets a national standard to protect medical records and other personal health information. Congress passed this legislation in 1996.

IS HIPAA APPLICABLE TO ALL HEALTH CARE PROVIDERS?
Yes, HIPAA applies to public health clinics, hospitals, physicians, insurance companies, laboratories, dentist, ambulatory surgery centers, business offices, etc.

INDIVIDUAL RIGHTS UNDER HIPAA
Covered entities provide individual (our patients and their guardians) with certain rights regarding Protected Health Information (PHI) under HIPAA, including:

- Right to access a designated record set of their PHI
- Right to amend their PHI
- Right to an accounting of certain disclosures of their PHI
- Right to request confidential communication regarding their PHI
- Right to request confidential communications regarding their PHI
- Right to request additional restrictions of the uses and disclosures of their PHI

WHAT IS PROTECTED HEALTH INFORMATION (PHI)?
The following is considered PHI: addresses, telephone/fax numbers, social security numbers, medical record numbers, patient account numbers, insurance plan numbers, vehicle information, license numbers, medical equipment numbers, photographs, fingerprints, e-mail /internet addresses, and reasons a patient is being seen in the clinic.

WHAT IS CONSIDERED "HEALTH INFORMATION?
Any information whether oral, written, or electronic (computer) regarding a patient is considered "Health Information". Patient information can be related to past, present or future physical or mental health conditions.

WHY MUST WE GIVE PATIENTS A PRIVACY NOTICE?
The notice informs the patient of their rights to control who will see their protected health information. ADH volunteers have an ethical and legal obligation to protect and maintain our patient's PHI in a secure and confidential manner.

> *ADH health care providers with direct treatment relationships with individuals must (1) provide the Privacy Notice no later than the first date the provider delivers services to the patient, except in emergency situations; (2) make a good faith effort to obtain from each patient an acknowledgement of receipt of the Privacy Notice; and (3) post the Privacy Notice in a prominent location at the facility.*

I have read the Student/Volunteer HIPAA training handout, "Facts ADH Students and Volunteers Should Know About HIPAA" and I understand my responsibilities to protect and maintain patient confidentiality. Failure to follow federal HIPAA standards may result in dismissal from ADH student/volunteer activities and possible federal criminal and/or monetary penalties.

Student/Volunteer Signature _____Date_____

AS-54 (10/10)

ARKANSAS DEPARTMENT OF HEALTH
ADH STUDENT/VOLUNTEER INFORMATION FORM

(All Interns and Volunteers must complete HIPAA training prior to viewing any patient records. Volunteers are required to undergo a State Volunteer Criminal Background Check.)

To be completed by Student/Volunteer

Name of Student: _____ Name of School: _____

Address: _____ Address: _____

_____ _____

_____ _____

Telephone: _____ Telephone: _____

E-mail: _____ E-mail: _____

Semester: _____ Course: _____

Will student receive a grade? ☐ Yes ☐ No

Can student provide proof of professional liability insurance? ☐ Yes ☐ No

Can student provide proof of health insurance? ☐ Yes ☐ No

Student/Volunteer Signature _____ Date: _____

To be completed by ADH immediate supervisor prior to student/volunteer's first day of service.

Start Date: _____ End Date: _____ Number of Hours: _____

Badge: ☐ Yes ☐ No (Provide photo I.D.) E-mail: ☐ Yes ☐ No

ADH Immediate Supervisor _____ Date: _____

To be completed by immediate supervisor on student/volunteer's LAST day of service.

Evaluation Completed: ☐ Yes ☐ No (Please attach completed copy.)
Badge Returned: ☐ Yes ☐ No

ADH Immediate Supervisor _____ Date: _____

To be completed by ADH Office of Human Resources prior to first day of service.

Center: _____ Supervisor: _____

Location: _____ Title: _____

Work Unit: _____ Telephone: _____

HR Rep.: _____ Date: _____ HR Manager: _____ Date: _____

☐ All docs submitted ☐ All docs not submitted ☐ Approved ☐ Not Approved

HR-71 (6/11)

Arkansas Department of Health

VOLUNTEER IMMUNITY FORM

Date: _____

To: Volunteers Participating in the _____County Prophylaxis/Vaccination Clinic

From: Arkansas Department of Health (ADH)

RE: IMMUNITY FOR DELIVERING AND ADMINISTERING ACTIONS TAKEN IN A PROPHYLAXIS/VACCINATION CLINIC

Thank you for your willingness to help us with our current plan to deliver prophylaxis/vaccine to a large population in a short period of time. To participate in the clinic and possess qualified immunity equal to a state employee, you must fulfill the following requirements for participation. Please initial to acknowledge that you have read and understand the requirements.

- You must attend a brief orientation prior to participation. In the orientation, you must supply current contact information and display a valid state or federal picture ID. _____
- You must agree to serve free of charge during the clinic and to keep all medical information regarding the participants confidential in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). _____
- You must further agree that the ADH will not provide any worker's compensation or other health insurance coverage during your participation in the clinic. _____
- If you are a physician or a nurse, and intend to serve in a medical capacity, you must allow us to maintain a copy of your current medical/nursing license and verify your license status through the appropriate licensure board prior to providing care. _____

After you fulfill these requirements, the ADH will formally certify the following:

1) In acting as agents of the ADH while helping to deliver and administer Prophylaxis/ Vaccination, you will be **immune from liability and suit** to the extent that State employees are protected, although you will be responsible for adherence to HIPAA and all ADH HIPAA policies.

2) Any claims that arise as a result of your participation as an agent for the ADH shall be resolved through the Arkansas State Claims Commission or appropriate forum.

3) If any litigation is commenced against you during the course of your volunteer work, the Arkansas Department of Health will provide legal representation in the Arkansas State Claims Commission or other forums, except as shown below.

4) If you have applicable insurance, then that insurance coverage must be utilized before the Arkansas State Claims Commission will have jurisdiction of the claim.

5) If you commit an intentional, malicious act or gross negligence against someone during the course of your volunteer work, immunity will not apply. You will be responsible for your own defense and must pay for your own attorney.

Volunteer Contact Information

- **Volunteer Name:** _____ (last) _____ (first) _____ (middle)
- **Street Address:** _____

_____ (city) _____ (state) _____ (zip code)

- **Contact Information:** _____ (home phone) _____ (work phone) _____ (cell phone)

email: _____

- **Are you serving in a medical capacity?** (circle one) **YES** **NO**

If yes: (circle type): **M.D.** **Nursing** **Pharmacist**

Other: _____

License Number (and state): _____

** Would you be willing to register with the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP)? (circle one)

YES **NO**

- **Picture ID** (circle one): **Driver's License** **Other**

If other, please specify: _____

- **If above address does not agree with ID, please record information from ID as well:**

Street Address: _____

_____ (city) _____ (state) _____ (zip code)

- **Volunteer Signature:** _____ **Date:** _____

My signature certifies that I understand and agree to follow the aforementioned requirements for participation.

- **Witness Signature:** _____ **Date:** _____

CHS-60 (R 10/10)

AUTHORIZATION FOR VISUAL AND AUDIO REPRODUCTIONS

Name of Individual (or minor for whom authorization is given)	Date of Birth (individual or minor)

Address (street/city/state/zip)

I give my permission to the Arkansas Department of Health to make, publish or re-publish the following of me (or of the minor for whom I have custody):

- ☐ photographs
- ☐ videotape
- ☐ tape record
- ☐ illustration
- ☐ words
- ☐ other _____

I understand that the above visual and/or audio reproductions are made for the purpose of:

- ☐ medical research
- ☐ documentation of injury or abuse
- ☐ education of others
- ☐ publicity
- ☐ other _____

I give permission for my name, or the name of the minor for whom I have custody, to be used/published.

_____ Signature of Individual or Legal Guardian

_____ Date

This authorization will expire one year from today's date unless I write another date below:

_____ Alternate Date

I revoke this authorization.

_____ Signature of Individual or Legal Guardian

_____ Date of Revocation

HEP– 6 (R 11/02)

AUTHORIZATION FOR VISUAL AND AUDIO REPRODUCTIONS (HEP-6)

PURPOSE

To provide authorization by Health Department patients/employees for filming, producing, broadcasting, webcasting and/or publishing any words, audio/video tapes, photographs, motion pictures, images, and/or illustrations.

USED BY

Health Department employees.

EXPLANATIONS AND DEFINITIONS

Name of Individual:	Name of patient/employee or minor for whom authorization is given.
Date of Birth:	Self-explanatory.
Address:	Self-explanatory.
I give my permission...:	Check appropriate box(es). If other is checked, specify.
I understand that the above...:	Check appropriate box(es). If other is checked, specify.
I give permission for my name,...:	Signature of individual giving authorization and date of signature.
This authorization will expire...:	Patient/employee may enter alternate date, if desired. Note: LHU employee suggests to patient a maximum expiration date of one year.
I revoke this authorization.:	Signature of individual revoking authorization and date of signature.

MECHANICS AND FILING

Initiate an Authorization for Visual and Audio Reproductions (HEP-6) when using Health Department patients/employees as a source of materials.

For patient, file in the patient's Supplemental Folder. If the patient does not have a record, file in the A to Z file.

For Health Department employee, file in the employee's personnel folder.

FINAL DISPOSITION

Authorization for Visual and Audio Reproductions (HEP-6)

Document	Office	Retention	Scan	
			Yes	No
Original	Work Unit	Destroy when record/personnel folder is destroyed, OR Scan when record is scanned.	X	X