VERMONT

Agency of Human Services

Adult Protective Services, HC 2 South, 280 State Drive, Waterbury, VT 05671-2060
AND
Child Abuse Registry Unit, 280 State Drive, HC 1 North Bldg. B, VT 05671-2401

CONSENT FOR RELEASE OF REGISTRY INFORMATION

This form is for use with the ON-LINE registry checking system ONLY

****** This consent form must be filled out completely and signed by the current employee, prospective employee, contractor or volunteer and kept on file at the requesting organization. The Agency of Human Services reserves the right to audit these consent forms at any time.**

Current or Prospective Employee, Contractor, or Volunteer Information

Full Name: _____ Gender: _____
LAST FIRST Middle Initial

Address: _____

_____

Last four digits of social security number: XXX-XX_____

Phone number: _____ Birth Date: _____ Place of Birth: _____
City, State, Country

Other ***FIRST*** names I have used, if any (i.e. Nicknames, Aliases): _____
(Type or Print)

_____

Other ***LAST*** names I have used, if any (i.e. Maiden Names, Aliases): _____
(Type or Print)

_____

I hereby authorize release of any information of reports of abuse, neglect or exploitation substantiated against me and contained in the **Vermont Adult Abuse Registry** and/or the **Vermont Child Protection Registry** to:

AHS / DMH / VPCH
_____
(Print Organization Name)

_____ _____
(Prospective) Staff, Contractor, or Volunteer Signature **Date**

FORM D

Department of Public Safety
Vermont Criminal Information Center
103 South Main Street
Waterbury, VT 05671-2101

PUBLIC REQUEST FOR CRIMINAL CONVICTION INFORMATION

PLEASE TYPE OR PRINT ALL INFORMATION CLEARLY **FEE: $30 PER REQUEST - NO PERSONAL/BUSINESS CHECKS** **Reply will be mailed in 5 – 7 working days - A SELF ADRESSED, STAMPED, RETURN ENVELOPE IS REQUIRED TO FACILITATE RETURN OF YOUR REQUEST**

WE ARE A VULNERABLE POPULATIONS AGENCY. OUR AGENCY CODE IS:

NAME TO BE CHECKED: TYPE OR PRINT LEGIBLY

LAST NAME	FIRST NAME	MIDDLE INITIAL

DATE OF BIRTH (REQUIRED) Month / Day / Year	☐ MALE ☐ FEMALE	SOCIAL SECURITY NUMBER (OPTIONAL)

ALIAS NAMES (IF APPLICABLE)

PURPOSE OF REQUEST: (CHECK ONE)

☐ PERSONAL REVIEW ☐ FOREIGN TRAVEL/ IMMIGRATION ☐ MILITARY
☐ ADOPTION ☐ CIVIL COURT PROCEEDING ☐ PARDON
☐ CHILD CUSTODY ☐ LICENSING
☒ EMPLOYMENT ☐ HOUSING
☐ OTHER: INDICATE REASON FOR REQUEST IF OTHER THAN OPTIONS ABOVE

ACCESS TO CRIMINAL CONVICTION INFORMATION TERMS AND CONDITIONS

The following information is REQUIRED in order to successfully process your request.
Requestor MUST initial each line, fill out requestor information and sign below.

In accordance with Title 20, Chapter 117, Section 2056c, which governs the release of criminal conviction information to the public, I understand:

✓ **Alteration or modification of any report received as a result of this request is strictly prohibited by law.**

✓ **Disclosure of the contents of this criminal conviction report to anyone other than the subject of the record or properly designated employees of any agency with a documented need to know the contents of the record is prohibited.**

✓ **No person entitled to receive a criminal conviction record shall require an applicant to obtain, submit personally or pay for a copy of his or her criminal conviction record.**

REQUESTOR INFORMATION

Name	Street Address		
VPCH / Julie Vose	350 Fisher Road		
City	**State**	**Zip**	**Telephone Number**
Berlin	VT	056337901	8028282550

Signature of Requestor	Date (Mo/Day/Year)

RPP Appendix C: Medical Clearance Questionnaires

Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee: Your employer must allow you to answer the questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the healthcare professional who will review it.

PART A SECTION 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

Name (Print Clearly): _____ Today's Date: _____

Date of Birth:_____ Age:_____ Sex:_____

Height:_____Weight:_____ Job Title:_____

A **phone number** where you can be reached by the healthcare professional who reviews this questionnaire (include the Area Code): _____ The best time to call you at this number: _____

Has your employer told you how to contact the healthcare professional who will review this questionnaire?
Yes ☐ No ☐

Check the type of respirator you will use (you can check more than one category):

a. ☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only).

b. ☐ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

Have you worn a respirator: Yes ☐ No ☐ If "yes," what type(s): _____

PART A SECTION 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please select "yes" or "no").

1. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month?

Yes ☐ No ☐

2. Have you *ever* had any of the following conditions?

Seizures:	Yes ☐	No ☐
Claustrophobia (fear of closed-in spaces):	Yes ☐	No ☐
Diabetes(sugar disease):	Yes ☐	No ☐
Allergic reactions that interfere with breathing:	Yes ☐	No ☐
Trouble smelling odors:	Yes ☐	No ☐

3. Have you *ever* had any of the following pulmonary or lung problems?

Asbestosis:	Yes ☐	No ☐
Silicosis:	Yes ☐	No ☐
Asthma:	Yes ☐	No ☐
Pneumothorax (collapsed lung):	Yes ☐	No ☐
Chronic bronchitis:	Yes ☐	No ☐
Lung cancer:	Yes ☐	No ☐
Emphysema:	Yes ☐	No ☐
Broken ribs:	Yes ☐	No ☐
Pneumonia:	Yes ☐	No ☐
Any chest injuries or surgeries:	Yes ☐	No ☐
Tuberculosis:	Yes ☐	No ☐
Any other lung problem that you've been told about:	Yes ☐	No ☐

4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?

Shortness of breath:	Yes ☐	No ☐
Wheezing:	Yes ☐	No ☐
Wheezing that interferes with your job:	Yes ☐	No ☐
Chest pain when you breathe deeply:	Yes ☐	No ☐
Shortness of breath when walking fast on level ground or walking up a slight hill or incline:	Yes ☐	No ☐
Shortness of breath when walking with other people at an ordinary pace on level ground:	Yes ☐	No ☐
Have to stop for breath when walking at your own pace on level ground:	Yes ☐	No ☐
Shortness of breath when washing or dressing yourself:	Yes ☐	No ☐
Shortness of breath that interferes with your job:	Yes ☐	No ☐
Coughing that produces phlegm (thick sputum):	Yes ☐	No ☐
Coughing that wakes you early in the morning:	Yes ☐	No ☐
Coughing that occurs mostly when you are lying down:	Yes ☐	No ☐
Coughing up blood in the last month:	Yes ☐	No ☐
Any other symptoms that you think may be related to lung problems:	Yes ☐	No ☐

5. Have you *ever* had any of the following cardiovascular or heart problems?

Heart attack	Yes ☐	No ☐
Stroke	Yes ☐	No ☐
Angina	Yes ☐	No ☐
Heart Failure	Yes ☐	No ☐
Heart arrhythmia (heart beating irregularly):	Yes ☐	No ☐
High blood pressure:	Yes ☐	No ☐
Any other heart problem that you've been told about:	Yes ☐	No ☐
Swelling in your legs or feet (not caused by walking):	Yes ☐	No ☐

6. Have you *ever* had any of the following cardiovascular or heart symptoms?

Frequent pain or tightness in your chest:	Yes ☐	No ☐
Pain or tightness in your chest during physical activity:	Yes ☐	No ☐
Pain or tightness in your chest that interferes with your job:	Yes ☐	No ☐
In the past two years, have you noticed you heart skipping or missing a beat:	Yes ☐	No ☐
Heartburn or indigestion that is not related to eating:	Yes ☐	No ☐
Any other symptoms that you think may be related to heart or circulation problems:	Yes ☐	No ☐

7. Do you currently take medication for any of the following problems?

Breathing or lung problems:	Yes ☐	No ☐
Heart trouble:	Yes ☐	No ☐
Seizures:	Yes ☐	No ☐
Blood pressure:	Yes ☐	No ☐

8. If you've used a respirator, have you ever had any of the following problems? (if you have never used a respirator, check the following box and go to question 9):

☐ I've never used a respirator

Eye irritation:	Yes ☐	No ☐
Skin allergies or rashes	Yes ☐	No ☐
Anxiety:	Yes ☐	No ☐
General weakness or fatigue:	Yes ☐	No ☐
Any other problem that interferes with your use of a respirator:	Yes ☐	No ☐

If you answered YES to any of these questions, please describe below:

9. Would you be able to wear a respirator without any difficulty? Yes ☐ No ☐

10. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? Yes ☐ No ☐

You will be required to have both annual fit testing and refresher training. Your anticipated level of work effort is moderate and expected frequency of use falls into the occasional use category.

I verify that the above information is true and complete to the best of my knowledge. I hereby give permission for a physical examination *if needed to determine my suitability for respirator use. I understand that this

examination is designed to satisfy regulatory requirements and should not be considered to be a routine medical evaluation. I agree to "self-report" changes in my medical condition that may affect my ability to safely wear a respiratory by contacting my respiratory program administrator.

Employee Signature: _____ Date:_____

Question below to be completed by the individual reviewing the form.

11. Does the employee require further medical evaluation prior to fit testing? Yes ☐ No ☐

Reviewed By: _____ Date: _____

Signature: _____ Date: _____

Notes:

Hepatitis B Virus and Vaccination Fact Sheet

- ✓ Hepatitis B vaccine is recommended for all adults who work in a healthcare setting
- ✓ Hepatitis B vaccine is provided to VPCH/State of Vermont employees for free
- ✓ Obtain your no cost Hepatitis B vaccine at either Concentra or Champlain Medical. Inform them that you work for VPCH/the state of Vermont. Call to schedule a vaccination appointment that is convenient to you.
    - Concentra Barre: 802-223-7499

    654 Granger Rd, Suite 1, Barre, VT 05641
    - Concentra Burlington: 802-865-0042

    57 Fayette Drive Unit 4, South Burtlington, VT, 05403
    - Champlain Medical: 802-448-9370

    150 Kennedy Drive, South Burlington, VT 05403

Why get vaccinated?

- ✓ Healthcare workers are at high risk of acquiring hepatitis B through occupational exposure to contaminated needlestick and sharps injuries
- ✓ The vaccine is highly effective and safe
- ✓ Avoid acute illness and chronic infection which can lead to liver failure, liver cancer and even death

If you do not know your immune status to Hepatitis B, you do not need to have a blood test done in order to get the Hepatitis B vaccine

Want more information? Check out these resources

Ask the Experts: Hepatitis B Vaccines (immunize.org)

Hepatitis B - FAQs, Statistics, Data, & Guidelines | CDC

Select the option below that best describes you.

☐ I have completed the Hepatitis B vaccination series, or have serologic evidence of immunity or a known past/current infection of Hepatitis B.

Employee Signature:_____ Date: _____

Employee Name (Print legibly): _____

☐ I have not completed the Hepatitis B vaccination series or decline to provide information about my hepatitis B vaccination status. You **MUST** complete the section "Hepatitis B Vaccination Declination Statement" below.

Hepatitis B Vaccination Declination Statement

Declination Statement

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to me; however, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring hepatitis B, a serious disease. If, in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Employee Signature: _____ Date: _____

Employee Name (Print legibly): _____

Routing Information: Please place in infection control mailbox or scan and email to elizabeth.saxton@vermont.gov