

# Background Check Request

## Section 1: To be completed by the Contracted Dental Hygienist

I have verified the identity of the subject individual.

Current/valid government-issued photo ID checked:  Name  DOB  Address  Photo

Signature of Dental Hygienist \_\_\_\_\_ Date \_\_\_\_\_

## Section 2: To be completed by the subject individual. Please read instructions first.

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
(Last) (First) (Middle) (Month/day/year)

All other names used: \_\_\_\_\_ SSN or INS number (voluntary): \_\_\_\_\_

Sex:  Male  Female Driver's license or other valid government ID number: \_\_\_\_\_ State: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Ck if Passport:

Street/mailling address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP: \_\_\_\_\_  Message or  Cell phone #: \_\_\_\_\_

Check only if you prefer correspondence be sent to your residential or mailing address identified above (rather than by e-mail.)

If additional space is needed for any of the following questions, attach additional pages.

If you disclose criminal or abuse history, attach your responses to "Questions to Answer." (See instructions)

During the last five years, have you been outside of Oregon for 60 days or more in a row?  Yes  No

If yes, complete the following for each residence in the past five years:

City/state/country:	From (mm/dd/yy):	To (mm/dd/yy):

Have you ever been involved with an abuse or protective services investigation as an accused person, reported perpetrator or alleged perpetrator, resulting in a founded or substantiated outcome?  Yes  No

If yes, complete the information requested below and attach your responses to "Questions to Answer." (See instructions)

Date (or estimate):	Allegation:	County:	State:

Have you ever been charged, arrested and/or convicted of a crime?  Yes  No

If yes, complete information requested below and attach your responses to "Questions to Answer." (See instructions)

Date (or estimate):	Charge, arrest or conviction:	County:	State:	Outcome:

I understand that a criminal records check, which may include a national criminal records check requiring fingerprints, will be completed on me. I understand that an abuse check will be completed on me. The BCU may share information with a designee at the facility associated with this request. My submission of this electronic signature authorizes the BCU to request and receive any juvenile, police, court, or investigation reports needed to complete this background check. In the event potentially disqualifying abuse is discovered, I will be notified at the address or e-mail I have given and asked to provide additional information.

I authorize the BCU to proces this background check request. I understand the background check may be repeated during the time I hold this position.

\_\_\_\_\_  
(Signature of subject individual) (Date)

## Conditions of Volunteer Services for Volunteers

As a volunteer working for the Oregon School-based Dental Sealant Program, you need to understand the extent to which you are covered by State of Oregon insurance for liability and personal injury and illness. *Please read the following carefully and sign below.*

### **TORT LIABILITY**

You will be protected from civil liability for injuries or damage to the person or property of others, subject to the following general conditions:

- You are working on a state agency task assigned by an authorized agency supervisor;
- You limit your actions to the duties assigned; and
- You perform your assigned tasks in good faith, and do not act in a manner that is reckless or with the intent to unlawfully inflict harm to others.

(The conditions and limits of this protection are as stated in the Oregon Tort Claims Act, ORS 30.260-300, and Oregon Department of Administrative Services Risk Management Division Policy Manual, 125-7-202.)

### **MOTOR VEHICLE LIABILITY**

If you use a personally owned vehicle in the course of your duties, you are required to have automobile liability insurance to provide your primary coverage for any accidents involving that vehicle.

### **VOLUNTEER INJURY COVERAGE**

**Worker's compensation IS NOT provided.** However, the agency has an injury protection plan to cover injuries of authorized volunteers. It is limited to only injuries due to an accident while performing volunteer duties.

The state will pay medical bills, disability, death and dismemberment benefits to the limits and under the terms described in the Oregon Department of Administrative Services Risk Management Division Policy Manual, 125-7-204. Injuries **MUST** be reported within 5 days of the incident to qualify for this coverage. If you are injured in a private vehicle, the owner's insurance is responsible for your medical bills.

Any time you are involved in any accident or exposed to a potential liability situation while performing assigned duties, you must inform the School-based Dental Sealant Program at [oral.health@state.or.us](mailto:oral.health@state.or.us) or Tracy Candela at [tracy.candela@state.or.us](mailto:tracy.candela@state.or.us) as soon as possible or within 5 days for any injuries.

### **DHS/OHA POLICY AND PROCEDURE SUMMARY AND STATEMENT OF UNDERSTANDING**

<https://apps.state.or.us/Forms/Served/de2400.pdf>

<https://apps.state.or.us/Forms/Served/de0885.pdf>

I have read and understand the above duties and conditions of volunteer service, as well as the DHS/OHA Policy and Procedure and Statement of Understanding.

Name (Printed):	Date:
Signature:	

**This form must be completed in its entirety and submitted to Tracy Candela via e-mail at [tracy.candela@state.or.us](mailto:tracy.candela@state.or.us).** The document should be saved and submitted as a PDF. You may also submit by FAX at (971) 673-1299 – please include a cover sheet identifying Tracy Candela as the recipient.