Stoughton Hospital
Trusted Care...Close to Home

Volunteen
Application for Volunteer Service

We welcome the opportunity to consider you for our Volunteer Program. It is our policy to seek and assign volunteers in positions best suited to the individual's skills/abilities, and the Hospital's needs. This is done without discrimination based on any characteristic protected by law. No question on this application is intended to secure information to be used for such discrimination. Our questions are designed to best match you with volunteer opportunities of most interest to you. Thank you for considering a gift of time to Stoughton Hospital and our family of patients.

Volunteen Information:

Full Name: _____
Last *First* *Middle*

Present Address: _____ **Phone:** (____)_____-_____
Street

_____
City *State* *Zip Code*

Email Address: _____

Parent/Guardian Information:

Full Name: _____
Last *First*

Home or Cell Phone Number: (____)_____-_____ **Work Contact Phone Number:** (____)_____-_____
In case of emergency

Work Preference:

- ☐ Spring
- ☐ Summer
- ☐ Fall
- ☐ Winter

Check hours available and most preferred:

- ☐ Days (Summer only)
- ☐ Evenings (3:30 – 6:30)
- ☐ Other _____

Volunteen's Must be 14 years of age or older.
If under age 18, please state your age: _____

Have you ever volunteered or worked at Stoughton Hospital before? __Yes __No

If yes, please indicate department and dates and under what name (if different): _____

Education:

Current High School: _____ Circle Grade Last Completed: 9 10 11 12

Indicate the reason you are seeking a ***Volunteen*** position *(check all the apply):*

- ☐ Interest in medical field.
  *What professions most interest you:*_____
- ☐ Family/friends volunteer/work for Stoughton Hospital.
  *Please list name and relationship:*_____
- ☐ Required for school
- ☐ Interested in Stoughton Hospital as a future employer
- ☐ Requirement for National Honors Society or like group/club
- ☐ Need service hours to graduate
  *How many hours:*_____ *By When:*_____

Please share how you learned about our volunteer program:

- ☐ Class presentation by a representative from Stoughton Hospital
- ☐ Craigslist
- ☐ Friend/Classmate
  *Who:*_____
- ☐ Guidance Counselor/School communication
- ☐ Newspaper advertisement
- ☐ Stoughton Hospital Employee
  *Who:*_____
- ☐ Stoughton Hospital Volunteer
  *Who:*_____
- ☐ United Way
- ☐ Social Media
  *Please List:*_____
- ☐ Other
  *Please List:*_____

Please tell us your shirt size so that if chosen we can order you a shirt:

Extra Small - Small - Medium - Large - Extra Large - Extra, Extra Large - Extra, Extra, Extra Large

Are there any units or situation which might make you feel uncomfortable? If so, please explain:

_____

_____

_____

_____

Do you have any special needs which we should accommodate? If so, please explain:

_____

_____

_____

_____

Please list any specialized training, skills, or abilities you can offer as a volunteer:

- ☐ Arts and crafts interest
- ☐ Ability to read, write and communicate at a basic reading level
- ☐ Ability to push, pull and safely transport patients
- ☐ General spa interest
- ☐ Basic keyboarding experience
- ☐ Basic computer competency
- ☐ Basic Microsoft Office suite experience
- ☐ Intermediate Microsoft Office suite experience
- ☐ Have a natural interest in using electronic devices and gadgets like iPads, smartphones, etc.
- ☐ Medical terminology experience or previous healthcare professional experience
- ☐ Basic mechanical aptitude
- ☐ Play a musical instrument
- ☐ Previous trade experience
- ☐ Previous leadership experience
- ☐ Other:

_____

_____

_____

Work Experience:

Most Recent Employer:_____

Start Date:_____ End Date:_____

Duties:_____

Reason for Leaving:_____

Character References:
(Please list those familiar with your background or work history who are not related to you)

	Name	*Address*	*Telephone*	*Relationship*
1				
2				
3				

Have you ever been convicted of, or are you currently charged with, a felony, misdemeanor or municipal ordinance violation? __ Yes __ No

If yes, please explain:

_____

(A conviction record will not necessarily bar a person from the opportunity to volunteer).

Parent/Guardian Authorization:

I hereby authorize Stoughton Hospital to medically treat or manage any injury sustained, if after reasonable effort, I cannot be reached. I consent for my child to serve as a volunteer at Stoughton Hospital and consider her/him capable of undertaking the responsibilities of the volunteen program as described in the attached volunteer job description. I hereby authorize Stoughton Hospital to contact any schools, former places of employment and/or persons who may aid the hospital in determining my son/daughter's suitability for volunteer work. Additionally, I release those individuals and/or organizations contacted from all liability whatsoever for issuing the requested information. This release is in effect for the period the volunteen serves as a volunteer for Stoughton Hospital.

I certify that the above information is correct and any false statements or omissions could be considered cause for immediate dismissal from the program. I understand that any offer of volunteer work made by the hospital shall be contingent upon satisfactory references, a background check and results of a health assessment. I understand the volunteer relationship can be terminated at any time, with or without cause, and with or without notice, at the option of the hospital, son/daughter or myself.

Signature of Parent/Guardian: _____ **Date:** _____

Volunteen **Authorization:**

I hereby authorize Stoughton Hospital to contact any schools, former places of employment and/or persons who may aid the hospital in determining my suitability for volunteer work. Additionally, I release those individuals and/or organizations contacted from all liability whatsoever for issuing the requested information.

I certify that the above information is correct and any false statements or omissions could be considered cause for immediate dismissal from the program. I understand that any offer of volunteer work made by the hospital shall be contingent upon satisfactory references, a background check and results of a health assessment. I understand the volunteer relationship can be terminated at any time, with or without cause, and with or without notice, at the option of either the hospital or myself.

Signature of *Volunteen*: _____ **Date:** _____

Volunteer and/or Guardian, please attach the following:

- ☐ This signed Volunteen Application
- ☐ Completed Health Assessment Form – (See form below)
- ☐ Completed Background Information Disclosure Form – (See form below)

These forms can be mailed or directed to:

Stoughton Hospital
Human Resources
900 Ridge St
Stoughton WI 53589

Contact Human Resources with questions: 608-873-2296 or 608-873-2213

Stoughton Hospital
Volunteen - Health Assessment Form

Last Name First Name MI Phone Number

Street Address City Zip

Date of Birth Department

Family Physician Clinic

Person to Contact in an Emergency Phone Number

A. Evidence of the following is required.

	History of Disease	Vaccination		
	Date:	Date #1:	Date #2:	Date #3:
Measles, Mumps, Rubella (MMR)				
Chicken Pox				
Hepatitis B				
Annual Influenza Vaccine - required				
Tetanus				
PPD Screening				

Parental Consent for Applicable Vaccinations Date

B. Current medications:

Please list

C. Do you have any **allergies** or disabilities that would require accommodation (examples may be lifting restrictions, hearing impairment)?

Please explain

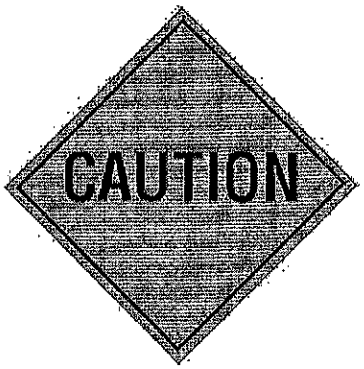
I certify this person to be free of clinically apparent communicable diseases and recommend them for their position.

RN/MD Signature Date

Criminal Background Check Caution

Failure to disclose <u>any</u> charges on question #1 of the Background Information Disclosure is considered falsification of document and grounds for the offer of employment to be rescinded, employment terminated, or volunteer role terminated.

(A conviction record will not necessarily bar a person from employment; Stoughton Hospital complies with the Wisconsin Fair Employment Act's restrictions on conviction record discrimination).



DEPARTMENT OF HEALTH SERVICES
Division of Enterprise Services
F-82064A (02/2014)

STATE OF WISCONSIN
Chapters 48.685 and 50.065, Wis. Stats.
DHS 12.05(4), Wis. Admin. Code

BACKGROUND INFORMATION DISCLOSURE (BID) INSTRUCTIONS

The Background Information Disclosure form (F-82064) gathers information as required by the Wisconsin Caregiver Background Check Law to help employers and governmental regulatory agencies make employment, contract, residency, and regulatory decisions. Complete and return the entire form and attach explanations as specified by employer or governmental regulatory agency. **NOTE:** If you are an owner, operator, board member, or non-client resident of a Division of Quality Assurance (DQA) facility, complete the BID, F-82064, and the Appendix, F-82069, and submit both forms to the address noted in the Appendix Instructions.

CAREGIVER BACKGROUND CHECK LAW

In accordance with the provisions of Chapters 48.685 and 50.065, Wis. Stats., for persons who have been convicted of certain acts, crimes, or offenses:

1. The Department of Health Services (DHS) may not license, certify, or register the person or entity (Note: Employers and Care Providers are referred to as "entities");
2. A county agency may not certify a child care or license a foster or treatment foster home;
3. A child placing agency may not license a foster or treatment foster home or contract with an adoptive parent applicant for a child adoption;
4. A school board may not contract with a licensed child care provider; and
5. An entity may not employ, contract with or, permit persons to reside at the entity.

The list of offenses affecting caregiver eligibility that require rehabilitation review is available from the regulatory agencies or through the Internet at http://DHS.wisconsin.gov/caregiver/StatutesINDEX.HTM.

THE CAREGIVER LAW COVERS THE FOLLOWING EMPLOYERS / CARE PROVIDERS (Referred to as "Entities"):

Programs Regulated under Chapter 48, Wis. Stats.	Treatment Foster Care, Family Child Care Centers, Group Child Care Centers, Residential Care Centers for Children and Youth, Child Placing Agencies, Day Camps for Children, Family Foster Homes for Children, Group Homes for Children, Shelter Care Facilities for Children, and Certified Family Child Care.
Programs Regulated under Chapters 50, 51, and 146, Wis. Stats.	Emergency Mental Health Service Programs, Mental Health Day Treatment Services for Children, Community Mental Health, Developmental Disabilities, AODA Services, Community Support Programs, Community Based Residential Facilities, 3-4 Bed Adult Family Homes, Residential Care Apartment Complexes, Ambulance Service Providers, Hospitals, Rural Medical Centers, Hospices, Nursing Homes, Facilities for the Developmentally Disabled, and Home Health Agencies – including those that provide personal care services.
Others	Child Care Providers contracted through Local School Boards

THE CAREGIVER LAW COVERS THE FOLLOWING PERSONS:

- Anyone employed by or contracting with a covered entity who has access to the clients served, except if the access is infrequent or sporadic and service is not directly related to care of the client. Exception: Emergency medical technicians and first responders are not covered under the Caregiver Law.
- Anyone who is a Child Care Provider who contracts with a School Board under Wisconsin Statute 120.13 (14).
- Anyone who lives on the premises of a covered entity and is 10 years old or over, but is not a client ("non-client resident").
- Anyone who is licensed by DHS.
- Anyone who has a foster home licensed by DHS.
- Anyone certified by DHS.
- Anyone who is a Child Care Provider certified by a county department.
- Anyone registered by DHS.
- Anyone who is a board member or corporate officer who has access to the clients served.

FAIR EMPLOYMENT ACT

Wisconsin's Fair Employment Law, Chapters 111.31 – 111.395, Wis. Stats., prohibits discrimination because of a criminal record or pending charge; however, it is not discrimination to decline to hire or license a person based on the person's arrest or conviction record if the arrest or conviction is substantially related to the circumstances of the particular job or licensed activity.

PERSONALLY IDENTIFIABLE INFORMATION

This information is used to obtain relevant data as required by the provisions set forth by the Wisconsin Caregiver Background Check Law. Providing your social security number is voluntary; however, your social security number is one of the unique identifiers used to prevent incorrect matches. For example, the Department of Justice uses social security numbers, names, gender, race, and date of birth to prevent incorrect matches of persons with criminal convictions. The Department of Health Services' Caregiver Misconduct Registry uses social security numbers as one identifier to prevent incorrect matches of persons with findings of abuse or neglect of a client or misappropriation of a client's property.

DEPARTMENT OF HEALTH SERVICES
Division of Enterprise Services
F-82064 (02/2014)

STATE OF WISCONSIN
Chapters 48.685 and 50.065, Wis. Stats.
DHS 12.05(4), Wis. Admin. Code

BACKGROUND INFORMATION DISCLOSURE (BID)

Completion of this form is required under the provisions of Chapters 48.685 and 50.065, Wis. Stats. Failure to comply may result in a denial or revocation of your license, certification, or registration; or denial or termination of your employment or contract. Refer to the Instructions (F-82064A) on page 1 for additional information. Providing your social security number is voluntary; however, your social security number is one of the unique identifiers used to prevent incorrect matches.

PLEASE PRINT OR TYPE YOUR ANSWERS.

Check the box that applies to you.

- [X] Employee / Contractor (including new applicant)
- [ ] Applicant for a license or certification or registration (including continuation or renewal)
- [ ] Household member / lives on premises - but not a client
- [X] Other – Specify: Volunteer

NOTE: If you are an owner, operator, board member, or non-client resident of a Division of Quality Assurance (DQA) facility, complete the BID, F-82064, and the Appendix, F-82069, and submit both forms to the address noted in the Appendix Instructions.

Name – (First and Middle)	Name – (Last)	Position Title (Complete only if you are a prospective employee or contractor, or a current employee or contractor.)

Any Other Names By Which You Have Been Known (Including Maiden Name)	Birth Date	Gender (M / F)

Race
- [ ] American Indian or Alaskan Native
- [ ] Asian or Pacific Islander
- [ ] Black
- [ ] White
- [ ] Unknown

Social Security Number(s)

Home Address	City	State	Zip Code

Business Name and Address – Employer or Care Provider (Entity)
Stoughton Hospital, 900 Ridge St, Stoughton WI 53589

SECTION A – ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION	YES	NO
1. Do you have any criminal charges pending against you or were you ever convicted of any crime anywhere, including in federal, state, local, military, and tribal courts? ➢ If **Yes**, list each crime, when it occurred or the date of the conviction, and the city and state where the court is located. You may be asked to supply additional information including a certified copy of the judgment of conviction, a copy of the criminal complaint, or any other relevant court or police documents.	☐	☐
2. Were you ever found to be (adjudicated) delinquent by a court of law on or after your 10th birthday for a crime or offense? (NOTE: A response to this question is only required for group and family day care centers for children and day camps for children.) ➢ If **Yes**, list each crime, when and where it happened, and the location of the court (city and state). You may be asked to supply additional information including a certified copy of the delinquency petition, the delinquency adjudication, or any other relevant court or police documents.	☐	☐
3. Has any government or regulatory agency (other than the police) ever found that you committed child abuse or neglect? A response is required if the box below is checked: ☐ (Only employers and regulatory agencies entitled to obtain this information per sec. 48.981(7) are authorized to, and should, check this box.) ➢ If **Yes**, explain, including when and where it happened.	☐	☐

Last Name –

SECTION A – ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION	YES	NO
4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client? ➢ If **Yes,** explain, including when and where it happened.	☐	☐
5. Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client? ➢ If **Yes,** explain, including when and where it happened.	☐	☐
6. Has any government or regulatory agency (other than the police) ever found that you **abused an elderly person?** ➢ If **Yes,** explain, including when and where it happened.	☐	☐
7. Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients? ➢ If **Yes**, explain, including credential name, limitations or restrictions, and time period.	☐	☐

SECTION B – OTHER REQUIRED INFORMATION	YES	NO
1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services? ➢ If **Yes,** explain, including when and where it happened.	☐	☐
2. Has any government or regulatory agency ever denied you permission or restricted your ability to live on the premises of a care providing facility? ➢ If **Yes,** explain, including when and where it happened and the reason.	☐	☐
3. Have you been discharged from a branch of the US Armed Forces, including any reserve component? ➢ If yes, indicate the year of discharge: _____ ➢ Attach a copy of your DD214 if you were discharged within the last 3 years.	☐	☐
4. Have you resided outside of Wisconsin in the last 3 years? ➢ If **Yes,** list each state and the dates you lived there.	☐	☐

Last Name --

SECTION B – OTHER REQUIRED INFORMATION	YES	NO
5. Have you had a caregiver background check done within the last 4 years? ➢ If **Yes**, list the date of each check, and the name, address, and phone number of the person, facility, or government agency that conducted each check.	☐	☐
6. Have you ever requested a rehabilitation review with the Wisconsin Department of Health Services, a county department, a private child placing agency, school board, or DHS designated tribe? ➢ If **Yes**, list the review date and the review result. You may be asked to provide a copy of the review decision.	☐	☐

A "NO" answer to all questions does not guarantee employment, residency, a contract, or regulatory approval.

I understand, under penalty of law, that the information provided above is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information may result in a forfeiture of up to $1,000.00 and other sanctions as provided in DHS 12.05 (4), Wis. Adm. Code.

SIGNATURE	Date Signed