



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.

Full Name: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> <i>Last</i> <i>First</i> <i>Middle</i> </div>											
Present Address: _____ Phone: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> <i>Street</i> <i>City</i> <i>State</i> <i>Zip Code</i> </div>											
Date of Application: _____	Date Available: _____										
Volunteer Work Preference: <input type="checkbox"/> Front Desk Information (greet and direct) <input type="checkbox"/> Escort (transport patients, deliver items) <input type="checkbox"/> Food & Nutrition (Deliver meal trays to patients, cashier duties) <input type="checkbox"/> Day Surgery Waiting Room (console, direct) <input type="checkbox"/> Gift Shop Clerk (Must be a Partners member) <input type="checkbox"/> Fundraising (for Partners or Foundation) <input type="checkbox"/> Other _____	Have you ever volunteered or worked at Stoughton Hospital before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate department and dates and under what name (if different): _____ _____ _____										
If under age 18, please state your age: _____	Check hours available and circle shifts most preferred: <input type="checkbox"/> Days <input type="checkbox"/> Evenings <input type="checkbox"/> Nights <input type="checkbox"/> Any										
Work Experience: _____ <div style="text-align: center; font-size: small;"><i>(Current Employer)</i></div> _____ <div style="text-align: center; font-size: small;"><i>(Work Phone)</i></div> Position Responsibilities: _____ _____	Education: (Circle Last Grade Completed) <table style="width: 100%; border: none;"> <tr> <td style="width: 60%;">High School</td> <td style="width: 10%; text-align: center;">9</td> <td style="width: 10%; text-align: center;">10</td> <td style="width: 10%; text-align: center;">11</td> <td style="width: 10%; text-align: center;">12</td> </tr> <tr> <td>College</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> <td style="text-align: center;">4</td> </tr> </table> College Major: _____	High School	9	10	11	12	College	1	2	3	4
High School	9	10	11	12							
College	1	2	3	4							
Are you required to volunteer? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, by whom? _____	How did you hear about our volunteer program? _____ _____										
Have you ever been convicted of, or are you currently charged with, a felony, misdemeanor or municipal ordinance violation? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____ _____ _____											
(A conviction record will not necessarily bar a person from the opportunity to volunteer).											

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

References:

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

	<i>Name</i>	<i>Address</i>	<i>Telephone</i>	<i>Relationship</i>
1				
2				
3				

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: _____ **Date:** _____

Please return completed Application for Volunteer Service and completed Background Information Disclosure Form to:

**Stoughton Hospital
Human Resources
900 Ridge St.
Stoughton, WI 53589**

Phone: 608-873-2296 or 608-873-2213

Fax: 608-873-2355

Email: hr@stohosp.com



Criminal Background Check Caution

Failure to disclose any 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).



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.

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

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		Social Security Number(s)	
<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black <input type="checkbox"/> Unknown <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> White			
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.	<input type="checkbox"/>	<input type="checkbox"/>
2. Were you ever found to be (adjudicated) delinquent by a court of law on or after your 10 th 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.	<input type="checkbox"/>	<input type="checkbox"/>
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: <input type="checkbox"/> (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.	<input type="checkbox"/>	<input type="checkbox"/>

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.	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you resided outside of Wisconsin in the last 3 years? > If Yes, list each state and the dates you lived there.	<input type="checkbox"/>	<input type="checkbox"/>

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.	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>

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