



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; width: 80%; margin: 0 auto;"> <i>Last</i> <i>First</i> <i>Middle</i> </div>	
Address: _____ Phone: _____	
City State Zip: _____ Email: _____	
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 (Café Cashier, Deliver meal trays to patients) <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: Days Evenings Nights Any
Work Experience: _____ <div style="text-align: center;"><i>(Current Employer)</i></div> _____ <div style="text-align: center;"><i>(Work Phone)</i></div> Position Responsibilities: _____ _____	Education: (Circle Last Grade Completed) High School 9 10 11 12 College 1 2 3 4 College Major: _____
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: _____ _____ _____	
<i>(A conviction record will not necessarily bar a person from the opportunity to volunteer).</i>	

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>Phone</i>	<i>Email</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.

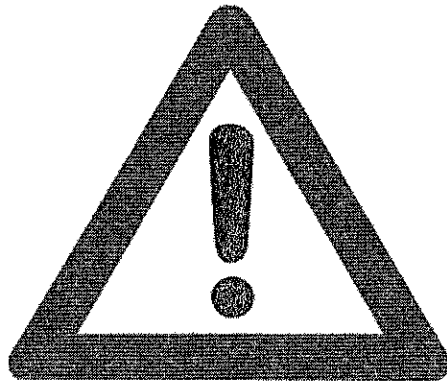
I certify that the above information is correct and any false statements or omissions could be considered cause for immediate dismissal from the program. I understand that any offer of volunteer work made by the hospital shall be contingent upon satisfactory references, a background check and results 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 questions #1 and #2 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)

- **PENALTY:** Knowingly providing false information or omitting information may result in a forfeiture of up to \$1,000 and other sanctions as provided in Wis. Admin. Code § DHS 12.05(4).
- Completion of this form is required under the provisions of Wis. Stat. § 50.065. 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.
- Providing your social security number is voluntary; however, your social security number is one of the unique identifiers used to prevent incorrect matches.
- Refer to DQA form F-82064A, *BID Instructions*, for additional information.

Check the box that applies to you.

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

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

Full Legal Name – *First* _____ *Middle* _____ *Last* _____

Position Title (Complete only if a prospective or current employee or contractor.) _____ Birth Date (MM/dd/yyyy) _____ Sex Male Female

Any Other Names By Which You Have Been Known (Including Maiden Name) _____

Race / Ethnicity (Check ONLY one.) _____ Social Security Number _____
 American Indian or Alaskan Native Asian or Pacific Islander Black White Unknown

Home Address _____ City _____ State _____ Zip Code _____

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

A “NO” answer to all questions does not guarantee employment, residency, a contract, or regulatory approval.
 Note: The areas below that are designated for responses are expandable.

SECTION A – ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION

1. Do you have any criminal charges pending against you, including in federal, state, local, military, and tribal courts?
 If **Yes**, list each charge, when it occurred or the date of the charge, and the city and state where the court is located. Yes No
 You may be asked to supply additional information, including a copy of the criminal complaint or any other relevant court or police documents.

2. 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. Yes No
 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.

3. **IMPORTANT: Read before completing item 3.**
Wis. Stat. § 48.981 Abused and neglected children and abused unborn children. (7)(a) CONFIDENTIALITY. “All reports made under this section, notices provided under sub. (3) (bm), and records maintained by an agency and other persons, officials, and institutions shall be confidential.” Reports and records may be disclosed only to the persons identified in this section.
 If you are the employer or prospective employer of the person completing this form and are entitled to obtain this information per the above, check this box.
 Has any government or regulatory agency (other than the police) ever found that you committed child abuse or neglect? Yes No
 If the above box has been checked, provide an explanation below, including when and where the incident(s) occurred.

4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client? Yes No

 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? Yes No

 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**? Yes No

 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? Yes No

 If **Yes**, explain, including credential name, limitations or restrictions, and time period.

SECTION B – OTHER REQUIRED INFORMATION

1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services? Yes No

 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? Yes No

 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? Yes No
 If **Yes**, indicate the year of discharge: _____

 Attach a copy of your DD214, if you were discharged within the last three (3) years.
-
4. Have you resided outside of Wisconsin in the last three (3) years? Yes No

 If **Yes**, list each state and the dates you resided there.
-
5. If you are employed by or applying for the State of Wisconsin, have you resided outside of Wisconsin in the last seven (7) years? Yes No

 If **Yes**, list each state and the dates you resided there.
-
6. Have you had a caregiver background check done within the last four (4) years? Yes No
 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.
-
7. 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? Yes No

 If **Yes**, list the review date and the review result. You may be asked to provide a copy of the review decision.

Read and initial the following statement.

_____ I have completed and reviewed this form (F-82064, BID) and affirm that the information is true and correct as of today's date.

Name – Person Completing This Form	Date Submitted
------------------------------------	----------------