



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-around; font-size: small;"> <i>Last</i> <i>First</i> <i>Middle</i> </div>											
Address: _____ Phone: _____											
City State Zip: _____ Email: _____											
Date of Application: _____	Date Available: _____										
Volunteer Position Preference: _____ (Visit www.stoughtonhealth.com for volunteer opportunities)	Have you ever volunteered or worked at Stoughton Health 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;">(Current Employer)</div> _____ <div style="text-align: center; font-size: small;">(Work Phone)</div> Position Responsibilities: _____ _____	Education: <div style="text-align: center; font-size: small;">(Circle Last Grade Completed)</div> <table style="width: 100%; border: none;"> <tr> <td style="width: 25%;">High School</td> <td style="width: 12.5%; text-align: center;">9</td> <td style="width: 12.5%; text-align: center;">10</td> <td style="width: 12.5%; text-align: center;">11</td> <td style="width: 12.5%; 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: _____ _____ _____ <div style="text-align: center; font-size: small; margin-top: 10px;">(A conviction record will not necessarily bar a person from the opportunity to volunteer).</div>											

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

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

Fax: 608-873-2355

Email: HR@StoughtonHealth.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) 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 facility regulated by the Division of Quality Assurance (DQA), complete the *BID*, F-82064, and the *BID Appendix*, F-82069, and submit both forms to the address noted in the *BID Appendix Instructions*.

CAREGIVER BACKGROUND CHECK LAW

In accordance with the provisions of Wis. Stat. § 50.065, 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. 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 <https://www.dhs.wisconsin.gov/caregiver/statutes.htm>.

The Caregiver Law covers the following EMPLOYERS / CARE PROVIDERS (aka ENTITIES) regulated under Wis. Stat. §§ 50, 51, and 146:

- | | |
|--|---|
| • Adult Family Homes (3-4 Bed) | • Intermediate Care Facility for Individuals with Intellectual Disabilities |
| • Ambulance Service Providers | • Home Health Agencies, including those that provide personal care services |
| • AODA Services | • Hospices |
| • Community Based-Residential Facilities | • Hospitals |
| • Community Mental Health Programs | • Mental Health Day Treatment Services for Children |
| • Community Support Programs (CSP) | • Nursing Homes |
| • Developmental Disabilities | • Residential Care Apartment Complexes |
| • Emergency Mental Health Service Programs | • Rural Medical Centers |

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 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 certified by DHS.
- 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, Wis. Stat. §§ 111.31 – 111.395, 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.

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.
You may be asked to supply additional information, including a copy of the criminal complaint or any other relevant court or police documents.
- Yes No
☐ ☐

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.
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.
- Yes No
☐ ☐

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?
If the above box has been checked, provide an explanation below, including when and where the incident(s) occurred.

Yes No
☐ ☐

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| 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. | Yes | No |
| | <input type="checkbox"/> | <input type="checkbox"/> |
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- | | | |
|--|--------------------------|--------------------------|
| 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. | Yes | No |
| | <input type="checkbox"/> | <input type="checkbox"/> |
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- | | | |
|--|--------------------------|--------------------------|
| 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. | Yes | No |
| | <input type="checkbox"/> | <input type="checkbox"/> |
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- | | | |
|--|--------------------------|--------------------------|
| 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. | Yes | No |
| | <input type="checkbox"/> | <input type="checkbox"/> |

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?
If Yes , explain, including when and where it happened. | Yes | No |
| | <input type="checkbox"/> | <input type="checkbox"/> |
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- | | | |
|---|--------------------------|--------------------------|
| 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. | Yes | No |
| | <input type="checkbox"/> | <input type="checkbox"/> |
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- | | | |
|---|--------------------------|--------------------------|
| 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 three (3) years. | Yes | No |
| | <input type="checkbox"/> | <input type="checkbox"/> |
-
- | | | |
|---|--------------------------|--------------------------|
| 4. Have you resided outside of Wisconsin in the last three (3) years?
If Yes , list each state and the dates you resided there. | Yes | No |
| | <input type="checkbox"/> | <input type="checkbox"/> |
-
- | | | |
|--|--------------------------|--------------------------|
| 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?
If Yes , list each state and the dates you resided there. | Yes | No |
| | <input type="checkbox"/> | <input type="checkbox"/> |
-
- | | | |
|--|--------------------------|--------------------------|
| 6. Have you had a caregiver background check done within the last four (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. | Yes | No |
| | <input type="checkbox"/> | <input type="checkbox"/> |
-
- | | | |
|--|--------------------------|--------------------------|
| 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?
If Yes , list the review date and the review result. You may be asked to provide a copy of the review decision. | Yes | No |
| | <input type="checkbox"/> | <input type="checkbox"/> |

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