STOUGHTON HEALTH
Creating Excellence Together

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: _____
Last *First* *Middle*

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? ☐Yes ☐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: _____ *(Current Employer)* _____ *(Work Phone)* Position Responsibilities: _____	**Education:** (Circle Last Grade Completed) High School ☐ ☐ ☐ ☐ College ☐ ☐ ☐ ☐ College Major: _____
Are you required to volunteer? __ Yes __ 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? __ Yes __ 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)

	Name	*Phone*	*Email*	*Relationship*
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 Hospital Foundation
900 Ridge St.
Stoughton, WI 53589

Phone: 608-873-2334
Email: foundation@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 Health complies with the Wisconsin Fair Employment Act's restrictions on conviction record discrimination).



Background Information Disclosure (BID) For Entity Employees and Contractors

Purpose: State and federal law require background checks for certain types of employment, contract, or other roles involving contact with vulnerable persons receiving care or treatment. The information you provide on this form will be used to verify your eligibility for such a role. Providing inaccurate or incomplete information on this form may result in a forfeiture or other sanction, as provided in Wis. Stats. § 50.065(6)(c).

Type

☐ Applicant/employee
☐ Contractor
☐ Student
☒ Volunteer
☐ Household member
☐ Other, specify: _____

Describe the position for which you are applying or renewing:

Applicant information

Name (First, Middle, Last): _____

Social Security number: _____ Date of birth (MM/DD/YYYY): _____

Sex: ☐ Male ☐ Female Phone number: _____

Address – Street: _____

City: _____ State: _____ ZIP code: _____

Have you had or used any other names, including prior to marriage?

☐ Yes ☐ No If yes, list each name fully: _____

Employer or organization verifying eligibility

Name of employer or organization that asked you to complete this form:
Stoughton Hospital Association

Address – Street: 900 Ridge St

City: Stoughton State: WI ZIP code: 53589

Disclosures

If additional space is needed for answering the questions below, please use the additional page at the end of this form.

1. Pending criminal charges

Do you have any criminal charges pending against you, including in federal, state, local, military, and Tribal courts? ☐ Yes ☐ No

If **yes**, describe the charge and indicate the name of the court, the state, city, month and year you were charged.

2. Convictions for crimes

Were you ever convicted of any crime anywhere, including in federal, state, local, military, and Tribal courts, or in another country? ☐ Yes ☐ No

If **yes**, describe the crime and indicate the name of the court, the state, city, month and year you were convicted.

3. Abuse or neglect of a child

Please note that Wis. Stat. § 48.981, *abused or neglected children and abused unborn children*, may apply to information concerning findings of child abuse and neglect.

Has a government or regulatory agency (other than the police) ever found that you abused or neglected a child? ☐ Yes ☐ No

If **yes**, describe the conduct and indicate the agency that made the finding, the state, city, month and year of the finding.

4. Abuse or neglect of an adult

Has a government or regulatory agency (other than the police) ever found that you abused or neglected an adult? ☐ Yes ☐ No

If **yes**, describe the conduct and indicate the agency that made the finding, the state, city, month and year of the finding.

5. Stealing or other misappropriation

Has a government or regulatory agency (other than the police) ever found that you stole or misappropriated (improperly took or used) a person's property (e.g., money, medications, etc.), identity, or financial information (e.g., credit card, checks, etc.)? ☐ Yes ☐ No

If **yes**, describe the conduct and indicate the agency that made the finding, the state, city, month and year it occurred.

6. Restriction on credentials

Do you have a government issued credential that is not current or has been revoked, suspended, or that limits you in any way from providing care to clients? ☐ Yes ☐ No

If **yes**, identify the type of credential and indicate the credentialing agency, the restriction, and the state, city, month and year it was issued.

7. Denial, revocation, or limitation on license, certification, or registration

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

If **yes**, indicate the license, certification, or registration type and indicate the issuing agency. Include a description of the denial, revocation, or limitation, and the state, city, month and year it was issued.

8. Denial, revocation, or limitation on ability to reside on certain premises

Has a government or regulatory agency ever denied, revoked or limited your ability to live on the premises of a facility that provides care or treatment? ☐ Yes ☐ No

If **yes**, describe the denial, revocation, or limitation and identify the issuing agency, the state, city, month and year issued.

9. Rehabilitation review

Have you ever requested a rehabilitation review from the Wisconsin Department of Health Services, a county department, private child placing agency, school board, or DHS-designated Tribe? ☐ Yes ☐ No

If **yes**, indicate the agency that conducted the review, the outcome, month, and year of the review.

Note: You must provide a copy of your rehabilitation review letter to your employer or organization. Your employer or organization must verify your status with the agency that issued the decision.

10. Armed forces

Have you been discharged from a branch of the US Armed Forces, including any reserve component? ☐ Yes ☐ No

If **yes**, indicate the month and year of discharge.

Note: You must provide your DD214 to your employer/agency, if you were discharged within the last three (3) years.

11. Out-of-state residence

Have you resided outside of Wisconsin in the last three (3) years? ☐ Yes ☐ No

If **yes**, list each state, city, and the dates you resided there.

12. Government employee

Are you applying or renewing eligibility to work as a government employee for the State of Wisconsin (e.g. a state agency, treatment facility, institute, etc.)? ☐ Yes ☐ No

If **no**, skip to the attestation below. If **yes**, have you resided outside of Wisconsin in the last seven (7) years? ☐ Yes ☐ No

If **yes**, list each state, city, and the dates you resided there.

Review your responses and the following attestation carefully before signing.

Attestation

I have completed and reviewed this form. The information I provided is accurate and complete. I understand that providing inaccurate or incomplete information on this form may result in a forfeiture or other sanction, as provided in Wis. Stats. § 50.065(6)(c).

Signature — Person completing this form: _____

Date signed: _____