



# 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.

<b>Full Name:</b> _____ <div style="display: flex; justify-content: space-around; font-size: small;"> <span><i>Last</i></span> <span><i>First</i></span> <span><i>Middle</i></span> </div>	
<b>Address:</b> _____ <b>Phone:</b> _____	
<b>City State Zip:</b> _____ <b>Email:</b> _____	
<b>Date of Application:</b> _____	<b>Date Available:</b> _____
<b>Volunteer Position Preference:</b>  _____  (Visit <a href="http://www.stoughtonhealth.com">www.stoughtonhealth.com</a> 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
<b>Work Experience:</b> _____ <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> <b>Position Responsibilities:</b> _____ _____	<b>Education:</b> (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: _____ _____ _____ <div style="text-align: center; font-size: small;"><i>(A conviction record will not necessarily bar a person from the opportunity to volunteer).</i></div>	

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

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**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 Hospital Foundation  
900 Ridge St.  
Stoughton, WI 53589**

**Phone: 608-873-2334  
Email: [foundation@StoughtonHealth.com](mailto: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)

- **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.
- Refer to DQA form F-82064A, *BID Instructions*, 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.
- **PRINT OR TYPE YOUR ANSWERS.**

**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 – <i>First</i>		<i>Middle</i>	<i>Last</i>	
Position Title (Complete only if a prospective or current employee or contractor.)			Birth Date ( <i>MM/dd/yyyy</i> )	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Any Other Names By Which You Have Been Known (Including Maiden Name)				
Race / Ethnicity (Check ONLY one.) <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Unknown				Social Security Number
Home Address		City	State	Zip Code
Business Name and Address – Employer or Care Provider (Entity)				

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

### 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?

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

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

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***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.

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Name – Person Completing This Form
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Date Submitted
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