STOUGHTON HEALTH
Creating Excellence Together

Volunteen 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. Our questions are designed to best match you with volunteer opportunities of most interest to you. Thank you for considering a gift of time to Stoughton Health and our family of patients.

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Volunteen Information:

Full Name: _____
Last *First* *Middle*

Address: _____ **Phone**: _____

City State Zip: _____ **Email**: _____

Parent/Guardian Information:

Full Name: _____
Last *First*

Home or Cell Phone Number: (____)_____-_____ **Work Contact Phone Number**: (____)_____-_____
In case of emergency

Volunteer Preference:

- ☐ Spring
- ☐ Summer
- ☐ Fall
- ☐ Winter

Check hours available and most preferred:

- ☐ Days (Summer only)
- ☐ Evenings (3:30 – 6:30)
- ☐ Other_____

Volunteen's Must be 14 years of age or older.
If under age 18, please state your age: _____

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):_____

Education:

Current High School:_____ Circle Grade Last Completed: ☐ ☐ ☐ ☐

Indicate the reason you are seeking a ***Volunteen*** position *(check all the apply):*

- ☐ Interest in medical field.
  *What professions most interest you:*_____
- ☐ Family/friends volunteer/work for Stoughton Health.
  *Please list name and relationship:*_____
- ☐ Required for school
- ☐ Interested in Stoughton Health as a future employer
- ☐ Requirement for National Honors Society or like group/club
- ☐ Need service hours to graduate
  *How many hours:*_____ *By When:*_____

Please share how you learned about our volunteer program:

- ☐ Class presentation by a representative from Stoughton Health
- ☐ Craigslist
- ☐ Friend/Classmate
  *Who:*_____
- ☐ Guidance Counselor/School communication
- ☐ Newspaper advertisement
- ☐ Stoughton Health Employee
  *Who:*_____
- ☐ Stoughton Health Volunteer
  *Who:*_____
- ☐ United Way
- ☐ Social Media
  *Please List:*_____
- ☐ Other
  *Please List:*_____

Please tell us your shirt size so that if chosen we can order you a shirt:

Extra Small - Small - Medium - Large - Extra Large - Extra, Extra Large - Extra, Extra, Extra Large

Are there any units or situations which might make you feel uncomfortable? If so, please explain:

_____

_____

_____

_____

Do you have any special needs which we should accommodate? If so, please explain:

_____

_____

_____

_____

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

☐ Arts and crafts interest
☐ Ability to read, write and communicate at a basic reading level
☐ Ability to push, pull and safely transport patients
☐ General spa interest
☐ Basic keyboarding experience
☐ Basic computer competency
☐ Basic Microsoft Office suite experience
☐ Intermediate Microsoft Office suite experience
☐ Have a natural interest in using electronic devices and gadgets like iPads, smartphones, etc.
☐ Medical terminology experience or previous healthcare professional experience
☐ Basic mechanical aptitude
☐ Play a musical instrument
☐ Previous trade experience
☐ Previous leadership experience
☐ Other:

_____

_____

_____

Work Experience:

Most Recent Employer:_____

Start Date:_____ End Date:_____

Duties:_____

Reason for Leaving:_____

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

	Name	*Address*	*Telephone*	*Relationship*
1				
2				
3				

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).

Parent/Guardian Authorization:

I hereby authorize Stoughton Health to medically treat or manage any injury sustained, if after reasonable effort, I cannot be reached. I consent for my child to serve as a volunteer at Stoughton Health and consider her/him capable of undertaking the responsibilities of the volunteen program as described in the attached volunteer job description. I hereby authorize Stoughton Health to contact any schools, former places of employment and/or persons who may aid the hospital in determining my son/daughter's suitability for volunteer work. Additionally, I release those individuals and/or organizations contacted from all liability whatsoever for issuing the requested information. I understand my child will need to be seen by Employee Health and his/her volunteer placement is contingent upon the outcome of the health assessment and determination of fitness for the prospective position.

This release is in effect for the period the volunteen serves as a volunteer for Stoughton Health.
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 the hospital, son/daughter or myself. I understand he/she will not receive monetary compensation for the services contributed.

Signature of Parent/Guardian: _____ Date:_____

Volunteen Authorization:

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 of Volunteen: _____ Date: _____

Volunteer and/or Guardian, please attach the following:

☐ This signed Volunteen Application
☐ Completed Background Information Disclosure Form – (See form below)

These forms can be mailed or directed to:

Stoughton Hospital Foundation
900 Ridge St
Stoughton WI 53589

Contact the Stoughton Hospital Foundation with questions: 608-873-2334

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 – *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.) ☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Black ☐ White ☐ 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 ☐

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