

Thank you for your interest in the Vernon Memorial Healthcare Volunteer Program.

Please find enclosed a blank volunteer application packet. The packet is very comprehensive and consists of many pages. Please take extra care to ensure that you have completed all the necessary sections.

When you have completed the application, please return it to Volunteer Services, Vernon Memorial Healthcare, 507 S. Main St., Viroqua, WI 54665.

Once we have received your application we will contact you to arrange a time for an interview. If you are accepted into the program you will be required to attend an orientation session to help introduce you to Vernon Memorial Healthcare and the volunteer opportunities we have.

After you have filled out all the forms please return them to Alycia Larson at VMH. Office hours are Monday through Friday 8:00am-4:30pm. Please contact me to set up a time for an interview.

Sincerely,

Alycia Larson | **Volunteer Coordinator**
Vernon Memorial Healthcare
507 South Main Street
Viroqua, WI 54665
(608) 637-4327 | al Larson@vmh.org | www.vmh.org



Confidentiality Agreement

Vernon Memorial Healthcare (VMH) has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health information. Additionally, VMH must assure the confidentiality of its human resources, payroll, fiscal, research, computer systems, and management information. In the course of my employment/assignment at a VMH organization/practice, I may come into the possession of confidential information. In addition, my personal access code [“USER ID(s) and PASSWORD(s)"] used to access computer systems is also an integral aspect of this confidential information.

By signing this document I understand the following:

1. I agree not to disclose or discuss any patient, human resources, payroll, fiscal, research and/or management information with others, including friends or family, who do not need-to-know.
2. I agree not to access any information, or utilize equipment, other than what is required to do my job, even if I don't tell anyone else.
3. I agree not to discuss patient, human resources, payroll, fiscal, research or administrative information where others can overhear the conversation, e.g. in hallways, on elevators, in the cafeterias, on public transportation, at restaurants, or at social events. It is not acceptable to discuss clinical information in public areas even if a patient's name is not used. This can raise doubts with patients and visitors about our respect for their privacy.
4. I agree not to make inquiries for other personnel who do not have proper authority.
5. I agree not to willingly inform another person of my computer password or knowingly use another person's computer password instead of my own for any reason.
6. I agree not to make any unauthorized transmissions, inquiries, modifications, or purgings of data in the system. Such unauthorized transmissions include, but are not limited to, removing and/or transferring data from VMH's computer systems to unauthorized locations, e.g. home.
7. I agree to log off prior to leaving any computer or terminal unattended.

Signature of Associate / Provider / Student / Volunteer

Date

Print Name _____



Volunteer Application

Vernon Memorial Healthcare

Please return your completed application to:
VMH Volunteer Services, 507 S. Main Street, Viroqua, WI 54665

about you

_____	_____	_____
first name	middle name	last name
_____	_____	_____
current address	city	state zip
_____	_____	_____
email address	phone	social security number
_____	_____	_____
emergency contact name	emergency contact phone	emergency contact relationship
_____	_____	_____
emergency contact name	emergency contact phone	emergency contact relationship

about your experience, skills and interests

please list your education, occupation or special training _____

please list your hobbies, extra-curricular activities, skills, talents or special interests _____

please provide two character references (other than family)

_____	_____
name	phone
_____	_____
address	city state zip
_____	_____
name	phone
_____	_____
address	city state zip

Volunteer Application

about your volunteer interests

do you have any restrictions that would limit your volunteering? yes no

if yes, please explain _____

what type of service do you wish to volunteer for?

when are you able to volunteer?

Monday	<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening
Tuesday	<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening
Wednesday	<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening
Thursday	<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening
Friday	<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening
Saturday	<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening
Sunday	<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening

I am voluntarily offering my services with the understanding that there will be no monetary compensation.

signature

date

For office use only

date application received

orientation date

start date

interview date

T.B.

background check

exit date



Public Relations Authorization

I hereby authorize the Marketing & Public Relations department of Vernon Memorial Healthcare (or its assignee) to photograph/video record me (or my dependent) and use my personal identity (or my dependent's). The photos/videos and information obtained may be used by Vernon Memorial Healthcare or by any other media agencies consistent with the normal practices of the Marketing & Public Relations Department for an unlimited period of time.

Media Waiver

On the request of the following named news agency _____
for an interview and/or still or motion/video pictures and/or sound recordings for purposes of publication in newspapers, magazines, other printed media or broadcast over television or radio, or for public display in an educational setting, I recognize Vernon Memorial Healthcare may be acting only as the intermediary, making it possible for the news agency, named above, to contact me. I relieve and hereby agree to hold Vernon Memorial Healthcare free and harmless from any and all liability arising out of the interviewing or photographing in subsequent publication or broadcast by either Vernon Memorial Healthcare or outside media. I understand the interviewing and photographing are being carried out with my consent to the news agency named above, and so assume full responsibility.

Exclusions:

Please Sign:

Date _____ Patient(s) or subject person(s) _____

Date _____ Parent or guardian _____

Date _____ Witness _____

Name: _____

Street Address: _____

City, State, Zip: _____

Telephone: _____



Parent/Guardian Consent for Volunteer

Student's Full Name

Has my permission to serve as a Volunteer at Vernon Memorial Healthcare.

The Volunteer Coordinator or Human Resources Manager has my permission to request school attendance and grade reference records.

I authorize the Marketing/Public Relations department of Vernon Memorial Healthcare (or its assignee) to photograph/video record my dependent and use my dependent's personal identity. The photos/video and information obtained through interviews may be used by Vernon Memorial Healthcare or by any other media agencies consistent with the normal practices of the Marketing/Public Relations Department for an unlimited period of time.

I hereby grant permission for medical treatment should injury occur to my dependent while volunteering. I also grant permission for a TB skin test to be performed on my dependent.

Parent/Guardian Signature _____

Relationship to Dependent _____

Date _____



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.

CAREGIVER BACKGROUND CHECK LAW

In accordance with the provisions of Chapters 48.685 and 50.065, Wis. Stats., 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. A county agency may not certify a child care or license a foster or treatment foster home;
3. A child placing agency may not license a foster or treatment foster home or contract with an adoptive parent applicant for a child adoption;
4. A school board may not contract with a licensed child care provider; and
5. An entity may not employ, contract with or, permit persons to reside at the entity.

A list of barred crimes and offenses requiring rehabilitation review is available from the regulatory agencies or through the Internet at <http://dhs.wisconsin.gov/caregiver/StatutesINDEX.HTM>.

THE CAREGIVER LAW COVERS THE FOLLOWING EMPLOYERS / CARE PROVIDERS (Referred to as "Entities"):

Programs Regulated under Chapter 48, Wis. Stats.	Treatment Foster Care, Family Child Care Centers, Group Child Care Centers, Residential Care Centers for Children and Youth, Child Placing Agencies, Day Camps for Children, Family Foster Homes for Children, Group Homes for Children, Shelter Care Facilities for Children, and Certified Family Child Care.
Programs Regulated under Chapters 50, 51, and 146, Wis. Stats.	Emergency Mental Health Service Programs, Mental Health Day Treatment Services for Children, Community Mental Health, Developmental Disabilities, AODA Services, Community Support Programs, Community Based Residential Facilities, 3-4 Bed Adult Family Homes, Residential Care Apartment Complexes, Ambulance Service Providers, Hospitals, Rural Medical Centers, Hospices, Nursing Homes, Facilities for the Developmentally Disabled, and Home Health Agencies – including those that provide personal care services.
Others	Child Care Providers contracted through Local School Boards

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.
- Anyone who is a Child Care Provider who contracts with a School Board under Wisconsin Statute 120.13 (14).
- Anyone who lives on the premises of a covered entity and is 10 years old or over, but is not a client ("nonclient resident").
- Anyone who is licensed by DHS.
- Anyone who has a foster home licensed by DHS.
- Anyone certified by DHS.
- Anyone who is a Child Care Provider certified by a county department.
- 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, Chapters 111.31 - 111.395, Wis. Stats., 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)

Completion of this form is required under the provisions of Chapters 48.685 and 50.065, Wis. Stats. 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 the instructions (F-82064A) on page 1 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.

PLEASE PRINT YOUR ANSWERS.

Check the box that applies to you.

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

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

Name - (First and Middle)		Name - (Last)		Position Title (Complete only if you are a prospective employee or contractor, or a current employee or contractor.)		
Any Other Names By Which You Have Been Known (Including Maiden Name)				Birth Date	Gender (M / F)	Race
Address Street, City, State, ZIP Code					Social Security Number(s)	
Business Name and Address - Employer or Care Provider (Entity)						

SECTION A - ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION	YES	NO
1. Do you have any criminal charges pending against you or 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 judgement of conviction, a copy of the criminal complaint, or any other relevant court or police documents.		
2. Were you ever found to be (adjudicated) delinquent by a court of law on or after your 10 th birthday for a crime or offense? (NOTE: A response to this question is only required for group and family day care centers for children and day camps for children.) > If Yes , list each crime, when and where it happened, and the location of the court (city and state). You may be asked to supply additional information including a certified copy of the delinquency petition, the delinquency adjudication, or any other relevant court or police documents.		
3. Has any government or regulatory agency (other than the police) ever found that you committed child abuse or neglect? A response is required if the box below is checked: <input type="checkbox"/> (Only employers and regulatory agencies entitled to obtain this information per sec. 48.981(7) are authorized to, and should, check this box.) > If Yes , explain, including when and where it happened.		
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.		

(continued on next page)

SECTION A (continued)	YES	NO
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.		
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.		
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.		
SECTION B – OTHER REQUIRED INFORMATION	YES	NO
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.		
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.		
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 3 years.		
4. Have you resided outside of Wisconsin in the last 3 years? > If Yes, list each state and the dates you lived there.		
5. Have you had a caregiver background check done within the last 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.		
6. 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.		

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

I understand, under penalty of law, that the information provided above is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information may result in a forfeiture of up to \$1,000.00 and other sanctions as provided in HFS 12.05 (4), Wis. Adm. Code.

SIGNATURE

Date Signed

Vernon Memorial Healthcare Reference for Volunteer Applicant

Confidential Reference for Volunteer Applicant

I, _____, do hereby authorize the below named person to release the information requested within this reference form. I do hereby hold harmless and release said person from any liability in releasing this information to the Volunteer Office at Vernon Memorial Healthcare.

Applicant Signature _____ Date _____

Name of Person to Provide Reference Telephone Number

Address City State Zip

A Volunteer is an individual in the hospital or medical clinic setting who volunteers their services with the understanding that there will be no monetary compensation. A volunteer is held to the same expectations as a paid staff member and must exhibit commitment, promptness, cleanliness, courtesy, kindness, respect and confidentiality. Volunteer hours will be documented and kept on file. All applicants will be interviewed by the Volunteer Coordinator prior to their acceptance into the Vernon Memorial Healthcare Volunteer Program and go through an orientation. We would appreciate your input in determining his/her qualification by checking the following items. Please be specific in your comments for the benefit of the applicant and the volunteer program.

	Excellent	Above Average	Satisfactory	Unsatisfactory
Dependability				
Initiative				
Ability to get along with others				
Confidentiality				
Responsibility				
Quality of work				
Quantity of work				
Attitude toward job				
Cooperation				
Absenteeism				

Relationship to volunteer applicant: _____

How long have you known this applicant: _____

Vernon Memorial Healthcare Reference for Volunteer Applicant

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Attitude toward job				
Cooperation				
Absenteeism				

Relationship to volunteer applicant: _____

How long have you known this applicant: _____

