Children's Hospital of Wisconsin®
A member of Children's Hospital and Health System.
Fox Valley

Adult Volunteer Application Instructions

Please take a moment to read through the following checklist designed to help you complete the application process.

Volunteer Services CANNOT process or review incomplete applications.

COMMITMENT PROMISE:

- Volunteers are asked to commit to two hours of volunteer time per week for a period of at least six months.
- In our promise to keep patients safe, Volunteers will complete all required TB screenings and provide all necessary medical documentation.

STEP ONE: To be completed by volunteer applicant

- ☐ **Completely fill out all 6 pages of the application**- including the Volunteer Health Assessment, Signed Background Check form and Confidentiality Statement
- ☐ **Include one letter of reference**. From an employer, teacher, coach or co-worker.
- ☐ **Include a copy** of an **official documentation** of having received **two measles, mumps and rubella (MMR)** immunizations from a Doctor or a Clinic.

MMR notice for individuals born before 1968: This information may not be available. A volunteer staff member will discuss the MMR requirement at your interview.

STEP TWO: Mail completed application = ALL 8 pages

☐ **Mail completed application to The Volunteer Department – address details on application form.**

STEP THREE: Orientation

- **Invitations to the orientation are sent directly to you in the mail if your availability matches a current vacancy.**
- **Information on the Two-step TB screen tests is provided during orientation.**
  - **Volunteers are not permitted to start until both tests are complete and read by validated personnel.**

STEP FOUR: Interview

- **Interviews are scheduled during the orientation. Please bring your calendars.**

PLEASE NOTE:

- Volunteer placements are determined by availability and need within the hospital.
- ***If you do not receive an invitation to orientation, we will keep your application on file for one month. If your availability changes or you want to check for new openings, please call the Volunteer Services Department.***

Thank you for your interest in volunteering at Children's Hospital of Wisconsin – Fox Valley.
We look forward to having you as a member of our team!

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Adult Volunteer Application

NAME: (last, first, middle initial) **DATE:**

_____ _____

Please print clearly

HOME ADDRESS: **Last 4 digits of your SOCIAL SECURITY # XXX-XX-**_____

Street: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (_____) _____ **E-mail address:** _____

Please print clearly

Cell phone: (_____) _____ **Work phone:** (_____) _____

AVAILABILITY: Please indicate which day(s) of the week and specific times you would like to volunteer. Example: if you can volunteer on Monday's from 3:30 pm to 6:30 pm, just enter the time in the Monday column. Do the same process for each day of the week. Do not enter anything on the days you are not available to volunteer. **What date can you start?** Please be specific.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Number of hours you want to volunteer each week._____ **Date available to start**_____

EDUCATION:

High School Name: _____ Graduation year: _____

College/Technical School Name: _____ Graduation year: _____

Major: _____ Minor: _____

Graduate/Other Education: _____

Please help us learn more about you:

How did you hear about us? _____

Tell us why you selected Children's Hospital as a place to volunteer:

_____

What special skills or talents do you bring to your volunteer placement?

_____

COMMITMENT AGREEMENT: I am willing to commit 2 hours a week to a volunteer placement at Children's Hospital of Wisconsin for a minimum term of 6 consecutive months.

Signed: _____ Date: _____

Please complete other side of application.

Adult Volunteer Application

EMPLOYMENT:

Most recent employer: _____ Start date: _____

Address: _____ End Date: _____

City, State, Zip _____ Hours/week: _____

Supervisor & phone: _____ Position: _____

OTHER ACTIVITIES Including volunteer work (current & past), and any group/community affiliations.

_____

_____

SECONDARY CONTACT (example: family member)

Name: _____ Relationship: _____

Home phone: ( ) _____ Work phone: ( ) _____

Cell phone: ( ) _____

- If I'm offered and accept a volunteer placement at Children's Hospital of Wisconsin, I will commit to at least two hours of service each week for six months. ☐ I agree.
- I agree to have any medical tests and immunizations (example: TB and Measles-Mumps-Rubella) required by Children's Hospital. ☐ I agree.
- I understand that this application does not guarantee a volunteer placement at Children's Hospital. ☐ I understand.
- I certify that the statements made in this application are true and complete.

_____ _____

Signature Date

Please return this application ***with*** one letter of reference* to:

Children's Hospital of Wisconsin – Fox Valley
Volunteer Services
130 Second Street
West Pavilion, 2nd Floor
Neenah, WI 54956

***Due to the high volume of volunteer applications, if your application is received without a reference letter, it cannot be processed. Please be sure to send both the application and letter of reference together. Thank you.

Volunteer Health Assessment

TO: Volunteer Applicant
FROM: Employee Health and Wellness Children's Hospital of WI
RE: Pre-Volunteer Health Screening

The Wisconsin Department of Health and Social Services requires all hospital volunteers who may have patient contact to complete a health history and provide proof of measles, mumps and rubella immunity or vaccination. If no record exists, a blood test is needed to determine immune status. Children's Hospital may perform this lab work for you. Those individuals lacking immunity must be vaccinated prior to having patient contact.

In addition to the required health documentation you have provided, **please explain any ongoing health problems, communicable diseases and/or any physical, cognitive, or learning limitations** which may require accommodation in order to allow you to perform volunteer duties at Children's Hospital of Wisconsin:

_____

_____

_____

_____

_____

I hereby declare that all statements include in this Health Assessment are true and correct to the best of my knowledge.

Signature: _____ Date: _____

_____ Date: _____

Signature of parent or guardian, if minor

The information you provide will be maintained in your volunteer file and is ***confidential.***
Thank you for your cooperation.

If you are currently under the care of a physician for an ongoing health issue - the following must be completed by a health care practitioner:

➢This patient is free of communicable disease and current with his/her immunizations: **Y N**

As a volunteer, this applicant may be assigned to a patient care area, walk a significant distance, and/or perform light physical duties such as pushing a wheelchair.

This patient may volunteer:
☐ Without restrictions.
☐ With the following restrictions: _____

_____ Date: _____

Signature of physician, Nurse Practioner, or Physician assistant

Jenny Krikava, Community Relations Coordinator 920.969.5303 jkrikava@chw.org
www.chw.org/foxvalley **Fax Number: (920) 969-7979 Phone Number: (920) 969-5304**

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Confidentiality Statement of Understanding (Volunteers)

I understand that information contained in medical or electronic records are the property of Children's Hospital and Health System. Therefore, the patient has the right to expect that health records will be managed confidentially. It is the responsibility of Children's Hospital and Health System to protect the confidentiality of such information. I agree to adhere to the following policies and I understand that any violation of these guidelines could result in corrective action up to and including immediate dismissal.

1. Volunteers who are granted access to confidential information are accountable to for the protection of the information.

2. Confidential documents may not be removed from Children's Hospital and Health System except as ordered by judicial process.

3. Employees, physicians, volunteers or other representatives only have the right to access information directly related to patients for whom they are providing care or services.

4. Access to written, electronic or verbal information about family, friends, fellow employees or acquaintances is prohibited.

5. Uniform and photo identification are issued on the day a volunteer begins and are to be returned to the volunteer office on the last day of service.

Volunteer Name (Please print): _____

Volunteer Signature: _____

Date: _____

Confidentiality Statement.doc
Revised 7/31/06

Jenny Krikava, Community Relations Coordinator 920.969.5303 jkrikava@chw.org
www.chw.org/foxvalley **Fax Number: (920) 969-7979 Phone Number: (920) 969-5304**

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NOTICE TO VOLUNTEERS

Effective October 1, 1998, the State of Wisconsin requires all hospitals to conduct background checks for all persons who seek to be employed or to volunteer in the caregiving industry.

Wisconsin's Fair Employment Law prohibits discrimination because of a criminal record or pending charges, unless the record or charge is substantially related to the circumstances of the particular job or licensed activity.

Please complete the attached form to assist us in this process.

BACKGROUND INFORMATION DISCLOSURE INSTRUCTIONS

The Background Information Disclosure form (HFS64) 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 sections 48.685 and 50.065 of the Wisconsin Statutes, for persons who have been convicted of certain acts, crimes or offenses:

1. The Department of Health and Family Services (DHFS) 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://www.dhfs.state.wi.us/ at the Licensing link and then under the Caregiver Program link.

THE CAREGIVER LAW COVERS THE FOLLOWING EMPLOYERS / CARE PROVIDERS (REFERRED TO AS "ENTITIES")

Programs Regulated Under Chapter 48 of Wisconsin Statute	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 of Wisconsin Statute	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 DHFS.
- Anyone who has a foster home licensed by DHFS.
- Anyone certified by DHFS.
- Anyone who is a Child Care Provider certified by a county department.
- Anyone registered by DHFS.
- Anyone who is a board member or corporate officer who has access to the clients served.

FAIR EMPLOYMENT ACT

Wisconsin's Fair Employment Law, ss. 111.31 - 111.395, Wisconsin Statutes, 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 and Family Services' Caregiver 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

Completion of this form is required under the provisions of sections 48.685 and 50.065 of the Wisconsin Statutes. 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 attached instructions (HFS-64 A) 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.

- ❑ Employe / Contractor (Including new applicant)
- ❑ Applicant for a license or certification or registration (including continuation or renewal)
- ❑ Household member / lives on premises - but not a client
- ❑ Other – specify:

NOTE: If you are an owner, operator, board member, or nonclient resident of a Bureau of Quality Assurance (BQA) regulated facility (1) print only your first, middle and last name; (2) complete Sections A and B; (3) sign the form; (4) complete the Appendix, HFS-69, in its entirety and (5) submit this form and the Appendix to the address noted in the Appendix Instructions.

Name - First and Middle	Name - Last	Position Title (Complete only if you are a prospective employe or contractor, or a current employe or contractor.)		
Any other names by which you have been known (including maiden name)		Birthdate	Gender (M / F)	Race
Address			Social Security Number(s)	
Business Name and Address of 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 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 10th 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: ❑ (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**, attach a copy of your discharge papers (DD214) if you were discharged within the past 3 years. ➢ You may be asked to provide a copy of your DD214 if your discharge occurred more than 3 years ago.		
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 and Family Services, a county department, a private child placing agency, school board, or DHFS 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.

YOUR SIGNATURE	Date Signed