SANFORD HEALTH
Marshfield Clinic

Volunteer Application

DEMOGRAPHICS

First Name	Last Name	Middle Initial	Preferred Name
Primary Phone	Secondary Phone	Date of Birth	
Street Address (City, State, ZIP)		Email Address	

EMERGENCY CONTACT

Be sure to select an individual that could generally be reached during the time you are volunteering.

First Name	Last Name	Primary Phone	Secondary Phone
Relationship			

EDUCATION – RELEVANT OR MOST RECENT

Name of School			Degree Area of Study
Years Attended from	to		

Name of School			Degree Area of Study
Years Attended from	to		

RELEVANT WORK OR VOLUNTEER HISTORY

Name of Organization			Name of Supervisor
Dates start	end		Phone

Duties Performed

Name of Organization			Name of Supervisor
Dates start	end		Phone

Duties Performed

List your skills and interests related to the opportunity you are applying for:

AVAILABILITY

Check all of your availability (morning, afternoon, evening) below.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning	☐	☐	☐	☐	☐	☐	☐
Afternoon	☐	☐	☐	☐	☐	☐	☐
Evening	☐	☐	☐	☐	☐	☐	☐

When would you like to start volunteering?	How did you hear about this volunteer opportunity?

Other:

The information I have provided on this application is true and complete to the best of my knowledge. Any misrepresentation or omission of any information during the volunteer onboard process may result in refusal of volunteer services. Any offer of volunteering I may receive from Marshfield Clinic Health System is contingent upon my successful completion of the System's total volunteer process. I understand that Marshfield Clinic Health System will perform a caregiver/criminal background check as a condition of volunteering. I agree to cooperate with this check as requested and complete the Background Information Disclosure form upon request.

It is System policy to screen for illegal drug use as part of the volunteer process. As a potential volunteer, I understand I must consent to, report for and pass a urine drug test. A failure to consent to and pass the tests will terminate the volunteer process, and I will not be eligible to reapply for volunteering with Marshfield Clinic Health System for 1 year. I also understand and agree that if volunteering, I may be required to submit to alcohol and/or drug testing at any time when there is reasonable belief, post-accident, or follow-up testing at the discretion of the System. Refusal to take the required test may result in disciplinary action up to and including discharge.

I authorize and request that all of my present and former employers, education facilities, and those individuals listed as references furnish information about my employment and/or educational record(s), including a statement of the reason for the termination of employment, work performance, abilities, and other qualities pertinent to my qualifications for employment, and release them from any and all liability for damages arising from furnishing the requested information. I hereby authorize Marshfield Clinic Health System, its employees and agents to inquire and receive such information and release Marshfield Clinic Health System, its employees, and agents from any and all liability for claims or damages arising from receiving the requested information.

I represent and warrant that I am not and at no time have I been excluded from participation in any federally funded programs, including Medicare and Medicaid. I will immediately notify Marshfield Clinic Health System if I am threatened to be or am excluded from any federally funded program, including Medicare and Medicaid. If I am excluded from participation in any federally funded program during the application process or during volunteer service, the application process or such term may be terminated at the sole discretion of Marshfield Clinic Health System.

If selected for volunteer service, I will comply with the policies, rules, regulations and procedures of Marshfield Clinic Health System, and I understand that my term of volunteering is at-will and may be terminated with or without cause or notice, at any time, at the option of either Marshfield Clinic Health System or me. I further understand that no manager or representative of Marshfield Clinic Health System, other than the President, General Counsel, Executive Director or the Director of Human Resources, has any authority to enter into any agreement with me for volunteering for any specified period of time or to make any agreement different from or contrary to any Marshfield Clinic Health System policy. I further understand that any such agreement, if made, shall not be enforceable unless it is in writing and signed by me and by one of the individuals designated above.

I have carefully read the above Information Acknowledgment and I understand and agree to all of the statements.

☐ Yes ☐ No

IMPORTANT NOTE REGARDING E-SIGNATURE: By typing your full name below and submitting this expression of interest, you acknowledge and agree that your typed name represents your signed name (signature) and that you intend for this electronic signature to have the same force and effect as a manual (handwritten) signature.

Signature	Date	Parent/Guardian's Signature *(if under 18)*	Date