Marshfield Medical Center
Neillsville

**Welcome!**

I am happy you have chosen to help serve our patients, their families, visitors and staff here at Marshfield Medical Center - Neillsville. You will be serving in a vital capacity requiring dedicated effort, loyalty and enthusiasm. There are many volunteers, like you, who have discovered a new way of life by serving others.

Every volunteer is a vital link between the hospital and the community and, as such, promotes understanding by stimulating interest in the hospital's achievements, progress and future goals.

Volunteers provide services sometimes not available to our patients and their families. As a volunteer, you will maintain a regular volunteer schedule.

I am here to answer your questions and make your volunteer efforts and experience as effective and rewarding as possible. I am always available to help you in your new position. Please feel free to seek assistance and contact me whenever necessary. Your comments, suggestions and concerns are very important to me.

I sincerely hope you enjoy your volunteer experience.

Candy Marg

Manager, Volunteer Services
(715) 743-8423
cmarg@memorialmedcenter.org

Marshfield Clinic
Health System

# 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** |
|---|---|---|---|
| | | | |

**DEPARTMENT OF HEALTH SERVICES**
Division of Quality Assurance
F-82064A (07/2018)

**STATE OF WISCONSIN**
Wis. Stat. § 50.065
Wis. Admin. Code § DHS 12.05(4)

# 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.
- **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 *BID Appendix*, F-82069, and submit both forms to the address noted in the *BID Appendix Instructions*.

## CAREGIVER BACKGROUND CHECK LAW

In accordance with the provisions of Wis. Stat. § 50.065, 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. An entity may not employ, contract with, or permit persons to reside at the entity.

The list of offenses affecting caregiver eligibility that require rehabilitation review is available from the regulatory agencies or through the Internet at https://www.dhs.wisconsin.gov/caregiver/statutes.htm.

**The Caregiver Law covers the following EMPLOYERS / CARE PROVIDERS (aka ENTITIES) regulated under Wis. Stat. §§ 50, 51, and 146:**

- Adult Family Homes (3-4 Bed)
- Ambulance Service Providers
- AODA Services
- Community Based-Residential Facilities
- Community Mental Health Programs
- Community Support Programs (CSP)
- Developmental Disabilities
- Emergency Mental Health Service Programs
- Intermediate Care Facility for Individuals with Intellectual Disabilities
- Home Health Agencies, including those that provide personal care services
- Hospices
- Hospitals
- Mental Health Day Treatment Services for Children
- Nursing Homes
- Residential Care Apartment Complexes
- Rural Medical Centers

**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. Exception: Emergency medical technicians and first responders are not covered under the Caregiver Law.
- Anyone who lives on the premises of a covered entity and is 10 years old or over, but is not a client ("non-client resident").
- Anyone who is licensed by DHS.
- Anyone certified by DHS.
- 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, Wis. Stat. §§ 111.31 – 111.395, 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)

- **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.
- Providing your social security number is voluntary; however, your social security number is one of the unique identifiers used to prevent incorrect matches.
- Refer to DQA form F-82064A, *BID Instructions*, for additional information.

**Check the box that applies to you.**

☐ Employee / Contractor (including new applicant)
☐ Applicant for a license, certification, or registration (including continuation or renewal)
☐ Household member (lives on premises, but is not a client)
☐ 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)

Marshfield Clinic Health System, Inc.; Marshfield Clinic, Inc.; MCHS Hospitals, Inc.; Lakeview Medical Center, Inc. of Rice Lake; Family Health Center of Marshfield, Inc.

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

Note: The areas below that are designated for responses are expandable.

## 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?
   **If the above box has been checked**, provide an explanation below, including when and where the incident(s) occurred.
   Yes ☐ No ☐

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 |
|---|---|
| | |

Marshfield Clinic Health System

# Confidentiality Statement

I understand and agree that in performance of my duties as a Volunteer at Marshfield Clinic Health System, I must hold as absolutely confidential all information which I may obtain directly or indirectly concerning patients, patient's family members, physicians, and Marshfield Clinic Health System personnel in accordance with HIPAA regulations. I will not seek out confidential information in regard to patients, patient's family members, physicians, or Marshfield Clinic Health System personnel.

I understand that intentional or unintentional violation of confidentiality may result in disciplinary action including termination by Marshfield Clinic Health System and/or possible legal action by patients or families.

_____

Print Name

_____

Signature

_____

Date

Please sign and date Volunteer Acknowledgement on reverse side

Marshfield Clinic Health System

# Volunteer Acknowledgement

I am interested in providing volunteer services for Marshfield Clinic Health System (MCHS) or one of its wholly owned subsidiaries (collectively – "MCHS"). I understand that I will receive no pay or other benefits for the volunteer services I provide to MCHS.

MCHS has made no promise of pay or benefits now or in the future. I wish to volunteer my time to support MCHS's goal of creating healthy communities through accessible, affordable, compassionate health care.

I understand and agree that I am voluntarily offering my services to MCHS freely and without pressure or coercion, direct or implied, from MCHS or any of its employees or representatives. In addition, I understand and agree to abide by all policies and procedures governing my volunteer work as determined by MCHS.

_____

Print Name

_____

Signature

_____

Date

Please sign and date Confidentiality Statement on reverse side

Marshfield Clinic
Health System

# Release for Use of Information, Photographs and/or Videotapes

Name (PRINT) _____

Address _____

Phone number _____

Subject/Comments _____

I hereby consent to the use, for news release publication, web site use, and education purposes by Marshfield Clinic Health System and publications who the forgoing may authorized, of my name, photographs and/or videotapes of me and/or digital manipulations. I agree that all such photographs, negatives and/or videotapes are and shall remain the property of Marshfield Clinic Health System or publications authorized by Marshfield Clinic Health System.

_____ _____
Signature of person **or** authoirzed person to give consent (Relationship)

_____ ____/____/____ _____
Witness signature Date (month/day/year) Time

  White: Customer Yellow: Graphic Arts

Marshfield Clinic
Health System

# Volunteer Verification Checklist

The completed paperwork necessary for the transition for becoming a volunteer with Marshfield Clinic Health System. All paperwork will need to be completed and returned to me by or before May 30, 2019 in order to be eligible to continue your volunteer duties after that date.

We greatly appreciate your part in this transition and look forward to working together as always.

*Please place a V'by each item below once completed and return this cover sheet with your forms:*

— Volunteer Acknowledgement _ Volunteer Application

— Release of information to MCHS (The use of this form is intended only for the purpose of transitioning from an MMC Volunteer to a Marshfield Medical Center-Neillsville volunteer. Your personal information will not be used inappropriately and will be kept confidential).

— Background Information Disclosure

— Confidentiality agreement (We will review Confidentiality at the annual In-Service)

— TB Risk Assessment Questionnaire Screen form

— Security Photo Release Form

----- Badge Photo

Please be sure to check both sides of forms for information and to sign, print name and date all forms.

Feel free to contact Candy Marg, Volunteer Services if you have any questions or if there is information you do not understand. Thank you again for coming alongside us as one of our Team!

_____
Volunteer Signature

_____
Print Name

_____
Date