St. Croix HEALTH

Volunteer Partners

Our Purpose is to promote & advance the welfare of St. Croix Health and its services to the community by fundraising to provide support to patients and staff.

Since 1984, the Volunteer Partners have provided time and resources to enhance the experience of patients at St. Croix Health and our community.

Volunteer Partners have provided 150 Scholarships totaling over $80,000 and approximately $300,000 of equipment contributions to the medical center, including: kits for homeless individuals receiving care, clothing for patients, electrical doors, defibrillator, EKG machine, fetal heart monitor, furniture, and more.

Departments where you may be able to support as a Volunteer:

Gift Shop, Administration, Business Office, Clinic, Marketing, Emergency Room, Human Resources, Information Desks, Kitchen, Lab, Maintenance, Medical Records, Medical Surgical Unit, Obstetrics, Oncology, Quality Assurance, Radiology, Social Services, Surgery, Spiritual Care

Events Volunteers Support:

Blood Drive, Disaster Drills, Open Houses, Conferences Fairs, Seasonal Decorating, Various Fundraisers.

Who can volunteer?

Anyone who is over 14 years of age and has passed the background check and health requirements for working in a medical facility. (Please reach out if you have questions or concerns.)

Why volunteer?

Meet new people, make friends, learn new skills, explore careers, build your resume, positively impact your community.

If you have questions, would like to volunteer, or donate see our information below:

St. Croix Health
Volunteer Partners
235 State Street
St. Croix Falls, WI 54024
volunteer@scrmc.org

St. Croix Health Volunteer Application

Please complete full application and mail it to ***Attn: Volunteers, 235 State Street, St. Croix Falls, WI 54024,*** *or email it to* ***volunteer@scrmc.org.***

Date: _____

Legal Name: _____

Preferred Name: _____

Address: _____

Phone: _____

Email: _____

Emergency Contact: _____

Relationship: _____

Address: _____

Phone: _____

Email: _____

Are you currently employed? NO YES, Name of Employer: _____

Have you previously been an Employee or Volunteer at St. Croix Health?

NO YES, Dates: _____

Are you volunteering to fulfill a Community Service or Volunteer Requirement? NO YES

IF YES: Who is required by? _____

How many hours are required? _____

St. Croix Health Volunteer Application *(cont.)*

Name of School/University: _____

Graduated, Enrolled, Other: _____

Career Field or Career Interest: _____

Relevant Skills or Experience: _____

_____

Other Community Involvement: _____

_____

Volunteer Placement Preference: _____

Restrictions (Health or Physical) that may impact your volunteer placement: _____

_____

Volunteer Availability:

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

Comments about availability: _____

St. Croix Health Volunteer Application *(cont.)*

REFERENCES:

ADULT VOLUNTEERS

Reference Name:_____

Address:_____

Phone:_____

How do you know them?_____

YOUTH VOLUNTEERS (Age 14-17)

Volunteer's Grade:_____

Volunteer's Graduation Year:_____

School:_____

Teacher/Coach Name:_____

Reference Phone:_____

GUARDIAN CONSENT *(For volunteers aged 14-17)*

I have read the application/consent form and give the following individual *(volunteer name)* _____ permission to be a youth volunteer at St. Croix Health.

GUARDIAN SIGNATURE: _____ DATE:_____

I understand St. Croix Health Volunteers are required to:

- Have a background check and agree to complete the necessary forms with Human Resources.
- Have a health screening/test (Mantoux) provided by St. Croix Health and agree to complete with Infection Control.
- Have a general orientation and agree to complete with Volunteer Services.

APPLICANT SIGNATURE:_____ DATE:_____

BACKGROUND INFORMATION DISCLOSURE (BID) FOR ENTITY EMPLOYEES AND CONTRACTORS

- **PENALTY:** A person who provides false information on this form may be subject to forfeiture and sanctions, as provided in Wis. Stat. § 50.065(6)(c) and Wis. Admin Code § DHS 12.05(4).
- Completion of this form to verify your eligibility for employment/service as a "caregiver" is required by Wis. Stat. § 50.065 and Wis. Admin Code ch. DHS 12. Failure to complete this form may result in denial or termination of your employment, contract or service agreement.

Refer to DQA form F-82064A, *Instructions*, for additional information.

Reset

Check the box that applies to you.

☐ Applicant / Employee ☐ Student / Volunteer

☐ Contractor ☐ Other – Specify:

NOTE: This form should NOT be used by applicants for *entity operator approval* (license, certification, registration or other DHS approval) or by entities requesting approval for an individual to reside in entity facilities as a *non-client resident*. Applicants for *entity operator approval* or for a *non-client resident* background check must request an *entity* background check from the Division of Quality Assurance.

Full Legal Name – *First*	*Middle*	*Last*

Other Names (including prior to marriage)

Position Title (applied for or existing)	Birth Date *(MM/DD/YYYY)*	Sex ☐ Male ☐ Female

Home Address	City	State	Zip Code

Business Name and Address – Employer (Entity)

Answering "NO" to all questions does not guarantee employment, a contract, or service agreement.
If more space is required, attach additional documentation to this form and indicate "see attached" in your answer.

SECTION A – DISCLOSURES

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. Please note that Wis. Stat. § 48.981, *Abused or neglected children and abused unborn children*, may apply to information concerning findings of child abuse and neglect.
   Has any government or regulatory agency (other than the police) ever found that you committed **child** abuse or neglect?
   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**?
   If **Yes,** explain, including when and where it happened.
   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? 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

VOLUNTEER IMMUNIZATION REQUIREMENTS

Please complete the form below to comply with State Laws, CDC recommendations and St. Croix Health Policy

Last Name: _____ First Name: _____ MI: _____

Previous Names Used: _____

Home Address: _____

VACCINATION/IMMUNITY/SCREENING REQUIREMENTS

Vaccination/Immunity/Screening	Documentation Needed
Influenza Vaccine	Documentation of current annual vaccination (Oct-Mar)
Measles, Mumps, & Rubella (MMR)	Documentation of blood screen immunity for Measles, Mumps & Rubella; *OR* Documentation of 2 MMR vaccinations
Tetanus, Diphtheria Pertussis (DTaP/TDaP)	Documentation of TDaP vaccine within the last 10 years
Tuberculosis (TB)	TB Screening Form; AND 2-Step TST*; OR TB Blood test* (QuantiFERON Gold/TSPOT) **Within the past 12 months*
Varicella (Chickenpox)	Documentation of blood screen immunity; OR Documentation of 2 varicella vaccinations
Hepatitis B-*highly recommended by not required*	Documentation of Hepatitis B series (3-doses) AND Documentation of blood screen immunity
St. Croix Health recommends that all volunteers stay up to date with COVID-19 vaccinations.	

Please send any immunization/immunity, or TB testing records to Human Resources promptly.

I understand that my vaccination history will be looked up on MIIC (MN Immunization Information Connection) or WIR (WI Immunization Registry) to verify accuracy and completeness. To help locate your record, please include your maiden name (or previous names used): _____ and your mother's maiden name: _____.

I understand I will be subject to a possible blood draw or have vaccinations administered if I do not have proof of the requirements as noted above.

Signature: _____ Date: _____

Legal Guardian signature if needed for Vaccination/Testing if a minor _____

Attach Immunization/testing documentation and volunteer services will return to: **Employee Health**

TUBERCULOSIS (TB) SCREENING & RISK ASSESSMENT QUESITONNIARE

NAME: _____ DOB: _____

		NO	YES
1.	Do you have any recent symptoms of TB disease: Persistent cough lasting three or more weeks AND one of more of the following symptoms: Coughing up blood Fever/chills Night sweats Unexplained weight loss or loss of appetite Fatigue/weakness	☐	☐
2.	Have you ever had a positive TB blood test or TB skin test? If so, when: _____	☐	☐
3.	Have you ever received treatment for latent or active TB disease? If so, when: _____		
4.	Were your born, travelled ≥ 1 month or resided in a country ≥ 1 month with high TB prevalence? *Includes any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.*	☐	☐
5.	Have you had close contact with someone with active/infectious TB disease?	☐	☐
6.	Do you have current or planned immunosuppression, including human immunodeficiency virus infection (HIV), receipt of an organ transplant, treatment with a TNF-alpha antagonist, chronic steroids (equivalent to ≥ 15m/day for ≥ 1month), or other immunosuppressive medication.	☐	☐

☐ A TB risk assessment has been completed for the person named above. No risk factors for TB were identified. Baseline TB testing has/will be completed.

☐ A TB risk assessment has been completed for the person named above. Risk factors for TB have been identified. Further testing is recommended to determine the presence or absence of tuberculosis in a communicable form.

Employee Health Nurse Signature: _____ Date: _____