Marshfield Clinic®

HEALTH SYSTEM

Marshfield Medical Center

Volunteer Paperwork

Please complete the following pages and return them to the Volunteer Services Office at Marshfield Medical Center.

Name: _____

Date: _____

611 Saint Joseph Avenue
Marshfield, WI 54449
phone: 715.387.7106
fax: 715.389.3993
kilty.keresa@marshfieldclinic.org

Marshfield Clinic HEALTH SYSTEM FOUNDATION

Volunteer Application

OFFICE USE ONLY

App Received: _____
Interview Date: _____
Volunteer No.: _____

APPLICANT INFORMATION:

NAME (LAST, FIRST, MIDDLE INITIAL):		DOB (00/00/0000):	
STREET ADDRESS:	CITY:	STATE:	ZIP:
EMAIL:		PRIMARY PHONE:	

EDUCATION:

SCHOOL:	DATE(S) ATTENDED:	DEGREE/DIPLOMA:

REFERENCES: ***(Work related or previous volunteer work)***

NAME:	RELATIONSHIP:	PHONE:

CURRENT EMPLOYMENT INFORMATION:

EMPLOYER:	OCCUPATION:	WORK PHONE:

SCHEDULE: ***(Fill in the days and times you are available.)***

	MON	TUES	WED	THUR	FRI	SAT	SUN
MORNING							
AFTERNOON							
EVENING							

EMERGENCY CONTACT INFORMATION:

NAME:	RELATIONSHIP:	PHONE:

VOLUNTEER PREFERENCES:

AREA OR SERVICE PREFERRED:	
AGE GROUPS YOU'D LIKE TO WORK WITH:	
START DATE:	

By signing below, you agree that you will: (1) adhere to all Marshfield Clinic Health System (MCHS) Policies and Procedures, including but not limited to the MCHS governing confidentiality, infection control, and safety if MCHS selects you as a volunteer; (2) adhere to the attached Letter of Agreement if MCHS selects you as a volunteer; (3) grant MCHS permission to contact the above references and any other person or organization having any information related in any way to your fitness to be a MCHS volunteer; and (4) release from any and all liability and agree not to bring any claim or suit against, MCHS, its officers, directors, shareholders, affiliates, employees, insurers, agents, successors, and assigns, for collecting or disclosing the above-mentioned information or for any consequence related to such a collection or disclosure.

_____
VOLUNTEER SIGNATURE

_____ _____
PRINT NAME DATE

Marshfield Medical Center

VOLUNTEER INFORMATION & REQUIREMENTS

Adult & College Students

Marshfield Medical Center is a 500-plus bed tertiary care teaching facility and is one of the largest rural referral medical centers and one of only three Children's Hospitals in Wisconsin. It provides health care, including all major medical and surgical specialties and subspecialties, to an ever increasing service area in Wisconsin and Upper Michigan. More than 400 Marshfield Clinic physicians are on its medical staff, with more than 2,000 quality caregivers and support staff providing round-the-clock support. Marshfield Medical Center's mission is to enrich lives through accessible, affordable and compassionate health care.

MISSION

WE ENRICH LIVES

…to create healthy communities through accessible, affordable, compassionate health care.

Volunteers contribute in many ways providing comfort, care and unexpected joy to the children and families in the hospital, as well as supporting the professional staff. We are excited and want to thank you for your interest in wanting to volunteer at Marshfield Medical Center. The Volunteer Services Department interviews, orients, schedules training and places all qualified who want to volunteer. We enthusiastically welcome individuals of all backgrounds and abilities. Applicants must have good general health and be able to communicate well in English (knowledge of a second language is a plus!).

Areas of Service include but are not limited to:

Info Desk–Welcome Ambassador
Direction Desk
Critical Care Waiting Room
Intensive Care Waiting Room
Library Cart
Main Lobby Escort
Family Waiting Room (Escort and Phones)
House of the Dove – Hospice Services
Eucharistic Minister (*must be a member of a local parish*)
Home Delivered Meals
Projects/Clerical
Hospital Tour Guides
Patient Mail
Magazine Cart
Children's Miracle Network
Special Events
Home Projects (*sewing, crocheting, knitting*)
Activity Cart Entertainment
Emergency Room
Gift Shop
Coffee Cart
Musical Entertainment
Nursing Unit
Patient Care Unit – Pediatrics

Volunteer Commitment & Requirements

Volunteers are asked to commit 2-3 hours per week to volunteering here for a year. Will you be able to make that commitment?

☐ Yes, I will commit to a minimum of a year and 2-3 hours per week
☐ No, I am unable to make that time commitment

Please return this form in the enclosed Pre-paid postage envelope.

Marshfield Clinic
HEALTH SYSTEM

Marshfield Medical Center
NEW VOLUNTEER ASSESSMENT

Name:_____ Birthdate:_____ Sex: _____

Phone Number:_____ Address: _____

City / State: _____ Zip Code: _____

Please indicate where at Marshfield Medical Center you will be volunteering: _____

Immunization History:

Have you been fully immunized against the following:

	Yes	No
Diphtheria (3 doses DPT)	☐	☐
Pertussis (Whooping Cough) (3 doses DPT)	☐	☐
Tetanus Booster, Year_____	☐	☐
Polio	☐	☐
Measles	☐	☐
Mumps	☐	☐
Rubella	☐	☐
Small Pox	☐	☐
Varicella (Chicken Pox)	☐	☐
Did you experience any adverse reactions to any of the above:	☐	☐

Do you have or have you ever had any of the following:

	Yes	No
Drainage or discharge from the eyes, ears or nose:	☐	☐
Hepatitis A	☐	☐
Hepatitis B	☐	☐
Hepatitis C	☐	☐
Polio	☐	☐
Malaria	☐	☐
Rubella (German Measles)	☐	☐
Rubeola (Measles)	☐	☐
Chicken Pox	☐	☐
Mumps	☐	☐
Rheumatic Fever	☐	☐
Scarlet Fever	☐	☐
Any other infectious disease, other than colds/flu?	☐	☐

_____

TB Screening:

Please answer the following questions so Employee Health can determine if you need a TB skin test. If you would rather have a TB skin test instead of answering the questions, please indicate by checking this box: ☐

		YES	NO
1.	Do you have a requirement for an annual TB test at another facility outside of the Marshfield Clinic Health Systems? If yes, please provide results.	☐	☐
2.	Do you currently have:		
	a. Persistent productive cough (greater than 2 weeks duration unrelated to another diagnosis)	☐	☐
	b. Night sweats (unrelated to menopause)	☐	☐
	c. Unexplained weight loss	☐	☐
	d. Coughing up blood	☐	☐
	e. Loss of appetite	☐	☐
	f. Fever – with unknown cause	☐	☐
3.	To your knowledge, during the course of this past year, have you provided medical care, or become exposed to a patient with known active TB? If yes, explain _____	☐	☐
4.	To your knowledge, have you had an exposure to a known active TB patient in the community setting or at home this past year (i.e., a relative, friend, or other contact)? If yes, explain _____	☐	☐
5.	Have you had a positive TST or positive Q-Gold/T-spot test in the past? If yes, when: _____	☐	☐
6.	Have you done any travel outside of the U.S. and/or Canada for greater than a total of 60 days in the last year? If yes, where _____. What date did you return to the U.S. _____	☐	☐
7.	Have you performed missionary work in the last year, either in or out of the U.S.?	☐	☐
8.	Were you on military/leave duty in the last year?	☐	☐

**Be certain to contact the Hospital Employee Health Office if you ever have an exposure to a known active TB patient, or you develop any of the above symptoms or concerns during the course of your volunteering.

Signature: _____ **Date:** _____

Reviewed July 2017

Marshfield Clinic
HEALTH SYSTEM
FOUNDATION

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.

_____

Name (Please print)

_____

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 or one of its wholly owned subsidiaries (Marshfield Medical Center). I understand that I will receive no pay or other benefits for the volunteer services I provide to Marshfield Medical Center. Marshfield Medical Center has made no promise of pay or benefits now or in the future. I wish to volunteer my time to support Marshfield Medical Center's goal of creating healthy communities through accessible, affordable, compassionate health care.

I understand and agree that I am voluntarily offering my services to Marshfield Medical Center freely and without pressure or coercion, direct or implied, from Marshfield Medical Center 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 Marshfield Medical Center.

_____

Name (Please print)

_____

Signature

_____

Date

Please sign and date Confidentiality Statement on reverse side

Marshfield Clinic®

Release for Use of Information, Photographs and/or Videotapes

Name (print) _____ Date _____

Address _____

Phone number _____

Subject/comments _____

I hereby consent to the use, for news release publication, web site use, and education purposes by Marshfield Clinic, Marshfield, Wisconsin 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 or publications authorized by Marshfield Clinic.

_____

Witness

_____

Signature of person **or** authorized person to give consent (relationship)

White: Customer Yellow: Graphic Arts

DEPARTMENT OF HEALTH SERVICES
Division of Enterprise Services
F-82064 (02/2014)

STATE OF WISCONSIN
Chapters 48.685 and 50.065, Wis. Stats.
DHS 12.05(4), Wis. Admin. Code

BACKGROUND INFORMATION DISCLOSURE (BID)

For Instructions, see F-82064A.
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 OR TYPE YOUR ANSWERS.

Check the box that applies to you.

☐ Employee / 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: Volunteer

NOTE: If you are an owner, operator, board member, or non-client resident of a Division of Quality Assurance (DQA) 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	Social Security Number(s)
☐ American Indian or Alaskan Native ☐ Black ☐ Unknown ☐ Asian or Pacific Islander ☐ White	

Home Address	City	State	Zip Code

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 judgment 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.	☐	☐
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.	☐	☐

Last Name –

SECTION A – ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION	YES	NO
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 DHS 12.05 (4), Wis. Adm. Code.

SIGNATURE	Date Signed

Marshfield Medical Center

HIPAA - Competency Quiz

1. **What does HIPAA stand for?**
   ___ Health Insurance Portability and Accountability Act
   ___ Hospital Information Protection and Accountability Act
   ___ Honest Information Protecting All Americans

2. **Who does HIPAA pertain to?**
   ___ Only Hospitals
   ___ All health care providers
   ___ Only pharmacies and insurance companies

3. **Placing patient information in a wastebasket is okay as long as it is behind a desk.**
   ___ True ___ False

4. **PHI stands for:**
   P_____ H _____ I _____

5. **Reporting HIPAA violations is everyone's responsibility.**
   ___ True ___ False

6. **TPO stands for:**
   T_____ P_____ O_____

7. **Is it possible for a volunteer to be fined and imprisoned for disclosure of health information?**
   ___ YES ___ NO

I have completed HIPAA training and have been given the opportunity to ask questions. I agree to comply with HIPAA regulations and to follow Marshfield Medical Center's privacy and confidentiality policies.

_____ _____ _____

Volunteer Signature *Print Name* *Date*

Reference HIPPA section

Marshfield Clinic
HEALTH SYSTEM
FOUNDATION

INFECTION PREVENTION AND CONTROL QUIZ

1. If you notice your hands are visibly soiled, what should you do?
   - **a.** Find the nearest alcohol sanitation dispenser to clean your hands.
   - **b.** Wipe your hands on your volunteer smock.
   - **c.** Find the nearest sink and thoroughly wash your hands with soap and water.

2. Where do you find a patient's contact precautions?
   - **a.** On signage right under their room number.
   - **b.** Inside the patient's room on the whiteboard.
   - **c.** On signage taped to the patient's door.

3. If you have been asked to deliver something to a patient's room but have not been trained with appropriate infection precaution procedures, what should you do?
   - **a.** Go in anyway and give the items to the patient.
   - **b.** Go to the nurses's station and explain who the items are for and that you do not have training for their contact precaution.
   - **c.** Leave the items outside the patient's door.

4. How many seconds does proper hand-washing require?
   - **a.** 15 seconds
   - **b.** 5 seconds
   - **c.** 8 seconds

5. The influenza vaccination is offered each year through Associate Health, free of charge to volunteers, and if I'm under 18 I will need my parent's consent. **TRUE** **FALSE**

6. The **best** way to manage a cough is:
   - **a.** Cough into my hands then wash my hands.
   - **b.** Cough into my elbow then wash my hands.
   - **c.** Cough into my elbow while turning away from others and then wash my hands.

I understand that I am responsible for following infection prevention/control etiquette and best practices and should ask if I do not understand or need clarification.

Name (print): _____

Signature: _____ Date: _____

Volunteer Verification Checklist

The included packet contains all paperwork necessary to become an internal volunteer for Marshfield Clinic Health System. All paperwork needs to be completed and collected by Marshfield Clinic Health System before volunteers will be eligible to begin volunteering.

Please review and complete all forms and return to Volunteer Services

Please place a ✓ by each item below once completed:

- ___ Application
- ___ New Volunteer Assessment
- ___ Confidentiality Statement
- ___ Volunteer Acknowledgment Form
- ___ Photo Release Form
- ___ Background Information Disclosure
- ___ HIPAA Quiz

I realize it is my responsibility to contact Volunteer Services if I have any questions or if there is information I do not understand.

_____

Volunteer Signature

_____

Print Name

_____

Date