

HealthPartners Clinic Volunteer Application

Instructions:

1. Please print and complete all application materials:

- ✓ Volunteer Application
- ✓ MN DHS Background Study form
- ✓ Two (2) Volunteer Reference forms

2. **Two reference forms** are required as part of your overall volunteer application. These forms will need to be included with your application when submitted. Reference forms are not to be completed by family members. Some examples of appropriate references would be teachers, coaches, colleagues, school counselors, or former supervisors.

3. Mail all completed application materials and the 2 sealed reference forms to us in **one** envelope at:

**Regions Hospital Volunteer Services
640 Jackson Street
St. Paul, MN 55101
MS: 11502A**

4. Please allow two weeks for processing of your application. Incomplete applications will not be processed.

5. For questions, please contact the Volunteer Services Office at 651-254-5709.

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Personal Information:

Full Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Secondary Phone: _____

E-mail: _____ Birthday :(m/d)_____

Emergency Contact (name and phone):_____

Work Experience:

Current Employer: (if retired, please give name of previous employer)

_____ Position: _____ How Long? _____

Previous Employer:

_____ Position: _____ How Long? _____

Volunteer Experience:

Organization:

_____ Position: _____ How Long? _____

Organization:

_____ Position: _____ How Long? _____

Education:

Are you a student? Yes No Where? _____

Will your volunteer work be used to fulfill a school requirement? Yes No

If yes, how many hours are needed to fulfill the requirement? _____

Availability:

Please indicate days and times when available.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning (8am -12pm)							
Afternoon (12pm-4pm)							

Program Preference:

Please refer to our opportunities listing for a list of department placements. Please list your top three choices for placement. ***Some positions may be limited in availability.

Clinic Choice:

1. _____ 2. _____ 3. _____

Program Choice:

1. _____ 2. _____ 3. _____

I affirm that the information I have provided in this application form is true and correct to the best of my knowledge. **I understand that misrepresentation, omission or falsification of facts in connection with this information may be sufficient cause for cancellation of consideration for volunteer service or termination whenever discovered.**

Volunteers may work with legally vulnerable adults and/or children in their homes or in a clinic or hospital setting. The following questions are required to comply with Minnesota law. Your answers will be handled in a confidential manner.

<p>***Have you ever been convicted or been given a suspended sentence, placed on probation, or been imprisoned because of a misdemeanor or a felony?***</p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p style="text-align: center;"><i>(If yes, please explain and give dates)</i></p> <hr/>
<p>We are unable to offer positions to persons with misdemeanor or felony charges other than minor driving violations.</p>

I understand that as a condition of participation in this program, I will be required to comply with the following:

- Completion of a volunteer orientation provided by Regions Hospital Volunteer Services staff
- Completion of a Minnesota Criminal Background Study form
- Completion of a Mantoux test or other procedures confirming no instance of Tuberculosis *or* will supply proper documentation confirming no instance of Tuberculosis

Failure to cooperate or unsatisfactory results may result in withdrawal of an offer to participate in this volunteer program. As a condition of participation in this volunteer program, I hereby authorize Regions Hospital/HealthPartners Volunteer Services to conduct an inquiry into any service-related information contained in this application.

Signature of Applicant

Date

Parent/Guardian Signature (If under 18)

STATEMENT OF NONDISCRIMINATION: *In compliance with Federal, State, and local equal employment opportunity laws, qualified applicants are considered for all positions without regard to race, color, creed, religion, ancestry, sex, national origin, pregnancy, sexual orientation, age, physical handicap or disability, veteran status, marital status, or status with regard to public assistance.*

MINNESOTA DEPARTMENT OF HEALTH LICENSED FACILITIES

**SUPPLEMENTAL NURSING SERVICES AGENCIES, EDUCATIONAL PROGRAMS,
TEMPORARY EMPLOYMENT AGENCIES, PROFESSIONAL SERVICES AGENCIES**

BACKGROUND STUDY PRIVACY NOTICE

Because the Minnesota Department of Human Services is requesting that you provide private information about yourself, the Minnesota Government Data Practices Act requires that you be informed of the following:

1. Purpose and intended use of the information: Minnesota Statutes, section 144.057, requires the Minnesota Department of Human Services (DHS) to conduct background studies on individuals who have direct contact with patients and residents in hospitals, boarding care homes, outpatient surgical centers, nursing homes, home care agencies, residential care homes, board and lodging establishments registered to provide supportive or health supervision services, individuals employed by supplemental nursing services agencies, and controlling persons of a supplemental nursing services agency; and all other employees in nursing homes. The background studies are to be completed according to the requirements in Minnesota Statutes, chapter 245C. The information requested will be used to perform a background study of you that will include at least a review of criminal conviction records held by the Minnesota Bureau of Criminal Apprehension and records of substantiated maltreatment of vulnerable adults and children. DHS may also later require you to submit additional information and/or your fingerprints if necessary to complete your background study. For all individuals who are subject to background studies by DHS, the corrections system will report new criminal convictions for disqualifying crimes to DHS. County agencies and the Minnesota Department of Health report substantiated findings of maltreatment of minors and vulnerable adults to DHS.

2. Whether you may refuse or are legally required to provide the information: Minnesota Statutes, chapter 245C, states that the individual who is the subject of a study must provide sufficient information to ensure an accurate background study.

3. Known consequences that may arise from supplying the information: Individuals who have histories with the characteristics identified in Minnesota Statutes, chapter 245C, will be disqualified from positions allowing direct contact with (and, where applicable, access to) persons receiving services. Health-related licensing boards will make a determination whether to impose disciplinary or corrective action on individuals regulated by health-related licensing boards who have been determined to be responsible for substantiated maltreatment. Individuals who do not have disqualifying characteristics will not be disqualified.

4. Known consequences that will arise from refusing to supply the requested information: Only items identified as “optional” may be left blank. Refusal to provide the information necessary to ensure an accurate and complete background study will result in your disqualification and an order to the agency or facility to remove you from any position allowing direct contact with (and, where applicable, access to) persons receiving services.

5. Identification of other agencies or entities authorized to receive this information: The information you provide will be shared with the Minnesota Bureau of Criminal Apprehension. If DHS has reasonable cause to believe that other agencies may have information pertinent to a disqualification, the information may also be shared with county attorneys, county sheriffs, courts, county agencies, local police, the Federal Bureau of Investigation, the Office of the Attorney General, agencies with criminal record information systems in other states, and juvenile courts. Background study results may be shared with the Minnesota Department of Health, the Minnesota Department of Corrections, the Office of the Attorney General, non-licensed personal care provider organizations, and health-related licensing boards. If you have a disqualifying characteristic, the facility will be told only that you are disqualified and will not be told what caused your disqualification, unless you were disqualified for refusing to cooperate with the background study or for serious and/or recurring maltreatment of a minor or vulnerable adult. The information about you received as part of a background study is classified as private data and, except for the agencies noted, cannot be shared without your consent.

NETStudy - Online Background Study

Instructions: *Please collect this information at the time the new employee accepts their employment offer.*

Facility ID 00527

PRIVACY NOTICE: One of the contingencies of this position is to successfully pass a background study. Your privacy rights are outlined in a separate notice which will be given to you as part of your new hire paperwork.

OPTIONAL: Items marked with an asterisk (*) are optional. All other information is required.

IMPORTANT: PLEASE PRINT!

First Name _____ **Middle Name** _____ **Last Name** _____

Birthdate ____ / ____ / ____ **Gender:** Male Female

MN Drivers License / MN State ID (MN ONLY) _____

Address _____

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

Other first names you have used (please print) _____

Other last names you have used (please print) _____

Volunteer Reference Form

TO THE APPLICANT:

This form should be given to someone who knows you well and to whom you are not related (i.e. a teacher, employer, etc.) Your reference should complete the form and return it to you directly to include with your application or they may fax or mail it to Regions Hospital Volunteer Services.

Applicant's Name: _____

TO THE REFERENCE:

The person named above is applying to participate in the Regions Hospital Volunteer Program. If selected, this person will potentially be working closely with vulnerable adults and children. We ask that you provide an honest opinion of how well you think this applicant is suited to volunteering in a hospital environment. We thank you for your time. If you have any questions or concerns, please feel free to contact the Regions Hospital Volunteer Services Office at 651-254-5709.

Please tell us how long you have known the applicant and in what capacity.

Please describe the applicant's ability to work with different age groups, people with disabilities, and people of diverse cultures.

Please describe characteristics that this applicant possesses that make them a good candidate for volunteering. Please consider maturity, communication skills, motivation, and reliability.

Would you recommend this person as a potential volunteer? Why or why not?

Signature of Reference: _____ Phone Number: _____

Printed Name of Reference: _____

Completed forms need to be returned to the applicant for submission to the Regions Hospital Volunteer Services Office.

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