CRMC
CUYUNA REGIONAL MEDICAL CENTER
Dedicated to You. Every Day.

Volunteer Application

Name: _____

Primary Address: _____

City, State, Zip: _____

How long at this address?_____

Previous Address:_____

In what other states have you lived?_____

E-mailAddress:_____

Birthdate: _____ Telephone Number: _____

Special training or skills you have that would assist us in your placement:

_____

_____

Previous volunteer or work experience: _____

_____

_____

Area of interest: _____

Days of service preferred:_____

Hours preferred: _____

Volunteer Application Page Two

References:

Name: _____ Address:_____

City, State, Zip: _____ Telephone number: _____

Name: _____ Address:_____

City, State, Zip: _____ Telephone number: _____

Name: _____ Address:_____

City, State, Zip: _____ Telephone number: _____

In the event of an emergency, please contact:

Name:_____
Telephone Number:_____
Relationship:_____

Name:_____
Telephone Number:_____
Relationship:_____

Final decisions on volunteer placement are based on ability of volunteer to perform the duty, interest of volunteer in volunteering in that capacity, and scheduling.

By signing this application:

- I give permission for the Volunteer Department of CRMC to contact my references and conduct a criminal check.
- I verify that I have never been convicted of a felony.
- I verify that the information on this application is true.

_____ _____

Signature: Date:

Minnesota Department of Health Licensed Facilities
Supplemental Nursing Services Agencies, Education 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, 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 the 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, accessible 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, can not be shared without your consent.

Background Study

Applicant Name: _____
Full name (including full middle name)

Date of Birth: _____ **Gender:** Male Female

MN DL#/State ID #: _____

Race: African American Hispanic White
(Please Circle) Asian Indian (American)
Other _____

Social Security #: _____

Phone Number: _____

Address: _____

City: _____ **State:** _____

Zip Code: _____

Alias: **(Ex: Maiden Names, Nick Names, Previous Married Names, etc):**

First Name (s): _____

Last Name (s): _____

I have read and understand the Minnesota Department of Health Regulated Facilities BACKGROUND STUDY PRIVACY NOTICE.
I understand that if the Department of Human Services disqualifies me, I will not be able to be employed for Cuyuna Regional Medical Center.

Signature: _____

Today's Date: _____

Human Resources Office Use Only

Date BSF Completed Online: _____