Thank you for your interest in Regina Hospital’s Youth Volunteer Program. Volunteering is a good way to make new friends and experience the personal gratification of having served your community.

Here is the process of getting ready to share your time and energy with us.

- **Enrollment** – Please call the volunteer office to schedule an interview after you have completed the attached enrollment paperwork. I hope that we can offer you an area of service that is compatible with your interests and availability. Regina Hospital is required to perform a background check, so be prepared to provide your MN or WI Driver’s license number (if you have one) and Social Security number.
  - A parent or guardian must complete the consent section.
  - The recommendation section needs to be completed by a school counselor, teacher, coach, youth group leader or other adult non-family member who has worked with you in a supervisory capacity.

- **Health** – Prospective volunteers must verify immunity to measles, mumps, rubella, chicken pox, and tuberculosis. When we meet, we will provide you with contact information for Infection Control. If your immunization record is unavailable, our infection control practitioner may arrange for a free test at an Allina Health laboratory to verify your immunity.

- **General Orientation** – We will schedule a time for you to attend a general orientation session to learn what you need to know about Regina Hospital before you get started.

I look forward to meeting with you and pursuing your interest in volunteering at Regina Hospital – Part of Allina Health. Please feel free to contact me if you have any questions.

Sincerely,

**Maria Reis**
Volunteer Services Coordinator
651.404.1104
Email: maria.reis@allina.com
YOUTH VOLUNTEER SERVICES ENROLLMENT FORM (Age 13-17)

Name ___________________________ Birth date ______________________
Address __________________ City __________________ State ______ Zip_____
Phone 1 _________________________ Phone 2 _________________________
Email address: _______________________________________________________

GENERAL INFORMATION
School presently attending _______________________________________________
Grade ___________________ Graduation year ____________________________
Are you performing this volunteer service because it is required? YES NO (circle one)
If YES: 1) Reason hours are needed ______________________________________
        2) Number of hours required ______________________________________
        3) Completion deadline ___________________________________________
How would you arrange transportation? _____________________________________
When are you available ___________________________________________________

AREA(S) OF INTEREST
Please indicate general area(s) that may interest you, keeping in mind that your choices may change as you
discover more about us.
_____ Patient experience cart (age 13-17) – pass out items (cards/crossword puzzles, Sudoku) to patients in
the Medical Surgical department
_____ Hospital unit helper (age 14-17) prepares ice pitchers and delivers to patients, runs errands, assists
with desk duties, restocks fridge
_____ Escort (age 14-17) assists in registration area (no Saturday or Sunday)
_____ Garden and Labyrinth assistant
_____ Other ________________________________ _____________________________

SIGNATURES
The information provided in this enrollment form is true. I understand that if this information is false in any way, I will be
dismissed without notice regardless of when the false information is discovered. I realize that if accepted as a volunteer, I
must abide by the rules, regulations and expectations of the Volunteer Department and Regina Hospital.

Youth signature ___________________________ Date _______________________
Parent/Guardian signature ___________________________ Date ___________________

Return application to: Regina Volunteer Services
Attn: Maria Reis
1175 Nininger Road
Hastings, MN 55033

Questions? Call Volunteer Services at 651.404.1104
YOUTH VOLUNTEER PARENTAL CONSENT FORM

In order for your child to become a volunteer with us, we need your consent and your involvement in helping them have a productive experience. Please read and sign this parental consent form if you would like us to consider your child as a possible volunteer. Feel free to call Volunteer Services at 651.404.1132 if you have any questions, would like further information, or would like to discuss this with someone.

- Your child will receive orientation and training which is necessary for the safe and responsible performance of the duties he or she will be asked to perform.
- Your child will be expected to meet all the requirements of the position, including regular attendance and adherence to policies and procedures.

VERIFICATION OF IMMUNITY

Medical staff personnel will verify immunity to the following diseases: measles, mumps, rubella, chicken pox, and tuberculosis. If your child’s immunization record is unavailable, our medical staff will provide a free test at Allina Health’s laboratory to verify immunity. Parental consent will be required for vaccination only.

IN CASE OF INJURY

If your child is injured while performing volunteer services, it is Regina’s policy to provide immediate first-aid treatment at the expense of the hospital. Your own insurance company shall be the primary carrier in the case of an injury that requires further treatment.

- I give permission for immediate emergency medical treatment. Notify emergency contact person listed below as soon as possible.
- I DO NOT give permission for emergency medical treatment until I have been contacted.

IN AN EMERGENCY PLEASE NOTIFY

| Name ____________________________ | Relationship ____________________________ |
| Address __________________________ | City __________________________ State _____ Zip _______ |
| Phone 1: ______________________ | Phone 2: ____________________ | Phone 3: ____________________ |

I understand that my child wishes to be considered for volunteer work and if accepted by Regina Hospital, I hereby give my consent for them to serve in that capacity. I understand that my child will not receive monetary compensation for the services contributed.

_______________________________ _______________________
Parent/Guardian signature Date

Questions?
Call Volunteer Services at 651.404.1104
YOUTH VOLUNTEER RECOMMENDATION FORM

Youth who wish to volunteer at Regina Hospital are required to submit a personal recommendation from a school counselor, teacher, coach, youth group leader or other adult non-family member who has worked with him or her in a supervisory capacity.

___________________________________________ is interested in volunteering at Regina Hospital.

Volunteer candidate name

Name of person providing this recommendation ______________________________________________

Please print name

How long have you known this youth? ______________________________________________________

What is your relationship? __________________________________________________________________

What three words would you use to describe this youth?

1 __________________________ 2 ___________________________ 3 ______________________

Describe how this youth gets along with people in general ____________________________________

________________________________________________________________________________

________________________________________________________________________________

Your recommendation _________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Signature ____________________________________ Date _________________________________

Phone ___________________________ Best time to reach you ______________________________

Return form to:
Regina Volunteer Services
Attn: Maria Reis
1175 Nininger Road
Hastings, MN 55033

Questions?
Call Volunteer Services at 651.404.1104
Regina Hospital Background Check
Volunteer Pre-Service Questionnaire

The background check process is used to help Regina Hospital provide a safe and secure environment for children, youth, young adults and vulnerable adults who use our facilities. Please fill in the blanks for all items. **Items with an asterisk* are voluntary.** Refusal to provide the information necessary to ensure an accurate and complete background study will result in your disqualification and negate any present or future volunteer possibilities with Regina Hospital.

**PLEASE PRINT LEGIBLY**

Legal Name: ________________________________________________________________

First                      Middle                      Last

Date of Birth: ________________ Gender: Male  Female

MN Driver’s License/MN State ID (if any) Number: __________________________________

*Race: _____________________ *Social Security Number ____________________________   *Phone ______________

Please list current address of residence and previous addresses within the past seven years:

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<tr>
<th>Current Home Address</th>
<th>Apt.</th>
<th>City</th>
<th>County</th>
<th>State</th>
<th>Zip Code</th>
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Have you used any other names in the past seven years? Yes   No

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<th>Dates Used</th>
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Have you ever been convicted of, or pled guilty or pled nolo contendere to a felony or misdemeanor? Yes   No

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*If additional space is required, please continue on the other side of this page.*

**Release Statement**

I, ____________________________________________, authorize Regina Hospital to submit this information to the MN Department of Human Services. I understand that being enrolled as a volunteer with Regina Hospital is contingent on the results of this investigation and that this release is valid for the duration of my service. I have received the Background Study Privacy Notice.

___________________________________________________________________________

Signature                      Date
[This page intentionally left blank.]
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.

6a. If CURRENT background study results in a disqualification that is set aside upon reconsideration: If you are disqualified as a result your background study, and you request reconsideration and your disqualification is set aside for the program/agency that initiated the current background study, subsequent background studies initiated by other programs/agencies may result in the disqualification being set aside for other programs/agencies when the following criteria are met:
1. While you are disqualified, you are not disqualified for an offense specified in section 245C.15, subdivision 1 or 2;
2. the program that initiates the subsequent background study is licensed or regulated under the same provisions of law and rule as the program for which your disqualification was previously set aside;
3. the commissioner has not received any new information to indicate that you may pose a risk of harm to any person served by the program; and
4. the previous set aside was not limited to a specific person(s) receiving services.

If the above criteria are met, the notice of disqualification sent to the program/agency that initiates the subsequent background study will state that you are disqualified and will include the reason you are disqualified. It will also state that your disqualification has been set aside for their program/agency, and that upon request, and without your consent, information about the factors that were the basis for the decision to set aside your disqualification are available to them. (§245C.22, subd. 5)

6b. If a PREVIOUS background study resulted in disqualification that was set aside: If you were the subject of a previous background study which resulted in your disqualification, and your disqualification was set aside upon reconsideration, DHS will review the information in your record in connection with your current background study and determine whether the following criteria are met:

1. While you are disqualified, you are not disqualified for an offense specified in section 245C.15, subdivision 1 or 2;
2. the program that initiated the current background study is licensed or regulated under the same provisions of law and rule as the program for which your disqualification was previously set aside;
3. the commissioner has not received any new information to indicate that you may pose a risk of harm to any person served by the program; and
4. the previous set aside was not limited to a specific person(s) receiving services.

If the above criteria are met, the notice of disqualification sent to the program/agency that initiated the current background study will state that you are disqualified and will include the reason you are disqualified. It will also state that your disqualification has been set aside for their program/agency, and that upon request, and without your consent, information about the factors that were the basis for the decision to set aside your disqualification are available to them. (§245C.22, subd. 5)