Return completed packet along with $20.00 check payable to WCTC:

Waukesha County Technical College
Attn: Health Offices, H101/H102
800 Main St
Pewaukee, WI 53072

WAUKESHA COUNTY TECHNICAL COLLEGE
School of Health
Release of Information

I authorize the School of Health at Waukesha County Technical College to release information to practicum sites as required per contracts:

- Waukesha County Technical College’s Personal History Health Forms;
- Background Information Disclosure Form, and/or
- Information received through the any of the following:
  - Department of Justice (DOJ) Identification Record Request
  - Department of Health Services (DHS) Caregiver Findings
  - Office of the Inspector General (OIG) Exclusions Screening
  - General Service Administration (GSA) Screening

I understand that historical findings from the above agencies may adversely affect my ability to proceed in my program area, find clinical placement or job placement upon graduation. I also understand that forgery or incorrect information in any documentation listed above is grounds for immediate dismissal from the program.

Name of Student (print)  ID Number

Signature of Student  Date

Program Area  Phone Number

Equal Opportunity Affirmative Action Employer/Educator  www.wctc.edu
For WCTC information, 262.691.5566
FUNCTIONAL ABILITY CRITERIA

Statement of Understanding

The Americans with Disabilities Act (ADA) of 1990 (42 U.S.C & 12101. et seq.), the ADA Amendment Act of 2008, and Section 504 of the Rehabilitation Act of 1973 (29 U.S.C & 794) prohibits discrimination of persons because of her or his disability. In keeping with these laws, Colleges of the Wisconsin Technical College System make every effort to ensure a quality education for students. The purpose of this document is to ensure that students acknowledge that they have been provided information on the functional abilities required of a student in a School of Health Program.

This form is to be completed upon admission to a School of Health Program and at the time of Clinical Placement/Petition.

___ I have read and understand the Functional Ability Criteria specific to a student in a School of Health Program.
(initial)

___ I am able to meet the Functional Abilities Criteria as presented with or without accommodation.
(initial)

___ I was provided with information concerning accommodations or special service if needed at this time.
(initial)

Name of Student (print) ___________________________ ID Number ___________________________

Signature of Student ___________________________ Date ___________________________

______ v12.12

Equal Opportunity Affirmative Action Employer/Educator www.wctc.edu
For WCTC information, 262.691.5566
BACKGROUND INFORMATION DISCLOSURE (BID)

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 YOUR ANSWERS.

Check the box that applies to you.

☐ Employee / Contractor (including new applicant)  ☐ Household member / lives on premises - but not a client
☐ Applicant for a license or certification or registration (including continuation or renewal)  ☐ Other – Specify:

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.

<table>
<thead>
<tr>
<th>Name – (First and Middle)</th>
<th>Name – (Last)</th>
<th>Position Title (Complete only if you are a prospective employee or contractor, or a current employee or contractor.)</th>
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Any Other Names By Which You Have Been Known (Including Maiden Name)  Birth Date  Gender (M / F)

Race

☐ American Indian or Alaskan Native  ☐ Black  ☐ Unknown
☐ Asian or Pacific Islander  ☐ White

Social Security Number(s)

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

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 judgement of conviction, a copy of the criminal complaint, or any other relevant court or police documents.
   YES ☐ NO ☐

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.
   YES ☐ NO ☐

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.
   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 ☐

(continued on next page)
**SECTION A (continued)**

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.
   - 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.
   - YES □ NO □

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.
   - YES □ NO □

**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?
   - If Yes, explain, including when and where it happened.
   - YES □ NO □

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.
   - YES □ NO □

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.
   - YES □ NO □

4. Have you resided outside of Wisconsin in the last 3 years?
   - If Yes, list each state and the dates you lived there.
   - YES □ NO □

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.
   - YES □ NO □

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.
   - YES □ NO □

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.

**PRINT NAME** – Required Individual  
**Date Submitted**
Conditions of Criminal Background Check

Wisconsin Caregiver Law, §§ 48.685 and 50.065, Wis. Stats (as amended).
Waukesha County Technical College, School of Health

STATUTORY RESTRICTIONS: I understand that the Wisconsin Caregiver Law bars individuals with certain types and recency of criminal convictions and other misconduct from placement in certain field or clinical sites. The Waukesha County Technical College (WCTC) program(s) for which I have applied require at least one clinical / practicum placement assignment subject to the Wisconsin Caregiver Law.

DOCUMENTATION: I agree to obtain any additional documentation necessary to complete my background check as required by clinical / practicum placement sites or the WCTC School of Health Office.

DISCLOSURE: I understand that the Wisconsin Caregiver Law requires that I inform WCTC of any new charges or convictions that occur after I have signed this document and completed the State of Wisconsin “Background Information Disclosure” form (HFS-64).

ADDITIONAL RESTRICTIONS:
1. I also understand that the clinical / practicum placement sites that are affiliated with my program(s) at WCTC may have policies that can result in additional restrictions relating to criminal or misconduct backgrounds that exceed those required by the Wisconsin Caregiver Law. By contract, WCTC complies with these additional restrictions imposed by clinical or field sites.
2. I understand that if I have a criminal or misconduct background, there is a possibility that one or more of WCTC’s clinical / practicum sites may deny me placement in their facility. If this occurs and despite due diligence WCTC cannot locate another site willing to accept me, I understand that I may not be able to complete my program nor graduate from that program.
3. I will at all times conduct myself in a professional manner consistent with the standards governing my chosen profession and in accordance with WCTC Student Handbook. Examples of inappropriate conduct include direct communication with clinical facilities to inquire regarding clinical placement processes, decisions or placement denials; attempts to make direct arrangements with clinical facilities for clinical placement.

WCTC LIMITATIONS: If I have a criminal or misconduct background, and I decide to continue to pursue a degree / diploma in a program requiring a background check; and later find that I am unable to complete my WCTC program due to inability to complete clinical / practicum placements because of my criminal or misconduct background, I understand that WCTC will not reimburse me for course fees, the cost of books, supplies, or other costs related to my enrollment.

__________________________________________
Name of Student (print)  _______________________
ID Number

__________________________________________
Signature of Student  _______________________
Date

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