U.S. Department of Veterans Affairs

OMB Number 2900-0090
Estimated Average: 15 min.

APPLICATION FOR VOLUNTARY SERVICE

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 15 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form. The form is used to assist personnel of both voluntary organizations, which recruit volunteers from their membership, and the VA in the selection, screening and placement of volunteers in the nationwide VA Voluntary Service program. The volunteer program supplements the medical care and treatment of Veteran patients in all VA facilities.

PRIVACY ACT INFORMATION: The information requested on this form is solicited under the authority of 38 U.S.C. 7405(a)(1)(D) and will be used in the selection and placement of potential volunteers in the VA Voluntary Service Program. The information you supply may be disclosed outside VA as permitted by law; possible disclosures include those described in the 'routine uses' identified in the VA system of records 57VA135 Voluntary Service Records-VA, published in the Federal Register in accordance with the Privacy Act of 1974. The routine uses include disclosures: in response to court subpoenas, to report apparent law violations to other Federal, State or local agencies charged with law enforcement responsibilities, to service organizations, employers and Unemployment Compensation Offices to confirm volunteer service, and to congressional offices at the request of the volunteer. Disclosure of the information is voluntary, however, failure to furnish the information will hamper our ability to arrange the most satisfactory assignment for you and the Department of Veterans Affairs.

NAME (Last, First, Middle Initial)

ADDRESS (Street, City, State and Zip Code)

DATE

TELEPHONE NUMBER

E-MAIL ADDRESS

DATE OF BIRTH

SEX ☐ M ☐ F

ORGANIZATION MEMBERSHIP(S) (Unit, Post, Chapter, if Affiliated)

ASSIGNMENT PREFERENCES

1.

2.

3.

EXPERIENCE AND TRAINING (Special Skills/Abilities)

RESTRICTIONS, LIMITATIONS OF SERVICE (Health Concerns, Medications, Allergies, etc.)

AVAILABILITY (Days and Times)

IN CASE OF EMERGENCY, PLEASE CONTACT (Name, Relationship, Phone Number)

Monetary Waiver: I hereby waive all claims to monetary benefits for services rendered as a volunteer worker on a "without compensation basis" for an indefinite period. I understand that this waiver applies only to remuneration (compensation) for specific services rendered in the VA Voluntary Service (VAVS) Program and is not related to any other VA services or benefits to which I may be entitled. (**NOTE:** VA has entered into this agreement by the authority of 38 U.S.C. 7405(a)(1)(D). This agreement may be canceled by either party upon written notice.) I hereby accept the volunteer appointment(s) as outlined above.

Volunteer Signature

Date

I hereby appoint this applicant as a VA without-compensation employee subject to the provisions on this application. The above individual has been provided basic and assignment specific orientations which have been documented in the official volunteer folder located in the VA Voluntary Service Office.

VAVS Program Manager - Appointing Official Signature

Date

OFFICE USE ONLY

1. SUPERVISOR

2. SUPERVISOR PHONE NUMBER

3. ORIENTATIONS

4. UNIFORM

COMMENTS

NAME AND TITLE OF REVIEWER

DATE

NOTE TO STUDENTS AND PARENTS: The VA medical center is a federal building, and, as such, must be open to the public. Our employees, patients, and volunteers come from diverse backgrounds. Eligible Veterans are entitled to services offered by VA, even if they have had problematic incidents in their past - unless the law specifically disqualifies them. Our job is to provide care to Veterans and to protect our employees, patients, and volunteers as that care is provided.

STUDENT VOLUNTEER: If accepted, I agree to adhere to the policies and procedures of this VA healthcare facility and to respect the confidentiality of information pertaining to the patients and their treatment. If a patient, staff member, volunteer, and/or visitor is abusive, makes inappropriate gestures, advances, or conversation, that is in a manner which makes me feel uncomfortable, I will immediately inform my supervisor or a VAVS staff member.

Signature____

Date __________________

PARENT/GUARDIAN: The above named student has my consent as parent/guardian to serve as a Student Volunteer in this VA healthcare system. I have read the above agreement as signed by my student and understand their obligation to the program if they are accepted into the VAVS Student Volunteer Program. I also grant permission for my child to receive emergency medical treatment if injured while volunteering.

Signature____

Date ___________________

NOTE: Completion of this application does not guarantee acceptance into this program.

SON:1230/ SOI:VA99

FINGERPRINT RECORD PREP

SHEET

Assignment over 120 days	
Yes	No

PLEASE PRINT CLEARLY

Providing Direct Patient Services	
Yes	No

NAME (LAST, FIRST MIDDLE)	
SS#	
DOB Yr/Month/Date	
ALIAS (MAIDEN NAME, etc)	
SEX	
RACE	
EYE COLOR	
HAIR COLOR	
HEIGHT	
WEIGHT	
PLACE OF BIRTH (CITY/STATE/COUNTRY)	
COUNTRY OF CITIZENSHIP	
DEPARTMENT	
POSITION	
ADDRESS Full address and Phone Number	

DATE PRINTED: ____

PRINTED BY: ____

SERVICE: ____

I understand that two of the following documents showing proof of citizenship or alien registration must be presented at the time of in-processing or I will not be able to in-process until these forms can be presented: Drivers License or U.S. Military I.D., and Social Security Card or Birth Certificate or other acceptable documents.

Candidate signature ________________________ E-mail address ________________________

Volunteer Contact Information

EMPLOYEE FULL NAME: (LAST, FIRST, MIDDLE) ____

FULL SSN: ________________________________DOB: __________________________________

HOME ADDRESS: ____

CITY: ____________________________STATE: ___________________________ZIP: ____________

HOME PHONE: (___)______________________ CELL PHONE: (___)___________________________

SEX (CIRCLE ONE): MALE FEMALE RELIGIOUS PREFERENCE: ___________________________

MARITAL STATUS (CIRCLE ONE): NEVER MARRIED, SEPARATED, MARRIED, DIVORCED, WIDOWED

PLACE OF BIRTH: (CITY AND STATE) ____

ETHNICITY: (CHECK ONE) __________SPANISH, HISPANIC OR LATINO __________ NOT SPANISH, HISPANIC OR LATINO

RACE: (CHECK ONE OR MORE) _____AMERICAN INDIAN OR ALASKA NATIVE, ____ASIAN, ____BLACK OR AFRICAN AMERICAN,

____WHITE, ____NATIVE HAWAIIAN OR ANOTHER PACIFIC ISLANDER

MOTHER'S NAME: (LAST, FIRST) ____

FATHER'S NAME: (LAST, FIRST) ____

MOTHER'S MAIDEN NAME: ____

EMERGENCY CONTACT

NAME: (LAST, FIRST)____

RELATIONSHIP:____

ADDRESS:____

CITY:______________________STATE:___________________ZIP CODE__________

TELEPHONE NUMBER:____