



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

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

ASSIGNMENT PREFERENCES

1. 2. 3.

SEX M F

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.

FOR VOLUNTEER DRIVER FITNESS DETERMINATION

1. DRIVER'S INFORMATION: Driver completes this section

Driver's Name _____ Social Security _____

Birth Date _____ Age _____ Sex _____

Address City, State, Zip Code _____ Telephone _____

2. HEALTH HISTORY: Driver completes this section

Yes No

- ____ Any illness or injury in the last 5 years?
- ____ Have you seen a doctor since your last exam?
- ____ Head/Brain injuries, disorders or illnesses
- ____ Seizures, epilepsy Medication _____
- ____ Eye disorders or impaired vision (MUST BE CORRECTED TO 20/40)
- ____ Heart disease or heart attack, other cardiovascular conditions
Medication _____
- ____ High or low blood pressure? Medication _____
- ____ Muscular disease
- ____ Shortness of breath
- ____ Lung disease, emphysema, asthma chronic bronchitis
- ____ Kidney disease, dialysis
- ____ Diabetes or elevated blood sugar controlled by:
Diet
Pills
Insulin
- ____ Nervous or mental trouble, (e.g., severe depression or PTSD)
Medication _____
- ____ Loss of consciousness (passed out) or altered consciousness
- ____ Fainting or dizziness
- ____ Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring
- ____ Do you use a CPAP or similar device for sleep apnea?
- ____ Stroke or paralysis
- ____ Missing or impaired hand, arm foot, leg, finger, toe
- ____ Spinal injury or disease
- ____ Regular or frequent alcohol use
Describe current alcohol use _____
- ____ Narcotic or habit forming drug use

For any YES answer, indicate onset date, diagnosis, treating physician's name & address, & any current limitations. List all medications that you currently take or have been prescribed for you (including over-the-counter medications, herbals, etc.)

I certify that the above information is complete & true. I understand that inaccurate, false or missing information may invalidate the examination & my Medical Examiner's Certificate.

Driver's Signature _____ Date _____

Medical Examiner's Comments on Health History (The medical examiner must review & discuss with the driver and "yes" answers & potential hazards of medication, including over-the counter medication, while driving. This discussion must be documented below.)



Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA10P2 "Patient Medical Record - VA" and in accordance with the Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. 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 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility) 	PATIENT NAME (Last, First, Middle Initial)
	SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

- DRUG ABUSE ALCOHOLISM OR ALCOHOL ABUSE TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

- COPY OF HOSPITAL SUMMARY COPY OF OUTPATIENT TREATMENT NOTE(S) OTHER (Specify)

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE (mm/dd/yyyy)	SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)
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FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)	TYPE AND EXTENT OF MATERIAL RELEASED	
	DATE RELEASED	RELEASED BY

SUPPLEMENTAL VOLUNTEER APPLICATION FORM

Voluntary Service will enter your name in the Office of Inspector General program to see if your name appears on a list. Any name appearing on the list is excluded from federal volunteer work.

Any investigation of your driving record will be performed by the Department of Veterans Affairs.

Guidelines:

1. More than 1 moving violation within the past 12 months.
2. Any DUI's within the past 5 years.
3. More than 3 speeding violations within the past 5 years.

If any of these items appear on the report, your application will not be considered.

Fingerprinting will be performed by VA Security as part of Homeland Security. Any finding can be cause for your application to be denied. Any criminal record history, i.e. arrest, conviction, time served, possession of illegal drugs, etc. will be part of this report.

I volunteer the following information regarding my driving record and any arrests, felonies, or criminal record I have.

I understand and agree to these investigations.

Signature: _____ Date: _____

Staff Signature: _____

Information required for identification badge

NAME: _____
 First Full Middle Last

PLACE OF BIRTH: _____
 City/Town State

DATE OF BIRTH: _____

SOCIAL SECURITY #: _____

As indicated on your driver's license:

Height _____

Color of hair _____

Weight _____

Color of eyes _____

PHOTO of ID seen:

Date _____