



Department of Veterans Affairs

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. 513 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 57VA125 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	Email Address (Optional)	[]	Date of Birth
[]	[]		[]
ORGANIZATION MEMBERSHIP(S) Unit, Post, Chapter, if affiliated)		ASSIGNMENT PREFERENCES	
[]		1. []	2. []
		3. []	SEX <input type="checkbox"/> M <input type="checkbox"/> 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., Section 513. This agreement may be canceled by either party upon written notice.) I hereby accept the volunteer appointment(s) as outlined above.

[]	[]
Volunteer's 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 veterans care 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.



FINGERPRINT RECORD PREP SHEET

PLEASE PRINT CLEARLY

MANAGER

START DATE: (mm/dd/yy): TBD

POSITION (check all that apply)

Is this a paid position? Yes No

Employee Fee Basis Contractor Resident

Volunteer WOC Trainee

JOB TITLE: VOLUNTEER

Is this Appointment expected to last? Less than 6 months More than 6 months

Will this employee be assigned computer access? Yes No

DUTY LOCATION: Buffalo Batavia Dunkirk Jamestown Lackawanna
 Niagara Falls Lockport Olean Warsaw

CARE LINE / DEPARTMENT

Service Line _____ MVAC BVAC D&T GEC Research

Other _____ Department Contact: _____ Contact Phone: _____

APPLICANT

FULL NAME: _____ *Please print legibly!
(Last, First, Middle Name)

ALIASES (Maiden Name): _____

DAYTIME PHONE NUMBER: _____

SOCIAL SECURITY #: _____
**Full SSN Required or write "NONE" - DO NOT LEAVE BLANK!*

DATE OF BIRTH (dd/mm/yy): _____

CURRENT RESIDENCE: _____
(Complete Street Address)

(City, State, Zip)

COUNTRY OF CITIZENSHIP: _____

PLACE OF BIRTH: _____
(City and State) (If outside the USA, State and Country)

GENDER: Male Female

RACE: Black Native American Caucasian Hispanic Asian Other

COLOR OF EYES: _____ COLOR OF HAIR: _____

HEIGHT (FT/IN): _____ WEIGHT (LBS): _____

COMPLETED BY: _____ DATE: _____ *HR Rep MUST SIGN!!

Type of Background check required SAC NACI MBI

SEE REVERSE

IR

FOR VA POLICE USE ONLY

**** NOTE TO POLICE: THIS FORM MUST BE SIGNED BY A MEMBER OF HR DEPARTMENT BEFORE ANY FINGERPRINTS ARE TAKEN. PLEASE FILL OUT YOUR PORTION OF THIS FORM COMPLETELY TO AVOID DELAY IN PROCESSING****

DATE FINGERPRINTS TAKEN: _____

DATE FINGERPRINTS SUBMITTED TO

OPM DATE _____ LITTLE ROCK DATE _____

TRANSMITTAL NUMBER: _____

TRANSMITTED BY: _____

**Print name!*

RETURN THIS FULLY COMPLETED FORM TO HUMAN RESOURCES

PRIVACY STATEMENT

Solicitation of this information is authorized by sections 1304 (Loyalty Investigations) and 3301 (Civil Service) of Title 5, U.S. Code; Executive Order 10450 (Security Requirements for Government Employment); or Public Law 82-298 (Authority for Conducting Certain Personnel Investigations). This information will be used to search the Federal Bureau of Investigation's fingerprint files in determining your fitness for Federal employment, Volunteering or a security clearance. It may also be used for searches of other law enforcement agencies maintaining fingerprint files for the same purpose.

Your Social Security Number (SSN) is being requested under the authority of Executive Order 9397 (November 22, 1943). This Order requires agencies to use the SSN for the sake of economy and orderly administration in the maintenance of personnel records. Furnishing any of the requested information is voluntary. However, failure to furnish this information may result in your not being considered for employment or for a clearance. A false answer to any question on this form is punishable by law (Title 18, U.S. Code, Section 1001).

Volunteer Yearly TB Test

Instructions: Please ensure that all highlighted items are completed. Once all items are completed please return this sheet to Voluntary Service.

FOR QUESTIONS PLEASE CONTACT: *Voluntary Service*

Applicant's Name: _____

Phone: _____

<u>Procedure/Department/ Location</u>	<u>Date Completed</u>	<u>Follow-Up Req'd?</u>	<u>If Follow-Up Required</u>
<u>Fingerprints</u> Human Resources Buffalo - 6th Floor, Room 614C1 Batavia (Wednesdays) – Bldg. 1 Room 116		Y/N	For further information please contact Human Resources at 716-862-3134 Hours: (Buffalo) 9 a.m.- 11 a.m. and 1 p.m.- 3 p.m.
<u>TB Test</u> (Employee Health) Buffalo - Room 516A (sign in with Ambulatory clerk) Batavia – Bldg 1, Ambulatory Care		Y/N	Please Contact: Employee Health for appointment Buffalo Extension: 716-862-6047 Batavia Extension: 585-297-1051
<u>Physical</u> DAV Drivers Only Employee Health Buffalo - Room 516A Batavia – Bldg 1, Ambulatory Care		Y/N	Please Contact: Employee Health for appointment Buffalo Extension: 716-862-6047 Batavia Extension: 585-297-1051

****Please return this form upon completion Voluntary Service , Thank you.****



Statement of Commitment and Understanding

As a volunteer of the Department of Veterans Affairs (VA), I am committed to safeguarding the personal information that veterans and their families have entrusted to the Department. I am also committed to safeguarding the personal information which VA employees and applicants have provided.

To ensure that I understand my obligations and responsibilities in handling the personal information of veterans and their families, I will read the Orientation Handbook, General Privacy Awareness Training (or VHA Privacy Training, as applicable) and the VA Cyber Security Training. I know that I should contact my Supervisor, local Privacy Officer, Freedom of Information Act Officer, Information Security Officer, or Regional or General Counsel Representative when I am unsure whether or how I may gather or create, maintain, use, disclose or dispose of information about veterans and their families, and the VA employees and applicants.

I further understand that if I fail to comply with applicable confidentiality statutes and regulations, I may be subject to civil and criminal penalties, including fines and imprisonment. I recognize that VA may also impose administrative sanctions, up to and including removal, for violation of applicable confidentiality and security statutes, regulations and policies.

I certify that I have completed the mandatory training outlined above and am committed to safeguarding personal information about veterans and their families, and VA employees and applicants.

(Print or type volunteer name)

Volunteer Signature

Date