



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	
[]		SEX <input type="checkbox"/> M <input type="checkbox"/> F	

1. []	2. []	3. []
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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.



REQUEST FOR PERSONAL IDENTITY VERIFICATION CARD

PRIVACY ACT STATEMENT: VA is authorized to ask for the information requested on this form by Homeland Security Presidential Directive (HSPD)-12, and 31 USC 7701. The information and biometrics collected, collected as part of the Federal identity-proofing program under HSPD-12 are used to verify the personal identity of VA applicants for employment, employees, contractors, and affiliates (such as students, WOC employees, and others) prior to issuing a Department identification credential. The credentials themselves are to be used to authenticate electronic access requests from VA employees, contractors, and affiliates issued a Department identification credential to gain access to VA facilities and networks (where available) through digital access control systems, as well as to other federal government agency facilities and systems where permitted by law. The information collected on this form is protected by the Privacy Act, 5 USC Section 552(a) and maintained under the authority of 38 USC Section 501 and 38 USC Sections 901-905 in VA system of records "Police and Security Records-VA (103VA07B)". VA may make a "routine use" disclosure of the information in this system of records for the routine uses listed in this system of records, including: civil or criminal law enforcement, constituent congressional communications initiated at your request, litigation or administrative proceedings in which the United States is a party or has an interest, the administration of VA programs, verification of identity and status, and personnel administration by Federal agencies. Failure to provide all of the requested information may result in VA being unable to process your request for a Personal Identity Verification Card, or denial of issuance of a Personal Identity Verification Card. If you do not have a Personal Identity Verification Card, you may not be granted access to VA facilities or networks, which could have an adverse impact on your application to become, or status as, a VA employee, contractor or affiliate where such access is required to perform your assigned duties or responsibilities.

PAPERWORK REDUCTION ACT NOTICE: The public reporting burden is approximately 5 minutes including time to review instruction, find the information, and complete this form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the VA Clearance Officer (005E3), 810 Vermont Avenue, Washington, DC 20420.

SECTION I - APPLICANT INFORMATION

APPLICANT INFORMATION (Completed by Applicant)

1. LEGAL NAME OF APPLICANT (Insert last, first, middle and suffix name)		2. NICKNAME TO BE USED FOR APPLICANT (Insert last name and first name, if applicable)	
3. DATE OF BIRTH (MM/DD/YYYY)	4. SOCIAL SECURITY NO.	5. HOME PHONE NUMBER (Include Area Code) (Optional)	
6. HOME E-MAIL ADDRESS (Optional)		7. HOME ADDRESS	
8. SIGNATURE OF APPLICANT			9. DATE SIGNED

SECTION II - SPONSOR VERIFICATION (Completed by Sponsor)

PART A - APPLICANT EMPLOYMENT INFORMATION (Completed by Sponsor)

1. NAME AND ADDRESS OF FACILITY OR ASSIGNED DUTY STATION		2. NAME OF SPONSORING DEPARTMENT, SERVICE, OR SECTION, AND MAIL ROUTING SYMBOL	
Central Texas Veterans HCS 1901 Veterans Memorial Drive Temple, TX 76504		Voluntary service	
3. CREDENTIALS/ORGANIZATIONAL TITLE (AKA Position/Job Title)		4. COST CTR.	
Volunteer		8405	
5. WORK PHONE NUMBER (If applicable)	6. WORK E-MAIL ADDRESS		
Unknown	Not Applicable		

PART B - TYPE OF REQUEST AND EMPLOYMENT STATUS (Completed by Sponsor)

1. TYPE OF REQUEST			
<input checked="" type="checkbox"/> NEW ID <input type="checkbox"/> RENEWAL <input type="checkbox"/> REPLACEMENT ID (Damaged/Lost) <input type="checkbox"/> CHANGE LEVEL OF ACCESS			
2. TYPE OF CARD		3. TYPE OF ACCESS	
<input type="checkbox"/> PERSONAL IDENTITY VERIFICATION (PIV) <input checked="" type="checkbox"/> VA (NON-PIV)		<input type="checkbox"/> LOGICAL ACCESS (Domain) <input type="checkbox"/> PHYSICAL ACCESS (Complete Part D)	
4. EMPLOYMENT STATUS			
<input type="checkbox"/> VA EMPLOYEE <input type="checkbox"/> CONTRACTOR <input type="checkbox"/> AFFILIATE (Specify) <input checked="" type="checkbox"/> TEMPORARY VA EMPLOYMENT			

PART C - PHYSICAL SECURITY ACCESS DATA (Completed by Sponsor)

1. SPECIAL SECURITY ACCESS REQUIRED	2. SPECIFY LOCATION OF SPECIAL SECURITY (i.e. tower, bldg. no., etc.)	3. IS APPLICANT A KEY EMERGENCY RESPONDER, CRITICAL EMPLOYEE, OR NEITHER?
<input type="checkbox"/> YES (If "YES," Specify in Item 2) <input checked="" type="checkbox"/> NO		<input type="checkbox"/> EMERGENCY RESPONDER <input type="checkbox"/> CRITICAL EMPLOYEE <input checked="" type="checkbox"/> NEITHER

PART D - TYPE OF BACKGROUND INVESTIGATION FOR POSITION (Completed by Sponsor)

TYPE OF BACKGROUND INVESTIGATION FOR POSITION	
<input type="checkbox"/> SAC <input checked="" type="checkbox"/> NACI <input type="checkbox"/> SECRET <input type="checkbox"/> TOP SECRET <input type="checkbox"/> OTHER (Specify)	

PART E - CONTRACTORS, AFFILIATES, AND TEMPORARY EMPLOYMENT INFORMATION (Completed by Sponsor)

1. EMPLOYMENT EXPIRATION DATE /CONTRACT END DATE (MM/DD/YYYY)(For Contractors, Affiliates, and Temporary Employment)		2. NAME OF FIRM OR COMPANY (If applicable)		
/				
3. NAME OF CONTRACTING OFFICER TECH. REPR. (If applicable)	4. NAME OF RESPONSIBLE VA ORGANIZATION		5. MAIL ROUTING SYM.	

PART F - SPONSOR AUTHORIZATION AND CERTIFICATION (Completed by Sponsor)

CERTIFICATION: I Certify under penalty of perjury that the information in Section II is true and correct.

1. NAME OF SPONSOR Michael H. Wittrock		2. SPONSOR CREDENTIALS/ORGANIZATIONAL TITLE Voluntary Service Specialist	
3. CERTIFICATE NUMBER (Issued by PCI Manager or Registrar)		4. SIGNATURE OF SPONSOR	5. DATE SIGNED (MM/DD/YYYY)
6. WORK ADDRESS Central Texas Veterans HCS 1901 Veterans Memorial Drive Temple, TX 76504		7. NAME OF SPONSOR'S DEPARTMENT, SERVICE, OR SECTION Voluntary Service	
		8. WORK PHONE NUMBER (Include Area Code) (254) 742-4635	
		9. WORK E-MAIL ADDRESS Michael.Wittrock@va.gov	

SECTION III - APPLICANT IDENTITY VERIFICATION (Completed by Registrar)

INSTRUCTIONS: To be completed and signed by Registrar at the time of proofing. Review Section I - Applicant Information, and Section II - Sponsor Verification, assuring that information has been filled out correctly and signed accordingly. The identification must follow these guidelines:

- Applicant must present two (2) forms of identification from the Accepted Identification Documentation List.
- The names on the identification must match exactly (If one ID has a full middle name, and the other has a middle initial, then the initial must match).
- One State or Federal ID must contain a photograph. • Both IDs must be original documents. • Both IDs must be currently valid, not expired.
- Verify that the applicant has background information on file. If no evidence of a SAC exists, then capture fingerprint data and process accordingly.

PART A - BACKGROUND CHECK

1. TYPE OF BACKGROUND CHECK

	SAC (Fingerprint Check)	NACI	OTHER (Specify)					
1A. DATE INITIATED BACKGROUND CHECK (MM/DD/YYYY)								
1B. DATE ADJUDICATED BACKGROUND CHECK (MM/DD/YYYY)								
2. FINGERPRINTS CAPTURE REQUIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "NO," proceed to Part B)	3. SEX	4. RACE	5. HEIGHT	6. WEIGHT	7. EYES	8. HAIR	9. PLACE OF BIRTH	

10. NOTICABLE SCARS AND TATTOOS

PART B - PHOTOGRAPHIC IDENTIFICATION NUMBER 1

1. EXACT NAME LISTED ON PHOTO ID	2. DOCUMENT IDENTIFICATION NUMBER	3. EXPIRATION DATE (MM/DD/YYYY)
4. DOCUMENT TYPE	5. ISSUANCE DATE (MM/DD/YYYY)	6. ISSUING AUTHORITY

PART C - IDENTIFICATION NUMBER 2

1. EXACT NAME LISTED ON ID	2. DOCUMENT IDENTIFICATION NUMBER	3. EXPIRATION DATE (MM/DD/YYYY)
4. DOCUMENT TYPE	5. ISSUANCE DATE (MM/DD/YYYY)	6. ISSUING AUTHORITY

PART D - REGISTRAR INFORMATION AND SIGNATURE

1. WORK ADDRESS	2. PRINTED NAME OF REGISTRAR	
	3. NAME OF DEPARTMENT, SERVICE, OR SECTION	
	4. WORK PHONE NUMBER (Include Area Code)	5. WORK E-MAIL ADDRESS
6. DATE APPLICANT INITIATED BACKGROUND INVESTIGATION	7. APPLICANT'S REQUEST FOR PERSONAL IDENTITY VERIFICATION CARD ACTION TAKEN: <input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED	

CERTIFICATION: I certify that under penalty of perjury that I have examined the documents presented by the above named person, and that the above listed documents appear to be genuine and to relate to the person named.

8. SIGNATURE OF REGISTRAR	9. DATE SIGNED (MM/DD/YYYY)
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SECTION IV - PERSONAL IDENTITY VERIFICATION CARD ACCEPTANCE

PART A - CARD INFORMATION (Completed by Issuer)

1. NEW PIV CREDENTIAL SERIAL NUMBER	2. OLD ACCESS ID CARD NUMBER	3. EXPIRATION DATE (MM/DD/YYYY)
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PART B - PERSONAL IDENTITY VERIFICATION CARD ACCEPTANCE (Completed by Applicant)

ACKNOWLEDGEMENT: I acknowledge receiving my identity credential and will comply with the following obligations:

- I have been provided training on the responsibilities associated with receipt of this Personal Identity Verification Card.
- I will use my Personal Identity Verification card in accordance with the training I have been provided.

CERTIFICATION: I certify that I have read and agree to the above statements and that I have received my card.

1. PRINTED NAME OF APPLICANT	2. APPLICANT SIGNATURE OF ACCEPTANCE	3. DATE SIGNED (MM/DD/YYYY)
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PART C - PUBLIC KEY INFORMATION (PKI) CERTIFICATE ACCEPTANCE (Completed by Applicant)

AUTHORIZATION STATEMENT

You have been authorized to receive one or more private and public key pairs and associated certificates. A private key enables you to digitally sign documents and messages and identify yourself to gain access to information systems and facilities. You may have another private key to decrypt data such as encrypted messages. People and electronic systems inside and outside VA will use public keys associated with your private keys to verify your digital signature, or to verify your identity when you attempt to authenticate to systems, or to encrypt data sent to you. The certificates and private keys will be issued on a token, for example your Personal Identity Verification Card. The token and the certificates and private keys on your token are government property. Users are authorized to use the certificates within VA, as well as while conducting business with other Federal, state, and Local Government agencies.

ACKNOWLEDGEMENT OF RESPONSIBILITIES

- I represent and warrant that the information provided in application for this certificate is accurate, current, and complete. If this information changes, I will notify my Registrar of the changes;
- I will use my certificate(s) and private key(s) for official purposes only;
- I will comply with the Certificate Practices Statement for selecting a Personal Identification Number (PIN) or other required method for controlling access to my private keys and will not disclose same to anyone, leave it where it might be observed, nor write it on the token itself;
- I understand that digital signatures applied using my digital certificates carry the same legal obligation as my physically signing the document;
- I understand that if I receive key management (encryption/decryption) key pairs on my token, copies of the private decryption keys have been provided to the key recovery database in case they need to be recovered; and
- I will report any compromise (e.g., loss, suspected or known unauthorized use, misplacement, etc.) of my PIN or token to my supervisor, security officer, Certification Authority (CA), or a Registrar, immediately.

LIABILITY

I will have no claim against VA arising from use of the PKI certificates, the key recovery process, or a Certification Authority's (CA) determination to terminate or revoke a certificate. VA is not liable for any losses, including direct or indirect, incidental, consequential, special, or punitive damages, arising out of or relating to any certificate issued by a VA CA.

GOVERNMENT LAW

VA Public Key Certificates shall be governed by the laws of the United States of America.

CERTIFICATION: I certify that I have read and agree to the above statements and that I have received my PKI certificate(s).

1. FULL LEGAL NAME OF APPLICANT	2. SIGNATURE OF ACCEPTANCE	3. DATE SIGNED (MM/DD/YYYY)
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SECTION V - ISSUER (Completed by Issuer)

1. WORK ADDRESS	2. PRINTED NAME OF ISSUER	
	3. NAME OF DEPARTMENT, SERVICE, OR SECTION	
	4. WORK PHONE NUMBER (Include Area Code)	5. WORK E-MAIL ADDRESS

CERTIFICATION: I certify under penalty of perjury, that I have monitored the identity verification of the person above in accordance with applicable identity proofing processes and have witnessed that person sign this form.

6. SIGNATURE OF ISSUER	7. DATE SIGNED (MM/DD/YYYY)
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5

Parental Approval
(Please fill out all requested information)

Name of Youth Volunteer _____

Date of Birth _____ Social Security Number _____ - ____ - ____

Known allergies: _____

Current medical problems/physical limitations: _____

Indicate any medication the above named youth is currently taking:

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

I authorize the Central Texas Veterans Health Care System to provide treatment to my child in case of illness, injury, or medical emergency while conducting volunteer service or in attendance at youth volunteer functions.

I also give my permission for my child to receive a TB skin test/X-ray as part of the VA Voluntary Service health services requirement.

(Signature of Parent(s) or Guardian)

(Date Signed)

Printed Name

Youth Volunteer Initial Interview

Volunteer Name: _____ Date of Interview: _____

How did you hear about our youth program? _____

Why are you interested in volunteering? _____

What are your career goals? _____

(a) Do you plan on going into an allied health position? Yes No

(b) Do you plan on going to College? Yes No
If yes, where? _____

What class will you be in next school year? 8th Grade Freshman Sophomore Junior Senior

High school graduation date/year: _____

We offer a scholarship for youth volunteers who are seniors and completed a minimum of 150 hours. Would you be interested in receiving the application packet? Yes No

This is a place of business. We do not tolerate misbehavior (please see the Rules of Behavior for Student Volunteers) -- Veterans are our priority.

You are required to wear your youth volunteer polo shirt which will be provided to you free of charge. Youth not in compliance will be sent home.

If you take vacation or are sick, you MUST notify your service supervisor AND Voluntary Service.

When are you available to volunteer? (we limit new volunteers to two days per week)

Monday Tuesday Wednesday Thursday Friday

What hours do you want to volunteer? From _____ to _____.

Where are you interested in working? _____.

Do you have questions? _____.

Size of Polo Shirt Needed

(Please check one)

Small _____ Medium _____ Large _____ X-Large _____ XX-Large _____

Rules Of Behavior For Student Volunteers

The rules listed below will be followed by each student volunteer, violations of these rules may lead to termination. If this form is not signed by the student volunteer and parent you may not volunteer till signed and returned to Voluntary Service.

No Napping or sleeping.

No cell phones, I pods, or games.

No leaving campus without permission from Voluntary Service.

No going to each other's workstations to visit.

No horseplay in halls / wheelchairs.

No criticism or making fun of patients or fellow volunteers.

No shorts unless working in motor pool or permission is given for a recreational outing off station.

No opened toed shoes i.e. flip flops, sandals, etc.

Red shirts & badges must be worn while volunteering.

No tying shirts of any kind in front or back.

No profanity or smart back talking.

I _____ have read and understand the rules of behavior as stated above.

Date: _____

Parent or Guardian signature: _____

Date: _____

HIPAA Training Record For VA Volunteers

I hereby state that I have received training on the Health Information Portability and Accountability Act (HIPAA) Privacy Policy and understand my responsibility, as a VA volunteer, to safeguard and keep confidential any Protected Health Information (PHI) that I discover in the course of performing my assigned volunteer duties.

Please (1) print your name on the first line, (2) fill in the date, and (3) sign your name on the indicated line, (4) write in your social security number and (5) return the form to Voluntary Service.

Print Your Name Here

Date of Training

Signature Here

Social Security Number

Volunteer TB Notification and Verification Form

Volunteer's Name _____ Social Security# _____ - _____ - _____

Volunteers are required to have an annual TB skin test (screening or chest X-ray if TB skin test is positive). In order to notify volunteers routinely, we are sending you this form during the month of your birthday; however, if you have been tested within the current calendar year, please disregard this notice but make sure the VAVS Office has the date of your last TB test on file.

If you have not had your TB skin test this calendar year, please follow the directions below:

1. Take this form to Occupation Health (Employee Health Unit) located on B East (Building 162, adjacent to the back of Teague Tower) at the Olin E. Teague Veterans' Center, **Monday – Wednesday & Friday's from 7:30 a.m.-11:30 a.m. & 12:30 p.m.-3:30 p.m.**
2. After you receive the TB test return to Employee Health as instructed within 48 hours for the test to be read.
3. Have the nurse conducting the test date and sign this form.
4. Once the test and this form have been completed, please return form to:

Voluntary Service (135T)
Bldg 209
1901 Veterans Memorial Dr.
Temple, TX 76504

(Employee Health Union Use only)

Date Test given: _____ Date Test read: _____ Test ready by: _____
(Signature of Physician/Nurse)

EH&SS EMPLOYEE INFORMATION SHEET

DATE: _____

EMPLOYEE FIRST NAME: _____

EMPLOYEE MIDDLE NAME: _____

EMPLOYEE LAST NAME: _____

SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH: _____

HOME ADDRESS: _____

CITY: _____ STATE & ZIP: _____

HOME PHONE: (_____) _____

CELL PHONE: (_____) _____

EMERGENCY CONTACT # 1

NAME: _____
LAST FIRST

PHONE #: _____

EMERGENCY CONTACT # 2

NAME: _____
LAST FIRST

PHONE #: _____

Completed by: _____

Date: _____

