Ao 10/7/16

**Follow these Instructions to Complete the Application for a Volunteer Position**

| **Forms that must completed prior to in-processing as a volunteer** | **Key Points** |
|---|---|
| | |
| Application for Voluntary Service – 2 pages (VA Form 10-7055) | Page 1- Complete in full<br>Page 2- Must be signed by parent or guardian if volunteer is under 18 years of age |
| Parent/Guardian Permission Slip | Page 3 – Complete in full |
| Letter of Reference Forms – 2 pages | Forms must be filled out by two Non-Family members |
| Authorization for Release of Information- 2 pages (Standard Form 85) | Complete in full |
| HR Document Verification Form -1 page | Complete in full |
| Tell Us About Yourself Form | Complete in full |

**Additional Requirements:**

**NOTE: The Medical Center will arrange the below appointments for you; do not have them done yourself.**

All volunteers must be fingerprinted and a background investigation conducted. Also, a TB/PPD test must be administered and read between 48 and 72 hours, **or** documentation presented that verifies that a PPD test has been administered within the last 4 months.

When you come in for in-processing/orientation, **you must**:

- Present **two (2)** forms of identification, **2 from List A *or* one from List A plus one from List B. Names 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**, and must be currently valid, **not expired or cancelled**.

**PLEASE NOTE: School ID's w/o expiration dates are not valid for identification purposes.**

| **List A** | **List B** |
|---|---|
| • U.S. Passport or U.S. Passport Card<br>• Permanent Resident Card or Alien Registration Receipt Card (FormI-551)<br>• Foreign passport<br>• Employment Authorization Document that contains a photograph (Form I-766)<br>• Driver's License or an ID card issued by a State or possession of the United States provided it contains a photograph<br>• U.S. Military card<br>• U.S. Military dependent's ID card<br>• PIV Card | • U.S. Social Security Card issued by Social Security Administration<br>• Original or certified copy of a birth certificate issued by a state, county, municipality authority, or outlying possession of the U.S. bearing an official seal<br>• ID card issued by a federal, state or local government agency or entity, provided it contains a photograph<br>• Voter's registration card<br>• U.S. Coast Guard Merchant Mariner Card<br>• Certificate of U.S. Citizenship (Form N-560 or N-561)<br>• Certificate of Naturalization (Form N-550 or N-570)<br>• U.S. Citizen ID Card (Form I-197)<br>• ID Card for Use of Resident Citizen in the U.S. (Form I-179)<br>• Certification of Birth Abroad or Certification of Report of Birth issued by the Department of State (Form FS-545 or Form DS-1350)<br>• Temporary Resident Card (Form I-688)<br>• Employment Authorization Card (Form I-6888A)<br>• Reentry Permit (Form I-327)<br>• Refugee Travel Document (Form I-571)<br>• Employment Authorization Document issued by Department of Homeland Security (DHS)<br>• Employment Authorization Document issued by DHS with photograph (Form I-688B)<br>• Driver's license issued by a Canadian government entity<br>• Native American Tribal document |

**Please call the Voluntary Service Office at 401-273-7100 ext 3002 with questions.**

OMB Number 2900-0090
Estimated Average: 15 min.

U.S. Department of Veterans Affairs
Veterans Health Administration
Voluntary Service

# 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

DATE OF BIRTH

TELEPHONE NUMBER

E-MAIL ADDRESS

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



EXISTING STOCK OF VA FORM 10-7055, MAY 2007, WILL BE USED.

**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.

**PARENT/GUARDIAN PERMISSION SLIP**
**FOR VOLUNTEERS UNDER 18 YEARS OF AGE**
**Approval for Fingerprint-taking and TB/PPD Test**

**Dear Parent/Guardian:**

**In order for your adolescent to volunteer at the Providence VA Medical Center or its satellite locations, your permission to take their fingerprints and to administer a TB/PPD test is requested. Please complete the form below and return it with the application packet.**

**I, _____, parent/guardian of _____,**
**(PRINT NAME OF PARENT/GUARDIAN) (PRINT NAME OF MINOR)**

**grant permission for the Providence VA Medical Center (PVAMC) to take the fingerprints of, and administer a TB/PPD to, the above minor.**

_____ _____
**SIGNATURE OF PARENT/GUARDIAN** **DATE**

**DEPARTMENT OF VETERANS AFFAIRS**
**Medical Center**
**830 Chalkstone Avenue**
**Providence, RI 02908-4799**

In Reply Refer To: 650-135

## VOLUNTEER PROGRAM
## LETTER OF REFERENCE FORM

Reference is required from a Non-Family Member

Applicant's Name: _____

Length of time acquainted with applicant: _____ yrs/mos.

Relationship to applicant: Friend _____ Employer _____ Teacher _____ Other _____

The individual listed above has applied to be a volunteer. Please describe some attributes you feel would impact on his/her ability to volunteer. We may call you for further information. Thank you.

_____

_____

_____

_____

_____
SIGNATURE

_____
PLEASE PRINT NAME

_____
CITY, STATE, ZIP

_____
HOME TELEPHONE NUMBER

_____
WORK TELEPHONE NUMBER

Please return to Voluntary Service, Providence VA Medical Center, 830 Chalkstone Ave., Providence,RI 02908-4799.

**DEPARTMENT OF VETERANS AFFAIRS**
**Medical Center**
**830 Chalkstone Avenue**
**Providence, RI 02908-4799**

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_____

_____

_____

_____

_____
SIGNATURE

_____
PLEASE PRINT NAME

_____
CITY, STATE, ZIP

_____
HOME TELEPHONE NUMBER

_____
WORK TELEPHONE NUMBER

Please return to Voluntary Service, Providence VA Medical Center, 830 Chalkstone Ave., Providence,RI 02908-4799.

Standard Form 85
Revised September 1995
U.S. Office of Personnel Management
5 CFR Parts 731 and 736

Form approved
OMB No. 3206-0005
NSN 7540-00-634-4035
85-111

# UNITED STATES OF AMERICA

## AUTHORIZATION FOR RELEASE OF INFORMATION

**Carefully read this authorization to release information about you, then sign and date it in black ink.**

**I Authorize** any investigator, special agent, or other duly accredited representative of the authorized Federal agency conducting my background investigation to obtain any information relating to my activities from schools, residential management agents, employers, criminal justice agencies, retail business establishments, or other sources of information. This information may include, but is not limited to, my academic, residential, achievement, performance, attendance disciplinary, employment history, and criminal history record information.

**I Understand** that, for some sources of information, a separate specific release will be needed, and I may be contacted for such a release at a later date.

**I Authorize** custodians of records and sources of information pertaining to me to release such information upon request of the investigator, special agent, or other duly accredited representative of any Federal agency authorized above regardless of any previous agreement to the contrary.

**I Understand** that the information released by records custodians and sources of information is for official use by the Federal Government only for the purposes provided in this Standard Form 85, and may be redisclosed by the Government only as authorized by law.

Copies of this authorization that show my signature are as valid as the original release signed by me. This authorization is valid for two (2) years from the date signed.

| Signature (Sign in ink) | Full Name (Type or Print Legibly) | | Date Signed |
|---|---|---|---|
| Other Names Used | | | Social Security Number |
| Current Address (Street, City) | State | Zip Code | Home Telephone Number (Include Area Code)<br>(  ) |

Standard Form 85
Revised September 1995
U.S. Office of Personnel Management
5 CFR Parts 731 and 736

Form approved
OMB No. 3206-0005
NSN 7540-00-634-4035
85-111

# Authorization for Release of Information / Background Investigation

| | YES | NO |
|---|---|---|
| ❖ During the last 10 years, have you been convicted, been imprisoned, been on probation, or been on parole? Include felonies, firearms or explosives, violation, misdemeanors and all other offenses. If "YES", provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved. | ☐ | ☐ |
| ❖ Have you been convicted by a military court-martial in the past 10 years? If no military service, answer "NO". If "YES", provide the date, explanation of the violation, place of occurrence, and the name and address of the military authority or court involved. | ☐ | ☐ |
| ❖ Are you now under charges for any violation of law? If "YES", provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved. | ☐ | ☐ |

*Explanation Space*

## 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 Investigations). This information will be used to search the Federal Bureau of Investigation's fingerprint files in determining your fitness for Federal employment or security clearance. It may also be used for searches of other law enforcement agencies maintaining fingerprint files for the same purpose.

Public Law 104-134 (April 26, 1996) requires that any person doing business with the Federal government furnish a Social Security Number (SSN) or tax identification number. Furnishing any of the other 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).

## Public Burden Statement

We estimate the Public Burden for this collection of information is approximately five minutes per response. This includes time for reviewing the instructions, completing the form and the actual fingerprinting.

## Confidentiality Statement

I recognize a person's basic right to privacy and confidentiality of personal information. As a volunteer of the Providence VA Medical Center, I understand that I may be exposed to a variety of confidential information that may be in writing, oral, electronic or observed. The confidential information may pertain to patients, physicians, employees or other private aspects of hospital business. I believe said confidential information must be carefully protected and should be shared only with individuals who have a legitimate need for the personal/confidential information. The need for, and critical importance of, maintaining strict confidentiality of all private information has been fully explained to me. I understand that any unauthorized disclosure of said information will result in disciplinary action up to and including termination of my placement at the Providence VA Medical Center.

| _____ | _____ | _____ |
|---|---|---|
| VOLUNTEER NAME (Printed) | VOLUNTEER SIGNATURE | DATE |

**FINGERPRINT WORKSHEET**

OFFICIAL USE ONLY
DATE PRINTS TAKEN: _____
PRINTS TAKEN BY: _____

**PLEASE SELECT THE APPROPRIATE CATEGORY**

_____DISBURSEMENT RESIDENT _____WOC _____VOLUNTEER

_____COURTESY _____ FEE-BASIS _____ CONTRACTOR _____REGULAR EMPLOYEE

COURTESY AND CONTRACTS PLEASE PROVIDE: SON_____ SOI_____

OFFICIAL POSITION TITLE _____

THE FOLLOWING INFORMATION IS REQUIRED TO SUBMIT YOUR FINGERPRINTS. HUMAN RESOURCES WILL TAKE YOUR FINGERPRINTS AS PART OF PROCESSING YOUR APPOINTMENT OR IN CONNECTION WITH THE REINVESTIGATION REQUIRED DUE TO THE RISK LEVEL ASSOCIATED WITH YOUR POSITION.

FULL LEGAL NAME_____
(LAST NAME) (FIRST NAME) (FULL MIDDLE NAME) (SUFFIX)

OTHER NAMES USED _____
(MAIDEN NAME)

UNITED STATES SSN _____ DOB_____

US STREETADDRESS_____

_____
(COMPLETE STREET ADDRESS)

CITY OF BIRTH_____ STATE OR COUNTRY OF BIRTH _____

COUNTRY OF CITIZENSHIP _____

FOR THE FOLLOWING SECTION, PLEASE USE THE BELOW CHART

GENDER _____

RACE _____

EYE COLOR _____

HAIR COLOR _____

HEIGHT _____
(FEET, INCHES)

WEIGHT _____
(POUNDS)

**Race:**
A - Asian
B - African American
I - Native American
W - Caucasian/Latino

**Eye Color:**
BLK – Black BLU- BluE
BRO-Brown GRN- Green
GRY- Gray HAZ – Hazel

**Hair Color:**
BLK – Black
RED – Red/Auburn
GRY - Gray/Partially Gray
BRO – Brown
SDY – Sandy
WHI – White
BLN – Blonde/Strawberry
BAL -- Bald

**DEPARTMENT OF VETERANS AFFAIRS**
**Medical Center**
**Voluntary Service (135)**
**830 Chalkstone Avenue**
**Providence, RI 02908-4799**

**Please tell us about yourself:**

**1. Why do you want to volunteer?**

_____

_____

_____

**2. Would you prefer an assignment that is more active (walking, etc) or more sedentary (sitting)?**

_____

_____

_____

**3. Would you prefer working with patients or with hospital staff?**

_____

_____

**4. What days and hours would you like to volunteer? (Please be specific)**

_____

_____

**5. Please list any skills, experience and/or interests you have that would better help us place you as a volunteer.**

_____

_____

**6. Additional comments/thoughts you would like to add…**

_____

_____

_____