

Follow these Instructions to Complete the Application for a Volunteer Position

| Forms to be completed by each volunteer prior to placement at the Providence VA Medical Center | Key Points |
|---|---|
| VA Form 10-7055 Application for Voluntary Service – 2 pages | Page 1- Complete in full Page 2- Complete if applicable |
| Letter of Reference Forms – 2 pages | Forms <u>must</u> 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 |
| VA Form 0711 Request for Personal Identity Verification Card | Complete Section I in full and Section III, Part A, No. 3-10 only |

Other In-Processing Requirements:

All volunteers age 18 and older are required to have an ID badge and background investigation to include fingerprinting. Acceptable identification documents must meet the below requirements.

- You must present two (2) forms of identification, **2 from List A or one from List A plus one from List B.**
- The names on the ID 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.

List A

- Federal and/or State-Issued Drivers License or ID Card
- U.S. Passport
- Military ID Card
- Permanent Resident Card or Alien Registration Card with a photograph (INS Form I-151/I-551) (aka “Green Card”)

List B

- Non-Picture ID or Acceptable Picture ID not issued by Fed or State Government
- Social Security Card
- Certified Birth Certificate
- School ID with photograph
- ID card issued by local government agencies provided it includes the following information: name, date of birth, gender, height, eye color, and address
- Non-photo ID Card issued by federal or state government agencies provided it includes the following information: name, date of birth, gender, height, eye color, and address

Other In-Processing Requirements

A PPD (TB) test must be administered and read within 72 hours, or documentation presented that verifies that a PPD test has been administered within the last 4 months.

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



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 |

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) _____

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.



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



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 Medical Center
 830 Chalkstone Avenue
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 SIGNATURE

 PLEASE PRINT NAME

 CITY, STATE, ZIP

 HOME TELEPHONE NUMBER

 WORK TELEPHONE NUMBER

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) () |

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. | <input type="checkbox"/> | <input type="checkbox"/> |
| ❖ 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. | <input type="checkbox"/> | <input type="checkbox"/> |
| ❖ 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. | <input type="checkbox"/> | <input type="checkbox"/> |

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

Office Use Only:
Taken on: _____
By: _____

HR DOCUMENT VERIFICATION FORM

PLEASE PICK THE APPROPRIATE ONE:

- DISBURSEMENT RESIDENT WOC VOLUNTEER COURTESY FEE BASIS
 CONTRACT EMPLOYEE PAID INTERN/PAID RESIDENT REGULAR EMPLOYEE

The following information is required in order to submit your fingerprints which will be taken by Human Resources as a part of processing your appointment or in connection with the reinvestigation required due to the risk level associated with your position.

DATE: _____ SERVICE: _____

NAME: _____
(LAST NAME) (FIRST NAME) (MIDDLE NAME) (SUFFIX)

ALIASES: _____
(MAIDEN NAME, NICK NAME etc.)

SSN: _____ DOB: _____

ADDRESS: _____
(COMPLETE STREET ADDRESS)

(CITY) (STATE) (ZIP)

PLACE OF BIRTH: _____ COUNTRY OF BIRTH: _____
(CITY, STATE)

ARE YOU A US CITIZEN YES NO
(CHECK ONE)

FOR THE FOLLOWING SECTION, SEE CHART BELOW FOR SPECIAL CODES

GENDER: _____ RACE: _____

EYE COLOR: _____ HAIR COLOR: _____

HEIGHT: _____ WEIGHT: _____
(FEET, INCHES) (POUNDS)

CHART:

RACE:

- | | |
|---------------------|----------------------|
| A - ASIAN | W - CAUCASIAN/LATINO |
| B - BLACK | XXX - UNKNOWN |
| I - NATIVE AMERICAN | |

EYE COLOR:

- | | |
|-------------|---------------|
| BLK - BLACK | GRY - GRAY |
| BLU - BLUE | HAZ - HAZEL |
| BRO - BROWN | XXX - UNKNOWN |
| GRN - GREEN | |

HAIR COLOR:

- | | |
|------------------|---------------------------|
| BLK - BLACK | BAL - BALD |
| RED - RED/AUBURN | GRY - GRAY/PARTIALLY GRAY |
| BRO - BROWN | SDY - SANDY |
| WHI - WHITE | BLN - BLONDE/STRAWBERRY |
| XXX - UNKNOWN | |



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 Providence VA Medical Center 830 Chalkstone Avenue Providence, RI 02908 | | 2. NAME OF SPONSORING DEPARTMENT, SERVICE, OR SECTION, AND MAIL ROUTING SYMBOL Voluntary Service 135 | |
| 3. CREDENTIALS/ORGANIZATIONAL TITLE (AKA Position/Job Title) VOLUNTEER / | | 4. COST CTR. 042 | |
| 5. WORK PHONE NUMBER (If applicable) (401) 273-7100 | | 6. WORK E-MAIL ADDRESS | |

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 <input checked="" type="checkbox"/> PERSONAL IDENTITY VERIFICATION (PIV) <input type="checkbox"/> VA (NON-PIV) | | 3. TYPE OF ACCESS <input type="checkbox"/> LOGICAL ACCESS (Domain) <input checked="" 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"/> VOLUNTEER <input type="checkbox"/> TEMPORARY VA EMPLOYMENT | | | |

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

| | | | | | |
|---|--|---|--|---|--|
| 1. SPECIAL SECURITY ACCESS REQUIRED <input type="checkbox"/> YES (If "YES," Specify in Item 2) <input type="checkbox"/> NO | | 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"/> 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
 SAC
 NACI
 SECRET
 TOP SECRET
 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) Debra Veasey | | 4. NAME OF RESPONSIBLE VA ORGANIZATION Voluntary Service | | 5. MAIL ROUTING SYM. 135 |

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 Debra Veasey | | 2. SPONSOR CREDENTIALS/ORGANIZATIONAL TITLE Voluntary Service Program Support Assistant | |
| 3. CERTIFICATE NUMBER (Issued by PCI Manager or Registrar) 135-02 | | 4. SIGNATURE OF SPONSOR | 5. DATE SIGNED (MM/DD/YYYY) |
| 6. WORK ADDRESS Providence VA Medical Center 830 Chalkstone Avenue Providence, RI 02908 | | 7. NAME OF SPONSOR'S DEPARTMENT, SERVICE, OR SECTION Voluntary Service | |
| | | 8. WORK PHONE NUMBER (Include Area Code) (401) 273-7100 | |
| | | 9. WORK E-MAIL ADDRESS debra.veasey@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 checked="" 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) |
|---------------------------|-----------------------------|

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) |
|-------------------------------------|------------------------------|---------------------------------|

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) |
|------------------------------|--------------------------------------|-----------------------------|

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) |
|---------------------------------|----------------------------|-----------------------------|

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) |
|------------------------|-----------------------------|