



DEPARTMENT OF VETERANS AFFAIRS
VA Central California Health Care System
2615 East Clinton Avenue
Fresno, CA 93703-2286

Dear Volunteer Applicant,

Thank you for your interest in serving Veterans at the VA Central California Health Care System. The process to complete your volunteer registration is outlined below:

1. **Complete Application**
2. **Professional Resume**
3. **On-Boarding Orientation**
4. **Privacy and HIPAA Training**
5. **Background Check**
6. **TB Test**
7. **Online Orientation**
8. **Final Interview**
9. **Badge Issue**

Thank you again for your interest in serving our nation's heroes. If you have any questions, please contact the Voluntary Service Processing Team at (559) 225-6100 ext. 5006 or email V21FREVolunteerProcessing@va.gov.

- The Processing Team Lead is Shary Vargas
- Office hours: Monday-Friday; 9:00 a.m.—3:00 p.m.



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) <input style="width:95%; height: 20px;" type="text"/>		ADDRESS (Street, City, State and Zip Code) <input style="width:95%; height: 40px;" type="text"/>	DATE <input style="width:95%; height: 20px;" type="text"/>
Telephone Number <input style="width:95%; height: 20px;" type="text"/>	Email Address (Optional) <input style="width:95%; height: 20px;" type="text"/>		Date of Birth <input style="width:95%; height: 20px;" type="text"/>
ORGANIZATION MEMBERSHIP(S) Unit, Post, Chapter, if affiliated) <input style="width:95%; height: 20px;" type="text"/>		ASSIGNMENT PREFERENCES	
		1. <input style="width:80%; height: 20px;" type="text"/>	2. <input style="width:80%; height: 20px;" type="text"/>
		3. <input style="width:80%; height: 20px;" type="text"/>	

EXPERIENCE AND TRAINING (special skills/abilities)

RESTRICTIONS, LIMITATIONS OF SERVICE (Health concerns, medications, allergies, etc.) <input style="width:95%; height: 40px;" type="text"/>	AVAILABILITY (Days and times) <input style="width:95%; height: 40px;" type="text"/>
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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.

<input style="width:95%; height: 20px;" type="text"/> Volunteer's Signature	<input style="width:95%; height: 20px;" type="text"/> Date
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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	<input style="width:95%; height: 20px;" type="text"/>	2. SUPERVISOR PHONE NUMBER	<input style="width:95%; height: 20px;" type="text"/>
3. ORIENTATIONS	<input style="width:95%; height: 20px;" type="text"/>	4. UNIFORM	<input style="width:95%; height: 20px;" type="text"/>

COMMENTS <input style="width:95%; height: 40px;" type="text"/>	NAME AND TITLE OF REVIEWER <input style="width:95%; height: 40px;" type="text"/>	DATE <input style="width:95%; height: 40px;" type="text"/>
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Volunteer Acknowledgement

In order to provide the best service to our Veterans, please acknowledge your agreement with the following statements by placing your **INITIALS** in the appropriate boxes.

1. I agree to participate in the VA Hospital volunteer program for a minimum of 4 hours a week within the first 12 months of service (2 hours for minors) regardless of changes to my employment status.
2. I am at least 16 years of age.
3. I understand that I am not authorized to participate in direct patient care regardless of my experience or certifications.
4. I understand that I will undergo a background investigation upon acceptance. I will provide accurate information regarding my criminal history for the last 7 years, to include: date of offence, explanation of violation, place of occurrence, and name and address of police department or court involved.
5. I understand that job assignments are determined by the needs of the Veterans.
6. I agree to maintain an accurate schedule with my supervisor.
7. I understand that the process may exceed two months.

Print Name

Signature

Date (mm/dd/yyyy)

FINGERPRINT REQUEST FORM

Bring with you two (2) original IDs (Identity Source Documents) from the list below

https://www.oit.va.gov/programs/piv/_media/docs/IDMatrix.pdf

Complete all fields on this form to the best of your ability

Applicant Category: Check One

EMPLOYEE	CONTRACTOR	HEALTH PROFESSIONS TRAINEE (VHA intern, resident, fellow, student)
AFFILIATE	VOLUNTEER	OTHER:

ENTER YOUR NAME EXACTLY AS IT APPEARS ON IDs

Name: (Last, First, Middle)		Other Last Names Used
SSN (use of pseudo number is not permitted)	Position Title	Telephone #
Date of Birth: (mm/dd/yyyy)	City/State and Country of Birth	
E-Mail Address (long-term, sustained E-Mail)	Country of Citizenship	Dual Citizen? (Yes/No)
VA Work Location	POC/COTR/Sponsor/Supervisor	POC Phone #
Contractors Only: Company Name		Company Address
		Contract End Date
Health Professions Trainees Only: School/Affiliate Name		Training Program
		Program End Date

FINGERPRINT LOCATION		FINGERPRINT DATE (mm/dd/yyyy)		PREVIOUS PIV CARD HOLDER (Yes/No)	
GENDER (M/F)	HEIGHT (inches)	WEIGHT (US pounds)	HAIR COLOR	EYE COLOR	RACE/ETHNICITY

Courtesy Prints for another Facility

Facility Name/Location:	Facility SOI#	Facility SON#
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Personnel Security Specialist USE ONLY

Date Cleared	Signature
Comments	