OMB Number 2900-0090
Estimated Average: 15 min.

VA | U.S. 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. 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

VA FORM 10-7055
FEB 2016

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.

VA | U.S. Department of Veterans Affairs

Louis Stokes Cleveland VA Medical Center

STATEMENT OF COMMITMENT AND UNDERSTANDING

As an employee/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 that VA employees, volunteers and applicants have provided.

To ensure that I understand my obligations and responsibilities in handling the personal information of Veterans and their families, I have completed both the annual General Privacy Awareness Training (or VHA Privacy Training, as applicable) and the annual VA Cyber Security Training. I know that I should contact my 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, create, maintain, use, disclose or dispose of information about Veterans and their families, VA employees, volunteers 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 the VA may also impose administrative sanctions, up to and including removal, for violation of applicable confidentiality and security statues, regulations and policies.

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

DEPARTMENT OF VETERANS AFFAIRS POLICY REGARDING PRIVACY

I have read the Department of Veterans Affairs policy on privacy and have received a copy of this health care system's policy protecting the rights and keeping patient information confidential. I agree to adhere to the policy of the VA which strictly prohibits any disclosure of information regarding our Veteran patients.

Acknowledgement and Acceptance

a. I acknowledge that I have received a copy of these Rules of Behavior.
b. I understand, accept and agree to comply with all terms and conditions of these Rules of Behavior.

Initial_____ Date_____

VA

U.S. Department of Veterans Affairs

Louis Stokes Cleveland VA Medical Center

DEPARTMENT OF VETERANS AFFAIRS POLICY PROHIBITING PATIENT ABUSE

It is the policy of the Department of Veterans Affairs that under no circumstances will the mental, physical, sexual (including romantic, exploitative relationships) or verbal abuse, mistreatment or neglect of a patient be tolerated. This is true whether the employee feels provoked or not by any actions of the patient. By the same token, any abusive or dangerous action initiated by a patient should be reported by the affected employee(s) to their immediate supervisor as soon as is reasonably possible.

Any employee who witnesses any unkindness, rudeness or violence of any kind toward a patient and who does not promptly report it to the proper authority can also be subjected to a disciplinary action.

I have read the Department of Veterans Affairs policy on patient abuse and have received a copy of this health care system's policy prohibiting patient abuse. I agree to adhere to the policy of the VA which strictly prohibits any abuse against our Veteran patients.

_____

[Print or type your full name]

_____

Signature

_____

Date

Patient Data Sheet

(Please Print)

Name: _____
Last First MI

Social Security Number: _____

Home Street Address: _____

_____
City State Zip Code

Home: ( ) _____ Mobile: ( ) _____

Email: _____

Date of Birth: _____
Month / Day / Year

Place of Birth: _____
City & State (or Country)

Father's Name: _____
Last First MI

Mother's Name: _____
Last First MI

Mother's Maiden Name: _____
Last

Current Occupation: _____

Employment Status:

○ Permanent (Full-Time) ○ Permanent (Part-Time)
○ Temporary ○ WOC ○ Student ○ Volunteer

If Temporary, WOC, or Student List Term End Date: _____
Month / Year

Emergency Contact

Name: _____

Relationship: _____

Telephone Number: _____

Address: _____

_____
City State Zip Code

I consent to allowing VA to record and use a verbal or written statement, or produce and use photographs, digital images, and video or audio recording for the purpose(s) identified below:

This product will be used: (NOTE: At least one of these boxes must be checked as well as a purpose described below)
(to be completed by VA) ☐ Internally (stay within VA) ☒ Externally (shared outside VA)

Please check the applicable purpose(s) (to be completed by VA)

Promotional Efforts:

☒ Internal Publication (only VA) ☒ External publication (publicly available)

☐ Other (Specify): _____

Research Activities: ☐ Study

Education Purposes:

☐ Presentation ☐ Conference ☐ Publication in a Journal ☐ Training

☐ Other (Specify): _____

VA ONLY Use:

☐ Performance Improvement ☐ Quality Improvement ☐ Health Care Operations

☐ Other (Specify): _____

☐ All of the Above

NOTE: Do not sign this form unless one or more of the boxes above has been checked.

I have read and understand the foregoing, and I consent to the use of a verbal or written statement from me, and/or of my likeness and/or voice as specified for the above-described purpose(s). I understand that no royalty, fee, or other compensation of any kind will be made to me by the United States for such use. I understand that consent to obtain, produce, and/or use a verbal or written statement, photograph, digital image, and video or audio recording containing my likeness or voice is voluntary, and my refusal will not adversely affect my access to any present or future VA benefits for which I am eligible. I further understand that I may, at any time, rescind my consent prior to or during production of a photograph, digital image, or video or audio recording. I also understand that I may rescind my consent after production is complete if the burden on VA of complying with that request is not unreasonable considering the financial and administrative costs, the ease of compliance, and the number of parties involved.

Print Full Name (First and Last Name) _____ Signature _____ Date _____

Consent Obtained By (TO BE COMPLETED BY VA)

Print Employee Full Name _____ Title _____ Date _____

Signature of Person Obtaining Consent (TO BE COMPLETED BY VA)

_____
Signature

IMPORTANT: If VA is providing or releasing any patient health or demographic information with the verbal or written statement, photograph, digital image, or video or audio recording, VA Form 10-5345, Request for and Authorization to Release Medical Records or Health Information, is required prior to the release of such data to any source outside VA.

Department of Veterans Affairs

CONSENT FOR PRODUCTION AND USE OF VERBAL OR WRITTEN STATEMENTS, PHOTOGRAPHS, DIGITAL IMAGES, AND/OR VIDEO OR AUDIO RECORDINGS BY VA

Name of individual whose statement, likeness, or voice is requested

NOTE: The execution of this form does not authorize production or use of materials except as specified below. The specified material may be produced and used by VA for authorized purposes identified below, such as education of VA personnel, research activities, or promotional efforts. It may also be disclosed outside VA as permitted by law and as noted below. If the material is part of a VA system of records, it may be disclosed outside VA as stated in the "Routine Uses" in the "VA Privacy Act Systems of Records" published in the Federal Register.

The purpose of this form is to document your consent to the Department of Veterans Affairs' (VA) request to obtain, produce, and/or use a verbal or written statement or a photograph, digital image, and/or video or audio recording containing your likeness or voice. By signing this form, you are authorizing the production or use only as specified below.

You are NOT REQUIRED TO CONSENT TO VA's REQUEST to obtain, produce, and/or use your statement, likeness, or voice. Your decision to consent or refuse will not affect your access to any present or future VA benefits for which you are eligible.

You may rescind your consent at any time prior to or during production of a photograph, digital image, or video or audio recording, or before or during your provision of a verbal or written statement. You may rescind your consent after production is complete if the burden on VA of complying with that request is not unreasonable considering the financial and administrative costs, the ease of compliance, and the number of parties involved.

The photograph, digital image, and/or video or audio recording will be produced while I am (describe the activity or situation) *(To Be Completed by the Department of Veteran Affairs, if applicable)*

Check at least one of the following (to be completed by VA)

☒ I hereby voluntarily and without compensation authorize Cleveland VA Medical Center
Name of Facility

to produce a photograph, digital image, and/or video or audio recording of me (or of the above named individual if the individual is legally unable to give consent).

☒ I hereby voluntarily and without compensation authorize Cleveland VA Medical Center
Name of Facility

to obtain or use a verbal or written statement from me (or the of the above named individual if the individual is legally unable to give consent).

CONDENSED VHA PRIVACY POLICY TRAINING FOR CERTAIN VOLUNTEERS

ELIGIBILITY: THIS TRAINING MAY BE USED ONLY FOR THOSE VOLUNTEERS WHO HAVE LITTLE OR NO CONTACT WITH PATIENTS AND DO NOT HAVE ACCESS TO PAPER OR ELECTRONIC PATIENT RECORDS.

BACKGROUND AND PURPOSE

THE VETERANS HEALTH ADMINISTRATION (VHA) IS COMMITTED TO PROTECTING THE PRIVACY AND CONFIDENTIALITY OF PATIENT INFORMATION. SINCE IT IS THE RESPONSIBILITY OF THE ENTIRE VHA WORKFORCE TO PROTECT PATIENT INFORMATION, ALL (VHA) EMPLOYEES, INCLUDING VOLUNTEERS, MEDICAL RESIDENTS, STUDENTS, AND CONTRACTORS ARE REQUIRED TO COMPLETE PRIVACY POLICY TRAINING, EVEN IF YOU MAY NOT HAVE DIRECT PATIENT CONTACT RESPONSIBILITIES. THE PURPOSE OF THIS CONDENSED TRAINING IS TO PROVIDE THE PARTICIPANTS WITH THE REQUIRED KNOWLEDGE OF THE VHA PRIVACY POLICIES.

AS A VA VOLUNTEER, WHAT DO I NEED TO DO TO COMPLETE THIS TRAINING?

VOLUNTEERS SIMPLY NEED TO READ THIS INFORMATION AND THEN COMPLETE THE FORM PROVIDED: STATEMENT OF COMPLETION FOR VHA VOLUNTEERS. A MORE DETAILED PRINT-OUT ON VHA PRIVACY POLICIES IS AVAILABLE FROM THE VA LEARNING CATALOG, IF YOU WOULD LIKE ADDITIONAL INFORMATION. PLEASE PRINT YOUR NAME, DATE THE FORM, FILL IN THE LAST FOUR DIGITS OF YOUR SOCIAL SECURITY NUMBER, INDICATE THE TRAINING OPTION YOU COMPLETED, AND THEN RETURN THE FORM TO YOUR LOCAL VOLUNTARY SERVICE OFFICE.

VHA PRIVACY POLICY

VHA HAS ESTABLISHED POLICIES AND PROCEDURES THAT GRANT THE VETERAN CERTAIN RIGHTS REGARDING HIS/HER HEALTH INFORMATION AND PROVIDE GUIDANCE ON THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION.

PROTECTED HEALTH INFORMATION (PHI) CONSISTS OF THE FOLLOWING:

- INDIVIDUALLY IDENTIFIABLE INFORMATION (I.E. SOCIAL SECURITY NUMBER, HEALTH INFORMATION, ETC.)
- DEMOGRAPHIC INFORMATION (I.E. ADDRESS, PHONE, AGE, GENDER, ETC.)
- THIS INFORMATION CAN BE IN ANY FORM (VERBAL, WRITTEN, ELECTRONIC)

THE PRIVACY ACT, HIPAA PRIVACY RULE, AND VHA PRIVACY POLICY PROVIDE THE VETERAN WITH THE RIGHT TO:

- RECEIVE A COPY OF THE VA NOTICE OF PRIVACY PRACTICES
- RECEIVE A COPY OF HIS/HER OWN PROTECTED HEALTH INFORMATION
- REQUEST AN AMENDMENT TO HIS/HER PERSONAL RECORDS
- REQUEST A LISTING OF DISCLOSURES OF HEALTH INFORMATION FROM HIS/HER PERSONAL RECORDS
- REQUEST AND RECEIVE COMMUNICATIONS CONFIDENTIALLY
- REQUEST A RESTRICTION ON THE USE OR DISCLOSURE OF HIS/HER HEALTH INFORMATION.

VHA also has established policies and procedures providing guidance on how PHI may be used within VHA and disclosed to organizations outside of VHA.

VHA workforce members including volunteers may use PHI only when the information is needed to perform their official VHA duties for the purpose of treatment, payment, and health care operations. Use of PHI for any other purpose requires the written permission of the patient.

VHA may disclose PHI only if prior written permission from the patient has been obtained or other legal authority permits the disclosure.

AS A VOLUNTEER, YOU ARE REQUIRED TO KEEP ALL PHI THAT YOU MAY DISCOVER IN THE COURSE OF YOUR ASSIGNED VOLUNTEER DUTIES STRICTLY CONFIDENTIAL. HERE ARE SOME REQUIREMENTS:

- NO TALKING IN PUBLIC AREAS ABOUT PROTECTED HEALTH INFORMATION AS LISTED ABOVE
- KEEP PHI OUT OF PUBLIC AREAS (I.E. ELEVATORS, STAIRWAYS, OPEN AREAS, ETC.)
- SECURE ANY RECORDS YOU MAY BE WORKING WITH BEFORE WALKING AWAY
- NO DISCUSSING WITH ANYONE, INSIDE OR OUTSIDE THE HOSPITAL, ANY PHI YOU MAY LEARN WHILE CARRYING OUT YOUR ASSIGNED DUTIES AS A VOLUNTEER.

POSSIBLE OUTCOMES FOR NOT COMPLYING WITH VHA PRIVACY POLICY

UNLAWFUL RELEASE OF PROTECTED HEALTH INFORMATION COULD RESULT IN:

- ORGANIZATION-SPECIFIC SANCTIONS (I.E. LAWSUITS, NOT RECEIVING ACCREDITATION)
- FILING OF A COMPLAINT BY A VICTIM OF A PRIVACY POLICY VIOLATION
- CIVIL AND CRIMINAL PENALTIES FOR VHA PRIVACY POLICY VIOLATORS
- FINES UP TO $50,000 AND/OR IMPRISONMENT

SUMMARY

ALL VOLUNTEERS MUST BE RESPONSIBLE FOR SAFEGUARDING PROTECTED HEALTH INFORMATION (PHI). AS A VOLUNTEER IN OUR HOSPITAL, YOU HAVE A RESPONSIBILITY TO KEEP ALL PATIENT INFORMATION, LEARNED IN THE COURSE OF YOUR DUTIES, CONFIDENTIAL AND SECURE. DO NOT DISCUSS ANY PHI DISCOVERED IN THE COURSE OF YOUR ASSIGNMENT WITH ANYONE. REMEMBER THAT YOU WOULD WANT YOUR PERSONAL INFORMATION AND HEALTH RECORDS TREATED IN THE SAME CONFIDENTIAL, PROFESSIONAL MANNER.

AS A VOLUNTEER, TAKE PRIDE AND OWNERSHIP IN THE FACT THAT YOUR ORGANIZATION IS CONCERNED ABOUT PRIVACY AND RECOGNIZES ITS IMPORTANCE IN PROVIDING QUALITY HEALTHCARE.

IF A LOCAL FACILITY IS DISTRIBUTING THIS TRAINING, THE FOLLOWING INFORMATION MAY BE PROVIDED TO VOLUNTEERS:

HOSPITAL PRIVACY OFFICER

JOSEPH PICKLO IS OUR FACILITY PRIVACY OFFICER, AND THEIR PHONE NUMBER IS 216-791-3800 EXT.5539

VOLUNTEERS WITH ANY QUESTIONS SHOULD FIRST CONTACT THE VOLUNTARY SERVICE OFFICE *(216-791-3800 EXT.5110)*, AS WE CAN MOST LIKELY PROVIDE ANY ADDITIONAL INFORMATION YOU NEED TO KNOW.

U.S. Department of Veterans Affairs

Louis Stokes Cleveland VA Medical Center

Name: _____ **Location/County:** _____

Initial / Date

_____ Voluntary Application completed & Patient data sheet dropped off to Personnel Health

_____ **LEIE** – Completed and cleared

_____ **Finger prints: PIV Office (Room: 1B-467, 216-791-3800 ext.4610)**

Please bring two forms of ID with you. Common documents are: Driver's License, Birth Certificate, Passport, or Social Security Card. At least one needs to be a photo ID.

_____ **Interview - Voluntary Service will conduct interviews 0900-1500 Tuesdays and Thursdays by phone or in person**

VAVS Interviewer: _____

_____ **TB test (PPD): Report to blood draw Wade Park**

_____ **Employee Health Physical Pass** _____ **Fail** _____

(Employee Health Employee Circle and initial one)

_____ **Complete required TMS training.**

_____ **PIV Card has been issued and picked up by volunteer.**

Please bring two forms of ID with you. Common documents are: Driver's License, Birth Certificate, Passport, or Social Security Card. At least one needs to be a photo ID

_____ **Orientation: Date will be given after everything has been completed on this list**

Location: Recreation Hall

You are scheduled to attend on: _____ at: _____

_____ **Placement and tour**