OMB Number:
Respondent Burden: 5 minutes

Department of Veterans Affairs

CROSS COUNTRY SKI INSTRUCTOR PERSONNEL APPLICATION

[ ] NATIONAL DISABLED VETERANS WINTER SPORTS CLINIC
SNOWMASS VILLAGE AT ASPEN, COLORADO

PRIVACY ACT: 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.

RESPONDENT BURDEN: 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 5 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the forms. 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.

This application must be FULLY completed. ***(Please type or Print)***

NAME *(Last, First, Middle Initial)*	ADDRESS *(City, State and Zip Code)*	DATE OF BIRTH

DAYTIME PHONE NUMBER *(Include area code)*	EVENING PHONE NUMBER *(Include area code)*	E-MAIL ADDRESS	PREVIOUS VOLUNTEER *(If yes, how many years* [ ] NO [ ] YES _____

OCCUPATION	DEPARTMENT OF VETERANS AFFAIRS EMPLOYEE [ ] YES [ ] NO	IF THIS IS YOUR FIRST YEAR, WHO REFERRED YOU TO THE WINTER SPORTS CLINIC	ARE YOU CAPABLE OF BEING A PRIMARY INSTRUCTOR [ ] YES [ ] NO

NAME OF FACILITY / FACILITY DIRECTOR'S NAME	FACILITY ADDRESS *(City, State and Zip Code)*	PSIA ADAPTIVE CERTIFICATION? [ ] LEVEL I [ ] LEVEL II [ ] LEVEL III [ ] NONE CERTIFICATION IS IN _____

CAN YOU TEETHER A [ ] BI-SKI [ ] 4 TRACKER	TEACHING PREFERENCE *(1st & 2nd preference)*	REQUEST FOR PREVIOUS STUDENT'S

I support the above named individuals application to participate in the [ ] National Disabled Veterans Winter Sports Clinic. ***(Government Employees ONLY)***

IMMEDIATE SUPERVISOR'S SIGNATURE [ ] APPROVED [ ] DISAPPROVED	DIRECTOR'S NAME [ ] APPROVED [ ] DISAPPROVED

SKI INFORMATION

LIST YEARS OF TEACHING AS A ***PRIMARY*** INSTRUCTOR	LEVEL OF TEACHING ABILITY *(Please be accurate)*

WHERE ARE YOU CURRENTLY TEACHING **ADAPTIVE** SKIING?	DO YOU TEACH [ ] FULL TIME [ ] PART TIME	HOW MANY **ADAPTIVE** LESSONS DO YOU TEACH A WEEK?	IS THE WSC THE ONLY TIME YOU TEACH? [ ] YES [ ] **NO**

ABILITY LEVEL: B=BEGINNER; I=INTERMEDIATE; A=ADVANCED **(SIT-SKI AND SNOWSHOE PERTAIN TO NORDIC INSTRUCTORS)**

SKI TYPE	YEARS OF EXPERIENCE	ABILITY LEVEL	SKI TYPE	YEARS OF EXPERIENCE	ABILITY LEVEL
SNOWSHOE			SIT-SKI		

PLEASE LIST ANYTHING YOU DO NOT WANT TO TEACH OR ARE UNCOMFORTABLE TEACHING

IF YOU ARE A BUDDY, PLEASE FILL OUT THE ABOVE INFORMATION AND WRITE IN THE FOLLOWING SPACE THAT YOU ARE A BUDDY/ASSISTANT	PLEASE LIST A POC WHO CAN CONFIRM YOUR TEACHING EXPERIENCE *(Name)*	POC TELEPHONE NUMBER *(Include area code)*

MEDICAL DATA SHEET - THIS MUST BE FULLY COMPLETED

***NOTE**: If you have ANY changes in your medical condition notify your WSC supervisor immediately.*

IN CASE OF EMERGENCY, NOTIFY *(This is required for you to attend the WSC)*

NAME	RELATIONSHIP	DAYTIME PHONE NUMBER	EVENING PHONE NUMBER

MEDICAL HISTORY - *(Do you have any of the following? If yes, please explain and list current medications)*

HEIGHT	WEIGHT	GENDER	AGE
_____ *(inches)*	_____ *(pounds)*	☐ MALE ☐ FEMALE	_____

ALLERGIES ☐ NO ☐ YES IF YES, EXPLAIN _____

HEART PROBLEMS ☐ NO ☐ YES IF YES, EXPLAIN _____

DIABETES ☐ NO ☐ YES IF YES, EXPLAIN _____

HIGH BLOOD PRESSURE ☐ NO ☐ YES IF YES, EXPLAIN _____

BACK PROBLEMS ☐ NO ☐ YES IF YES, EXPLAIN _____

LIFTING RESTRICTIONS ☐ NO ☐ YES IF YES, EXPLAIN _____

OTHER *(Please specify)* ☐ NO ☐ YES IF YES, EXPLAIN _____

LIST PREVIOUS SURGERIES _____

PLEASE RETURN THIS FORM BY _____
RETURN COMPLETED FORMS TO:

Teresa Parks (11K) Teresa.Parks@va.gov
VA Medical Center
2121 North Avenue
Grand Junction, Colorado 81501
970-263-5040 or Fax 970-244-7726