OMB Number:
Respondent Burden: 5 minutes

Department of Veterans Affairs

# DOWNHILL 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 [ ] SNOWBOARDER | 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**

| SKI TYPE | YEARS OF EXPERIENCE | ABILITY LEVEL | SKI TYPE | YEARS OF EXPERIENCE | ABILITY LEVEL |
|---|---|---|---|---|---|
| 3 TRACK | | | TBI/COG | | |
| 4 TRACK | | | HEARING IMP. | | |
| MONO-SKI | | | SNOWBOARD | | |
| BI-SKI | | | VI | | |

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)*

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**