OMB Number:
Respondent Burden: 5 minutes

Department of Veterans Affairs

VOLUNTEER 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 _____

SHIRT SIZE *(Check one)*	ARE YOU A VETERAN OF THE ARMED FORCES	IF THIS IS YOUR FIRST YEAR, WHO REFERRED YOU TO THE WINTER SPORTS CLINIC	DEPARTMENT OF VETERANS AFFAIRS EMPLOYEE
[ ] SMALL [ ] X-LARGE [ ] MEDIUM [ ] XX-LARGE [ ] LARGE	[ ] NO [ ] YES		[ ] NO [ ] YES

NAME OF FACILITY	FACILITY DIRECTOR'S NAME	FACILITY ADDRESS *(City, State and Zip Code)*

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
_____		_____	

ARE YOU ATTENDING AS *(Check one)*
[ ] TEAM LEADER [ ] ALTERNATE ACTIVITIES [ ] HOST ROOM [ ] TRANSPORTATION [ ] OTHER *(Please specify)*

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 *(Include area code)*	EVENING PHONE NUMBER *(Include area code)*

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