



## 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 <i>(Include area code)</i>	CELL PHONE NUMBER <i>(Include area code)</i>	E-MAIL ADDRESS		PREVIOUS VOLUNTEER <i>(If yes, how many years)</i> <input type="checkbox"/> NO <input type="checkbox"/> YES _____
OCCUPATION	DEPARTMENT OF VETERANS AFFAIRS EMPLOYEE <input type="checkbox"/> YES <input type="checkbox"/> NO	IF THIS IS YOUR FIRST YEAR, WHO REFERRED YOU TO THE WINTER SPORTS CLINIC	ARE YOU CAPABLE OF BEING A PRIMARY INSTRUCTOR <input type="checkbox"/> YES <input type="checkbox"/> NO	
NAME OF FACILITY	FACILITY ADDRESS (City, State and Zip Code)		PSIA ADAPTIVE CERTIFICATION? <input type="checkbox"/> LEVEL I <input type="checkbox"/> NONE <input type="checkbox"/> LEVEL II CERTIFICATION IS IN <input type="checkbox"/> LEVEL III _____	
FACILITY DIRECTOR'S NAME				
CAN YOU TEETHER A <input type="checkbox"/> BI-SKI <input type="checkbox"/> 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 _____	<input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED	DIRECTOR'S NAME _____	<input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED
---	---	--------------------------	---

#### SKI INFORMATION

LIST YEARS OF TEACHING AS A PRIMARY INSTRUCTOR _____		LEVEL OF TEACHING ABILITY <i>(Please be accurate)</i> _____		
WHERE ARE YOU CURRENTLY TEACHING ADAPTIVE SKIING? _____	DO YOU TEACH <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME	HOW MANY ADAPTIVE LESSONS DO YOU TEACH A WEEK? _____	IS THE WSC THE ONLY TIME YOU TEACH? <input type="checkbox"/> YES <input type="checkbox"/> 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	CELL PHONE NUMBER
------	--------------	----------------------	-------------------

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

HEIGHT  <i>(inches)</i>	WEIGHT  <i>(pounds)</i>	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	AGE  _____
-------------------------------	-------------------------------	---	------------------

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