Hello Volunteer Applicant,

Thank you for your interest in volunteering at the VA Long Beach Health Care System. Voluntary Service has many volunteer opportunities within the Medical Center and Outpatient Clinics, we will do our best to find something that suits your goals and meets the needs of our patients.

We do ask that all new volunteers serve on a 90-day probationary period where you will become familiar with the hospital’s daily operations and patient needs. Please complete all forms, orientation and TMS training before calling for an interview.

Once completed please contact Voluntary Service at (562) 826-5715 and schedule an in-person interview with one of our Program Assistants. If you have any questions or need further assistance, please call (562)826-5715 and our Program Assistants will be happy to assist with any question.

Please Bring your Social Security Card and Government ID/DL to ALL appointments and interviews.

Steps within your process:
1. Complete the Volunteer Application and supporting documents.
2. Complete Orientation-review PowerPoint and sign acknowledgment form at the end. (Please bring with you the day of your interview).
3. Complete Medical Screening Forms-Must be done prior to interview.
4. Contact Voluntary Service Staff for interview
5. Complete Face-to-Face interview with supervisor.
6. Fingerprinting (If applicable)
7. Laboratory appointment (Bring shot records for vaccination review or have blood drawn to verify vaccinations)
8. Await background clearance
9. Create TMS (Talent Management System) account and complete mandatory training (Must be completed after FP/TB clearance)
10. Contact Voluntary Service Staff approximately 3 weeks following interview for update.
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  

Volunteer Signature  

I hereby accept the volunteer appointment(s) as outlined above.

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.)

Office Use Only

1. SUPERVISOR  
2. SUPERVISOR PHONE NUMBER  
3. ORIENTATIONS  
4. UNIFORM

Comments  

NAME AND TITLE OF REVIEWER  

Date
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.
As part of your registration process to volunteer, you have been scheduled for a Medical Screening at
*Occupational Health Clinic (OHC), Bldg. 8, Room 119. OHC is located down the hallway from the
Veteran Service Organization (VSO Office) on the first floor. Map is attached.

Name: ___________________________ Last 4 SSN: ________ DOB: ______________

Medical Screening Appointment Date: ______________ Time: ____________

1. **TB Screening / Titer Laboratory:** * Report to Occupational Health Clinic not the Laboratory.
   - Quantiferon-Gold (QFT) – Blood Test for Tuberculosis (TB)
   - Titers for MMR (Measles, Mumps, Rubella), Varicella Titer, Hepatitis B Titer.

   *** If you need to re-schedule your appointment, call Voluntary Services at (562) 826-5715.
   Please call at least 48 hours prior to your appointment.

2. **Medical Clearance - Follow up Blood Test Results**
   - If cleared, Occupational Health will update your medical status in the Voluntary Services
     Department record. Call Voluntary Services Department 562-826-5715 after 7 days of your
     blood test to check if you are medically cleared.
   - If you are not medically cleared, you will be instructed to return to Occupational Health
     Clinic so OH can go over lab results.
   - If you need a copy of the Lab results, fill-out the attached Request Form (VA Form 5345a).
   - Location: *Occupational Health Clinic (OHC), Bldg. 8, Room 119
     Best Time: 08:00 -10:30 am and 12:30 – 2:30 pm

3. **This packet includes the following forms that must be filled out prior to your appointment**
   (Complete highlighted areas on attached pages as it applies to you).

   **Forms / Map:**
   - Employee Health Record (VA Form 3831a)
   - Notice of Privacy Practices (VA Form 10-0483)
   - Titers and Immunization Checklist
   - Parental Consent for QFT Testing & Medical Clearance (for volunteers under 18 y/o only)
   - Individuals’ Request for a Copy of their own Health Information (VA Form 5345a)
   - Map / Route Guide from Voluntary Services to Occupational Health Clinic

4. **Volunteers must:**
   - Plan to arrive at least 15 minutes prior to scheduled appointment time.
   - Bring Social Security Card and Picture ID i.e. state-issued Driver’s License, or other state or
government identification card, School ID, passport, etc.
   - Bring your latest immunizations records
**Employee Health Record**

### Personal Information
- **Employee's Name**:
- **Address**: (Number, Street, City, State and ZIP code)
- **Home Phone**: 
- **Office Phone**: 
- **Social Security No.**:  
- **Date of Birth**:  
- **Sex**:  
- **Marital Status**:  
- **Position Title**:  
- **Department, Service, and/or Division**: Voluntary Services
- **Room No.**:  
- **Extension**:  
- **Volunteer Supervisor's Name**:  
- **Supervisor's Extension**:  
- **Volunteer Title**:  

### Physician Information
- **Physician's Name**: (Last, first, middle initial)  
- **Physician's Address**: (Number, Street, City, State and ZIP code)

### Medical History
- **Date**:  
- **Time**:  
- **History, Findings, Diagnosis, Examination or Test Required**:  
- **Treatment, Health, Guidance or Examination and Test Results**:  
- **Treated by or Examined or Treated by**:  
- **IN**:  
- **OUT**:  

### Drug Sensitivities / Allergies

### Privacy Act Notice
Section 7901 of Title 5, United States Code, is the basic legal authority for providing occupational health services to Federal employees. Office of Employee Health Program, to assist employees in case they suffer a medical emergency at work, and to develop statistical medical reports for the Office of Management and Budget Circular A-72 provides for the maintenance and control of employee health program. However, the VA needs this information to develop and maintain an efficient employee health records. Provision of this information is voluntary.
Acknowledgement of Department of Veterans Affairs, Veterans Health Administration (VHA)
Notice of Privacy Practices

The signature below only acknowledges receipt of the VHA Notice of Privacy Practices, effective date 23 September 2013.

<table>
<thead>
<tr>
<th>Signature of Patient/Patient Representative</th>
<th>Date</th>
</tr>
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<tbody>
<tr>
<td>Name of Patient/Representative</td>
<td>Relationship to patient (if applicable)</td>
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<tr>
<td>Last Four SSN</td>
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</tbody>
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Signature of Employee | Date of Visit | Signature of Employee | Date of Visit
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<th>IMMUNIZATIONS</th>
<th>DATE</th>
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<td>MUMPS TITER</td>
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<tr>
<td>MEASLES TITER</td>
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<tr>
<td>RUBELLA TITER</td>
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<tr>
<td>VARICELLA TITER</td>
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<td>MMR #1</td>
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<td>MMR #2</td>
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<td>VARICELLA #1</td>
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<td>HEP B ANTIBODY TITER</td>
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<tr>
<td>INFLUENZA VACCINE</td>
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</tbody>
</table>

**NAME:** ________________________________  **ALLERGIES:** ________________________________

**LAST 4 SSN:** ________________________________  ________________________________

Ver. Jan 2018
Parental Consent for QFT Testing and Medical Clearance

All volunteer and employees are required to undergo tuberculosis (TB) screening prior to beginning work at our facility. Quantiferon is a blood test used to screen for tuberculosis.

Individuals who have a positive QFT test are required to provide proof of a negative chest x-ray within the last 6 months as well as a tuberculosis questionnaire.

<table>
<thead>
<tr>
<th>Name of Minor:</th>
<th>Birth Date:</th>
<th>Social Security #:</th>
</tr>
</thead>
</table>

Has your child:

- Had a TB skin test in the last 12 months? [ ] Yes [ ] No
- Ever have a positive TB skin test? [ ] Yes [ ] No

Please list any allergies that your child has:

Please list any medical conditions that your child has that may affect his/her ability to perform tasks at this facility:

I give permission for my son/daughter to have Quantiferon-TB Gold blood test done at the VA Long Beach Medical Center. I also give permission for my child to be treated for minor injuries that may occur during his/her volunteer service.

<table>
<thead>
<tr>
<th>Signature of Parent or Guardian:</th>
<th>Date:</th>
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<table>
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<tr>
<th>Printed Name of Parent or Guardian:</th>
<th>Phone number where parent can be reached:</th>
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</table>

If you have any questions or concerns, please feel free to accompany your child to his/her Occupational Health Clinic appointment.

April 2018
INDIVIDUALS' REQUEST FOR A COPY OF THEIR OWN HEALTH INFORMATION

PRIVACY ACT INFORMATION

The purpose of this form is to provide an individual the means to make a written request for a copy of their information maintained by the Department of Veteran Affairs (VA) in accordance with 38 CFR 1.577. The information on this form is requested under Title 38 U.S.C. Your disclosure of the information requested on this form is voluntary. However, if the information including the last four of your Social Security Number (SSN) and Date of Birth (used to locate records for release) is not furnished completely and accurately, VA will be unable to comply with the request. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled.

TO: DEPARTMENT OF VETERANS AFFAIRS (Name and Address of VA Health Care Facility)
TIBOR RUBIN VA MEDICAL CENTER
ATTN: OCCUPATIONAL HEALTH CLINIC
5901 E. SEVENTH STREET
LONG BEACH, CA 90822

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MIDDLE INITIAL</th>
<th>LAST 4 SSN</th>
<th>DATE OF BIRTH</th>
</tr>
</thead>
</table>

DESCRIPTION OF INFORMATION REQUESTED

Check applicable box(es) and state the extent or nature of information to be provided:

☐ HEALTH SUMMARY (Prior 2 Years) ________________________________________________________________

☐ INPATIENT DISCHARGE SUMMARY (Dates): _________________________________________________________

☐ PROGRESS NOTES:
  ☐ SPECIFIC CLINICS (Name & Date Range): _______________________________________________________
  ☐ SPECIFIC PROVIDERS (Name & Date Range): _____________________________________________________
  ☐ DATE RANGE: ______________________________________________________________________________

☐ OPERATIVE/CLINICAL PROCEDURES (Name & Date): _________________________________________________

☐ LAB RESULTS:
  ✗ SPECIFIC TESTS (Name & Date): **QFT / TITERS**
  ☐ DATE RANGE: **Most current results**

☐ RADIOLOGY REPORTS (Name & Date): _____________________________________________________________

☐ LIST OF ACTIVE MEDICATIONS _________________________________________________________________

☐ OTHER (Describe): _____________________________________________________________

COPY OF HEALTH INFORMATION IS TO BE DELIVERED TO THE INDIVIDUAL

☐ PAPER ☐ CD-ROM ☐ OTHER: ____________________________

☐ IN-PERSON PICK-UP, PROVIDE CONTACT PHONE NUMBER: _________________________________________

☐ MAIL TO ADDRESS: _____________________________________________________________

PATIENT SIGNATURE *(Sign in ink)* DATE (mm/dd/yyyy)

NOTE: If signed by someone other than the individual, indicate the authority (e.g. guardianship or power of attorney) under which request is made.
HOW TO SELF-ENROLL INTO TMS 2.0 – VOLUNTEERS
A HOW-TO GUIDE FOR VA LONG BEACH NON-EMPLOYEE VOLUNTEERS TO REGISTER IN THE TALENT MANAGEMENT SYSTEM (TMS)

1. CLICK (or paste to browser) https://www.tms.va.gov/SecureAuth35/ (Save this link to favorites on your computer.)

2. Select CREATE NEW USER

3. Select VETERANS HEALTH ADMINISTRATION (VHA) and click NEXT

![Veterans Health Administration (VHA)](image)

The VHA is the nation’s largest health care system, administering TMS hospitals, clinics, community-living centers, domiciliaries, extended care homes, and other facilities.

4. Select VOLUNTEER and click on NEXT

- Volunteer (Those volunteering for VA without VA compensation)

5. Create a PASSWORD following the guidelines presented

6. Fill in all asterisked (*) information about yourself accurately. The password requirements are quite rigid, please read the requirements and when you’ve created a password notate it somewhere.

7. Complete MY JOB INFORMATION, including all requested POINT OF CONTACT information.
   a. Location Code: You must click the funnel to the right of the empty text field.
   b. VA Location:
   c. Then enter LON in the search filed and click Search. Select VA Long Beach.
   d. VA Point of Contact First Name: Willie
   e. VA Point of Contact Last Name: Raiford
   f. VA Point of Contact email address: willie.raiford@va.gov
   g. VA Point of Contact phone number: 562-826-8000 extension: 24677
   h. HIPAA Training Required: Check This Box
8. When you complete this page, click Submit.

9. You will then be taken to the “Congratulations” page where you can copy your USER NAME (initially, your email address).

10. After 20 minutes have passed, please return to https://www.tms.va.gov/SecureAuth35/. Enter your User Name and click “Submit”. You can then send a one-time passcode to your email address.

11. You will then be asked to create your security questions. You will use these to get a new password if you forget your current one. After selecting your questions & answers, click the SAVE button. Remember these ANSWERS ARE CASE SENSITIVE.

12. On your TMS home page you will find your required training course(s).