

Assignment: \_\_\_\_\_  
 Schedule: \_\_\_\_\_  
 Date: \_\_\_\_\_

**CONNECTICUT VETERANS HOME - VOLUNTEER APPLICATION**

**(Please Print)**

<b>Name:</b>		LAST	FIRST	MIDDLE INITIAL
<b>Address:</b>		STREET	CITY:	STATE: ZIPCODE
<b>Date of birth:</b>	MONTH	DAY	YEAR	<b>Phone #</b>
<b>Person to contact in case of emergency:</b>	Name	Address	Phone Number	Cell Phone Number
<b>REFERENCES: Please provide COMPLETE mailing address</b>				
	NAME	ADDRESS	PHONE	YRS KNOWN

- 1.
- 2.
- 3.

<b>What skills or hobbies would you like to share?</b>	Please circle	Musical performance	Art	Reading	Writing
		Library Cart	Pet Therapy	Wheelchair Escort	Board and Card Games
		Wii games	Computer helper	Memory Books	Bulletin Boards
	Other: (please explain)				

**Volunteers are asked to commit a minimum of 3 hours per month**  
**Hours for all volunteers: 9:30am to 3:30 pm, Monday – Friday, additional hours by arrangement**

<b>I would like to work:</b>	Monday	Tuesday	Wednesday	Thursday	Friday			
<b>(please circle)</b>	am/pm	am/pm	am/pm	am/pm	am/pm			
<b>I am ONLY available evenings or weekends. Please check here _____.</b>	Which evenings (6 to 9 pm)? (circle)			M	Tu	W	Th	F
	Weekend times			Sat (am or pm)	Sun (am or pm)?			

Are you volunteering in affiliation with a veteran's organization/church/school, other group or special program?  
 \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes please provide name of group/church/school or special program:

**I agree to complete training classes, honor patient privacy rules and be available a minimum of: 1 day per week \_\_\_\_\_ or 1 day per month \_\_\_\_\_ for a minimum of 3 hours per month.**

<b>Signature:</b>	<b>Date:</b>
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Revised 07/2011

Please Return to: [barbara.vaillancourt@po.state.ct.us](mailto:barbara.vaillancourt@po.state.ct.us) or  
 Barbara Vaillancourt  
 Department of Veterans' Affairs, 287 West Street, Rocky Hill, CT 06067

**DEPARTMENT OF VETERANS AFFAIRS  
Rocky Hill, CT**

**Name:** \_\_\_\_\_  
**Assignment:** \_\_\_\_\_

**Volunteer Medical History Form**

Volunteers of the Department of Veterans' Affairs, Rocky Hill, CT, involved in direct patient care are required to have a medical history submitted for purposes of health maintenance of the individuals and patients during the course of the volunteer's work. A physical examination performed by the Volunteer's private physician may be required if the medical history indicates a possible health problem(s).

**Medical History** (to be completed by the applicant) This history will be kept confidential.

<b>Name:</b>	LAST	FIRST	MIDDLE		
<b>Have you any mental or physical disabilities at this time</b>	Please circle: Yes                      No                      If yes please explain:				
<b>List major illnesses and operations you have had</b>					
<b>Condition</b>	<b>Yes</b>	<b>No</b>	<b>Condition</b>	<b>Yes</b>	<b>No</b>
Heart Disease			Joint Disease or "Trick Joint"		
Lung Disease			Backache or Back Problems		
Asthma			Sciatica or any Neuritis		
Shortness of breath			Epilepsy or Convulsions		
Blood Conditions			Head injury or loss of consciousness		
Tuberculosis			Alcohol or Drug Addiction		
Positive Tuberculin Test			Mental Disorder		
Liver Condition			Eye Disorder		
Rheumatism or Arthritis			Ear Disorder		
Chronic Diarrhea			Chronic Cough		
Chicken Pox			Measles		
If you answered yes to any of the above please give a brief explanation:					
<b>TB SKIN TEST* PPD Performed - Date</b>					

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Reviewed by Hospital Epidemiologist:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physical Exam Required: NO** \_\_\_\_\_ **YES** \_\_\_\_\_

\*TB test can be performed at Veterans Home clinic. Call 860-616-3734 for appointment.