

APPLICATION FOR VOLUNTEER SERVICE

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Address	City	1	State	Zip
Email				
Mobile Phone	Home Phone		Wo	ork Phone
Community/Club Affiliations				
Previous Volunteer Experience				
Present Occupation	Em	ployer		
Reason For Volunteering				
Special Skills - Abilities - Interests				
Name				
Address	Em	ail		Phone
Name				
Address	Em	ail		Phone
Name				
Phone	Relationship			

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APPROVAL FOR MINORS

Signature

I certify that all statements on this application are true and complete to the best of my knowledge. I grant permission to the Veterans Home at Holyoke (VHH) to investigate references needed to complete the application process, and I release the same from any liability resulting from such investigation. Volunteers who are at least 18 years old acknowledge that they will be subject to and must be cleared by a criminal background check. If selected as a volunteer, I understand that any omission, misrepresentation, or falsification of this record may be considered cause for removal. If selected as a volunteer, I will be required to attend a Volunteer Orientation as well as additional training where necessary. I will be required to sign a Confidentiality Agreement for Volunteers. I agree to observe all VHH regulations and policies. I understand that Volunteers are not covered by Worker's Compensation and that I am responsible for maintaining my own health insurance. I voluntarily offer my services with a clear understanding there will be no monetary compensation and that volunteering does not lead to employment.

Date

To be completed by Parent/Guardian if under 18 years of age: teer for the Veterans Home at Holyoke and receiving emergence	, , , , , , , , , , , , , , , , , , , ,
Parent/Guardian Name (Please print)	
Signature	Date

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VACCINATION STATUS

All staff and volunteers are mandated to up to date for COVID-19 and Influenza vaccinations. However, should you choose to opt-out, you are obligated to complete an exemption form. This form will require you to acknowledge your awareness of the associated risks and benefits and formally decline the vaccination(s).

Yes, I am up to date for:

- COVID-19
- Influenza vaccinations

No, I will complete a exemption form for:

- □ COVID-19
- ☐ Influenza vaccinations

Signature (I attest that the above information is true)

COVID-19 will be within our community for the foreseeable future. We must remain vigilant in our efforts to follow strict infection control protocols to keep veteran residents, staff and our volunteers safe.

- All staff and volunteers are required to ahere to current PPE requirements. Signs are posted to let you know what PPE is required at the time.
- At times you may be required to participate in outbreak testing, outbreak testing occurs when you were exposed to somone with COVID-19. The tests are provided at no cost to you.
- There may be times when we will suspend volunteer activity. We will reach out to you if this occurs.
- If you are not feeling well, or if you have been in contact with someone who has COVID-19, please stay home.
- If you have any questions or concerns about any of the above information, please call the Volunteer Coordinator at 413-552-

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I,	HH nclude, nsta- s sole title orm			
 health care environment for eligible veterans who reside in the Commonwealth of Massachusetts. I hereby forever release and discharge VHH from any and all claims, debts and demands, liabilities or causes of action every kind, character and nature, whether known or unknown, which I may now have or at any time hereafter have aga SHH arising from the use of my likeness and Biographical Information as described above. I understand that I do not have to sign this consent and that I am free to refuse to permit the use of my likeness and Biographical Information. This Agreement is entered into under the laws of the Commonwealth of Massachusetts. I hereby consent to such use I 	ainst o-			
signing this consent of my own free will.				
Signature Date				
If a minor, provide the signature of a parent or legal guardian below, we cannot accept volunteers under the age of 16:				
Printed Name				
Signature Date				

Due to the scope of patient confidentiality, an agreement between the VETERANS HOME AT HOLYOKE and the VOLUNTEER named below is required. This Agreement demands that all veteran contact, whether verbally communicated or written in the veteran's medical records shall be kept confidential. In no way shall any information learned through conversation or documents be discussed or divulged to any party within or outside the Veterans Home at Holyoke. No copies of any written or documented material of a confidential nature shall be taken off these premises. If any breach of confidentiality is discovered, serious consequences may result, including dismissal from the Veterans Home.

Volunteer Signature Date



THE COMMONWEALTH OF MASSACHUSETTS **EXECUTIVE OFFICE OF PUBLIC SAFETY AND SECURITY**

Department of Criminal Justice Information Services 200
Arlington Street, Suite 2200, Chelsea, MA 02150
TEL: 617-660-4640 | TTY: 617-660-4606 | FAX: 617-660-5973

MASS.GOV/CJIS



This form is not to be faxed. Please return form to organization .

Criminal Offender Record Information (CORI) Acknowledgement Form

To be used by organizations conducting CORI checks for employ	ment or licensing purposes.
	is registered under the
(Organization)	
provisions of M.G.L. c.6, § 172 to receive CORI for the purpose of screening cur employees, subcontractors, volunteers, license applicants, or current licenses	
As a prospective or current employee, subcontractor, volunteer, license applic CORI check will be submitted for my personal information to the DCJIS. I here	•
(Organization)	
to submit a CORI check for my information to the DCJIS. This authorization i signature. I may withdraw this authorization at any time by providing	is valid for one year from the date of my
	(Organization)
with written notice of my intent to withdraw consent to a CORI check.	
I also understand, that	may conduct
(Organization)	
subsequent CORI checks within one year of the date this Form was signed by m	ne.
By signing below, I provide my consent to a CORI check and affirm that the Acknowledgement Form is true and accurate.	e information provided on Page 2 of this
	 Date



THE COMMONWEALTH OF MASSACHUSETTS EXECUTIVE OFFICE OF PUBLIC SAFETY AND SECURITY

Department of Criminal Justice Information Services 200 Arlington Street, Suite 2200, Chelsea, MA 02150 TEL: 617-660-4640 | TTY: 617-660-4606 | FAX: 617-660-5973 SIGNATURE TO STORY TO THE STORY

SUBJECT INFORMATION

MASS.GOV/CJIS

Please complete this section using the information of the person whose CORI you are requesting.

The fields marked with an asterisk (*) are required fields.

* First Name:	Middle Initial:
* Last Name:	Suffix (Jr., Sr., etc.):
Former Last Name 1:	
Former Last Name 2:	
Former Last Name 3:	
Former Last Name 4:	
* Date of Birth (MM/DD/YYYY): Plac	e of Birth:
* Last SIX digits of Social Security Number:	
Sex: Height: ft in. Eye	Color: Race:
Driver's License or ID Number:	State of Issue:
Father's Full Name:	
Mother's Full Name:	
Current	Address
* Street Address:	
Apt. # or Suite: *City:	
SUBJECT VEF	RIFICATION
The above information was verified by reviewing the followin	
Verified by:	
Print Name of Verifying Employee	
Signature of Verifying Employee	