Certified Administrator of Volunteer Services (CAVS)

2019 Special Paper and Pencil CAVS APPLICATION

Email the completed form with required documentation to Ursula Pawlowski, upawlowski@aha.org by Feb. 1, 2019

NAME: _____

_ *** *Must match government-issued ID in order to gain access to testing room, Feb. 11, 2019, Santa Barbara Room, Hyatt Regency Sacramento.*

OPTIONAL - let us know how you'd like your name to appear on your certificate (if different than your full legal name that appears above):

_____

PREFERRED EMAIL: _____

PHONE NUMBER: *provide at least one where you can be contacted by phone on Feb. 11, 2019.*

Mobile: _____

Work: _____

Home: _____

PREFERRED MAILING ADDRESS:

Your score report and/or credential certificate will be mailed to this address

Please indicate whether this is a ☐ Work - *or* - ☐ Home address

Title (if applicable): _____

Organization (if applicable): _____

Street: _____

City: _____ State: _____ Zip: _____

EXAMINATION TYPE:

☐ I am applying for a special paper-and-pencil CAVS Exam administration:

Date: Feb. 11, 2019, CAHHS Conference, HYATT REGENCY Sacramento, Santa Barbara Room, Sacramento, California

ELIGIBILITY REQUIREMENTS:

To be eligible for the CAVS Examination, a candidate must fulfill one of the following requirements for education / work experience. Please indicate which category applies to you.

☐ Baccalaureate degree or higher plus two (2) years of paid associated professional experience in healthcare volunteer services management*.

☐ Associate degree or equivalent plus three (3) years of paid associated professional experience in healthcare volunteer services management*.

☐ High school diploma or equivalent plus four (4) years of paid associated professional experience in healthcare volunteer services management*.

** Associated professional experience in healthcare volunteer services management refers to paid work experience in a healthcare setting or provider of services to a healthcare facility in planning and program development, management of personnel and finances, organization and delivery of services, outreach, advocacy, public relations and professional development.*

☐ In addition, I confirm that at least 50% of my current position is related to volunteer management

RESUME: Please submit a copy of your resume with this application.

MEMBERSHIP STATUS and DISCOUNT:

To be eligible for the reduced CAVS examination fee, a candidate must be a current member of AHVRP. For information on joining the Association for Healthcare Volunteer Resource Professionals (AHVRP), visit www.ahvrp.org. Membership status will be verified by AHVRP.

EXAMINATION FEE: ☐Member of AHVRP: $300 ☐Non-member: $475

☐ Re-take fee (up to 12 months from initial exam: $95

PAYMENT OPTIONS:

☐ **Check:** Make checks payable to AHVRP. All checks and money orders must be in USD. You are responsible for any service fees incurred by returned checks.

☐ **Credit Card:** Credit card payments are accepted by phone only. Once your application has been approved, you will be contacted for payment.

I certify that the information I have submitted in this application is complete and correct to the best of my knowledge and belief. I understand that, if the information I have submitted is found to be incomplete or inaccurate, my application may be rejected or my examination results may be delayed or voided.

Signature:_____ Date:_____

REQUEST FOR SPECIAL EXAMINATION ACCOMMODATIONS

If you have a disability covered by the Americans with Disabilities Act, please complete this form and the Documentation of Disability-Related Needs (see next page) so your accommodations for testing can be processed efficiently. The information you provide and any documentation regarding your disability and your need for accommodation in testing will be treated with strict confidentiality. Please return this form with your examination application and fee to AHVRP, Ursula Pawlowski, upawlowski@aha.org by Feb. 1, 2019.

CANDIDATE NAME: _____

SPECIAL ACCOMMODATIONS

I request special accommodations for the CAVS examination.

Please provide (check all that apply):

- ☐ Special seating or other physical accommodation
- ☐ Reader
- ☐ Extended testing time (time and a half)
- ☐ Separate room (paper-and-pencil administration only)
- ☐ Large print test (paper-and-pencil administration only)
- ☐ Circle answers in test booklet (paper-and-pencil administration only)
- ☐ Other special accommodations
  Please specify:

Comments:

Signed: _____

Date: _____

If you have questions, contact Ursula Pawlowski, AHVRP, upawlowski@aha.org

DOCUMENTATION OF DISABILITY-RELATED NEEDS

Please have this section completed by an appropriate professional (education professional, physician, psychologist, psychiatrist) to ensure that AHVRP is able to provide the required examination accommodations.

Return this form to Ursula Pawlowski, upawlowski@aha.org

If you have questions, contact Ursula Pawlowski, upawlowski@aha.org or 312.422.3725

PROFESSIONAL DOCUMENTATION

I have known _____ since _____ /_____ /_____ in my capacity as a
Examination Candidate Date

_____.
Professional Title

The candidate discussed with me the nature of the examination to be administered. It is my opinion that, because of this candidate's disability described below, he/she should be accommodated by providing the special arrangements listed on the reverse side.

Description of Disability: _____

_____

_____

_____

_____

Signed: _____ Title: _____

Printed Name: _____

Address: _____

_____

Telephone Number: _____

Date: _____ License # (if applicable): _____