Paralyzed Veterans of America

Southeastern Chapter

1. **Volunteer Activation Form**

   New Volunteer, Reactivating Volunteer, or Current Volunteer-Updating Information Should complete the form and email to paravet@comcast.net.

2. **Volunteer Time Sheet**

   Members and Associate Members complete and email your VTS to paravet@comcast.net by 12 noon the 5th of each month for the previous month (your February 2026 VTS is due by 12 noon March 5th) to document your volunteer hours.

   Reference the Sample VTS on how to complete your VTS.

3. **Sample Volunteer Time Sheet**

   This is a sample of how you should complete your VTS.

If you have any questions, please contact us at paravet@comcast.net or 706-796-6301.

Volunteer Activation Form

Paralyzed Veterans of America
Membership & Volunteer Program
1875 Eye Street, NW, Suite 1100 * Washington, DC * 20006
888-838-7782 * Direct Membership Line

☐ New Volunteer ☐ Reactivating Volunteer (number if available) _____

☐ Current Volunteer-Updating information. Volunteer Number: _____

Chapter Name: _____ Date: ___/___/___

First Name: _____ Middle Initial: ____ Last Name: _____

Date of Birth: ___/___/___ (MM DD YEAR) Social Security Number: _____ ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Please provide the following information if you use your personal vehicle for volunteer related duties.

Driver's License # _____ State Held in: _____

EXCESS AUTOMOBILE LIABILITY INSURANCE

Excess automobile liability insurance provides coverage to protect all active registered volunteers who use their personal automobiles for program-related duties. This insurance is over and above their personal auto insurance and only volunteers maintaining required personal liability insurance are eligible for coverage. The volunteer will automatically be covered by this insurance if they have provided a driver's license number and the state in which it is held, when filing out their Volunteer Activation Form. If they do not provide this information they are not entitled to this insurance. If the volunteer enters an inactive status they will not be eligible for this insurance until their status is reactivated.

☐ **I hereby affirmatively waive coverage under the Business Travel Accident Program (see next page).**

NATIONAL OFFICE USE ONLY
Volunteer Identification Number _____

Processed by _____

DATE RECEIVED Process Date ___/___/___

Reset Form

BUSINESS TRAVEL ACCIDENT PROGRAM (BTAP)

This insurance provides 24-hour business travel accident coverage while the volunteer is away from the office performing official PVA business. All registered PVA volunteers are automatically covered under Class III, in accordance with PVA's insurance policy. The BTAP form, naming the beneficiary(ies) can be submitted anytime to National Office. The volunteer will remain insured until they are terminated or become inactive. Volunteers can change their beneficiary(ies) anytime by submitting a new BTAP

BENEFICIARY PROVISION

Affiliation:

☐ PVA Committee Member ☐ National Director

☐ PVA National Employee ☐ Executive Committee ☐ Chapter Employee

☐ Chapter Volunteer - Please provide volunteer number (if known) _____

☐ Other Member _____

DESIGNATION OF BENEFICIARY

Settlement of the proceeds payable under the terms of this policy by reason of death of the insured shall, subject to the applicable provisions printed below, be made in one sum to the beneficiary(ies) herein designated, EXCEPT as may be otherwise indicated by an "X" or check mark in the box preceding 1 below. Please type or print.

☐ 1. Pay proceeds in one sum to THE ESTATE OF THE INSURED.

☐ 2. Pay proceeds to the following beneficiary(ies)):

Name:_____ Relationship to the Insured: _____

Name:_____ Relationship to the Insured: _____

Name:_____ Relationship to the Insured: _____

Any amount payable to a beneficiary shall be paid to the beneficiary(ies) designated by the insured, except that, unless otherwise specifically provided by the insured in his/tier beneficiary designation:

(a) If more than one beneficiary is designated, the designated beneficiaries shall share equally.

(b) If any designated beneficiary predeceases the insured, the share which such beneficiary would have received if surviving the insured shall be payable equally to the remaining designated beneficiary or beneficiaries, if any, who survive the insured.

The General Provisions of this policy shall be considered as part of this Beneficiary Provision where applicable.

Signature of Insured:_____ Date: _____

Reset Form

Volunteer Time Sheet

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Membership & Volunteer Program
1875 Eye Street, NW, Suite 1100 * Washington, DC * 20006
888-838-7782 * Direct Membership Line

First Name: _____ Middle Initial: _____ Last Name: _____

Volunteer Identification Number: _____ Month: _____ Year: _____

Chapter Name: _____

Date	Program Code Number	Hours	Miles	Dollars Reimbursed

Program Codes

1. Service
2. Advocacy / Housing / Barrier-free Design / Employment
3. Research
4. Administrative / Secretarial* *(Chapter Totals Only)*
5. Legislation
6. Hospital Liaison
7. Attendant Program
8. Sports
9. Fundraising* *(Chapter Totals Only)*
10. Membership
11. Other (please specify _____)
12. Executive Committee* (*Chapter Totals Only)*

**Work performed in program code numbers 4, 9, and 12 can only be included as service for the chapters*

Volunteer's Signature _____ Date _____/_____/_____

Volunteer Coordinator's Signature _____ Date _____/_____/_____

04/21

Reset Form

Sample

Volunteer Time Sheet

Paralyzed Veterans of America
Membership & Volunteer Program
1875 Eye Street, NW, Suite 1100 * Washington, DC * 20006
888-838-7782 * Direct Membership Line

First Name: John or Jane Middle Initial: _____ Last Name: Doe

Volunteer Identification Number: _____ Month: Feb Year: 25

Chapter Name: Southeastern

Date	Program Code Number	Hours	Miles	Dollars Reimbursed
2/2	10	3	10	
2/5	10	5	6	

Program Codes

1. Service
2. Advocacy / Housing / Barrier-free Design / Employment
3. Research
4. Administrative / Secretarial* *(Chapter Totals Only)*
5. Legislation
6. Hospital Liaison
7. Attendant Program
8. Sports
9. Fundraising* *(Chapter Totals Only)*
10. Membership
11. Other (please specify _____)
12. Executive Committee* *(Chapter Totals Only)*

2/2 Home to VA 10 miles
2/3 Home to School 6 miles

**Work performed in program code numbers 4, 9, and 12 can only be included as service for the chapters*

Volunteer's Signature John or Jane Doe Date 03/05/2026

Volunteer Coordinator's Signature _____ Date ____/____/____

04/21

Reset Form