



Certified Administrator of Volunteer Services (CAVS)

**2018 APPLICATION**

**Mail the completed form with required documentation to  
CCVA, P.O. Box 2153, San Francisco, CA 94126**

Or scan and email to [cavs@cvacert.org](mailto:cavs@cvacert.org)

**NAME:** \_\_\_\_\_

\*\*\* *Must match government-issued ID in order to gain access to testing center.*

*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* 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 the on-line CAVS Examination.

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

Date: Sept. 29, 2018, 50th Annual AHVRP Conference

Location: HYATT REGENCY O'HARE, ROSEMONT, ILLINOIS

**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](http://www.ahvrp.org). Membership status will be verified by AHVRP.

**EXAMINATION FEE:**       Member of AHVRP: \$250       Non-member: \$425

**PAYMENT OPTIONS:**

- Check:** Make checks payable to CCVA. 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 electronically via PayPal on the CCVA website at [www.cvacert.org](http://www.cvacert.org).
- Purchase Order:** Please attach.
- Please email an invoice to:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I certify that I have read all portions of the CAVS Candidate Handbook including the *Professional Standards of Conduct*. I agree to abide by regulations contained therein. 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 CCVA.

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: \_\_\_\_\_

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CCVA  
P.O. Box 2153  
San Francisco, CA 94126

If you have questions, contact CCVA, [cavs@cvacert.org](mailto:cavs@cvacert.org)

# DOCUMENTATION OF DISABILITY-RELATED NEEDS

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

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If you have questions, contact CCVA at [cavs@cvacert.org](mailto:cavs@cvacert.org)

## 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): \_\_\_\_\_