



SAN FRANCISCO VETERANS AFFAIRS MEDICAL CENTER  
4150 Clement St  
San Francisco, CA 94121  
Phone: 415-221-4810

Dear Resident,

Congratulations on matching at the University of California at San Francisco (UCSF) for your training. As you know, a portion of your training will take place at the San Francisco Veterans Affairs Medical Center (SFVAMC). The SFVAMC has been affiliated with the UCSF School of Medicine for over 50 years and more than 700 UCSF trainees from 36 programs rotate through the SFVAMC annually. We sincerely look forward to working with you and extend a warm welcome.

In order to begin clinical work at the VA, there are several steps to complete:

1. Complete the enclosed checklist and packet of forms
2. VA mandatory on-line training course- A VA staff member will contact you by June 2, 2017 with instructions for completing a VA mandatory on-line training course prior to the start of your clinical work.
3. In person requirements- You will need to complete in-person requirements at the SFVAMC. These items include signing documents, getting fingerprints, a photo, and a PIV identification card. Your UCSF program will let you know the date and time of this. However-
  - a. If you are a *current* UCSF medical student or resident, we ask that you please complete the in-person requirements early, between May 1, 2017 and June 2, 2017 by making an appointment with HR. Please email [v21sfcwoc@va.gov](mailto:v21sfcwoc@va.gov) to schedule an appointment.

If you have questions when completing these steps, please email the Education Office at [v21sfceducation@va.gov](mailto:v21sfceducation@va.gov).

We look forward to meeting you and anticipate that your time at the San Francisco Veterans Affairs Medical Center will be an enriching and valuable addition to your education.

Sincerely,

Handwritten signature of Rebecca Shunk in black ink.

Rebecca Shunk, MD  
Associate Chief of Staff for Education

Handwritten signature of Melissa Bachhuber in black ink, with a circled "MB" initial.

Melissa Bachhuber, MD  
Deputy Associate Chief of Staff for Education

Handwritten signature of Diane Reppun in black ink.

Diane Reppun  
Education Technician, Education



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## TRAINEE CHECKLIST

**Trainee Name:** \_\_\_\_\_

**Program:** \_\_\_\_\_

### COMPLETED FORMS

Please place an X next to each item on this checklist that is completed and return this checklist with your packet.

**Application for Health Professions Trainees – VA Form 10-2850 D**

Complete entire form; answer all questions on each page and sign.

If you are not an American citizen, complete questions 13a, 13b, 13c, or 13d.

If you are a foreign medical graduate, please include your ECFMG number in questions 21a, 21b, and 21c.

**Declaration of Federal Employment VA Form OF-306**

Complete entire form; answer all questions on each page and sign.

**Fingerprint Request Form**

Write legibly, using your legal name, and sign the second page.

**DEA/NPI Card: Complete only if you are a licensed provider with a DEA number and/or have a National Provider Identifier (NPI #)**

### ADDITIONAL INFORMATION

- I am a **current** UCSF medical student and emailed [v21sfcwoc@va.gov](mailto:v21sfcwoc@va.gov) to schedule a Human Resources appointment to complete, in person requirements, for the VA.
- My appointment is scheduled between May 1, 2017 and June 2, 2017.

PLEASE ENSURE THESE FORMS ARE SENT ENCRYPTED IF ELECTRONICALLY SENT TO WOC OFFICE.

For questions regarding **these forms**, email [v21sfcwoc@va.gov](mailto:v21sfcwoc@va.gov).

For **all other** questions, contact the SFVAMC Education Office at [v21sfceducation@va.gov](mailto:v21sfceducation@va.gov).



Department of Veterans Affairs

**APPLICATION FOR HEALTH PROFESSIONS TRAINEES**

SEE LAST PAGE FOR PAPERWORK REDUCTION ACT, PRIVACY ACT AND INFORMATION ABOUT DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER

**INSTRUCTIONS:** Please submit this application furnishing all information in sufficient detail to enable the Department of Veterans Affairs (VA) to determine your eligibility for appointment. Type or print in ink. If additional space is needed, please attach a separate sheet and refer to items being answered by number. Applications for clinical training programs may require additional information. All information required by the training program to which you are applying, as well as information requested on all application forms, must be included.

VA must protect the safety of our patients. Therefore, at some point in the appointment process, you will be asked questions about your physical and mental health. This includes questions as to whether you have received tuberculin testing, hepatitis B vaccinations or any other vaccinations.

1A. NAME (Last, First, Middle)		1B. OTHER NAMES USED	
2. PRESENT ADDRESS (Include ZIP Code)		3A - PRIMARY PHONE (Include area code)	
		3B - ALTERNATE PHONE (Include area code)	
4. SOCIAL SECURITY NUMBER	5A. PRIMARY EMAIL ADDRESS	5B. ALTERNATE EMAIL ADDRESS	6. DATE OF BIRTH (mm/dd/yyyy)
7A. VA TRAINING FACILITY (City, State)		7B. VA TRAINING START DATE (mm/yyyy) <input type="checkbox"/> UNKNOWN	7C. VA TRAINING END DATE (mm/yyyy) <input type="checkbox"/> UNKNOWN

**II - U.S. MILITARY DUTY STATUS**

8A. ARE YOU NOW IN U.S. MILITARY? <input type="checkbox"/> YES (if YES, complete 8c) <input type="checkbox"/> NO	8B. ARE YOU IN THE RESERVES OR NATIONAL GUARD? <input type="checkbox"/> YES (if YES, complete 8c) <input type="checkbox"/> NO	8C. BRANCH OF SERVICE
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**III - CITIZENSHIP**

9A. CITIZENSHIP <input type="checkbox"/> U.S. CITIZEN BY BIRTH <input type="checkbox"/> NATURALIZED U.S. CITIZEN <input type="checkbox"/> NOT A U.S. CITIZEN (Complete item 9B)	9B. COUNTRY OF CITIZENSHIP USA
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NOTE: Complete items 10A, 10B, 10C, or 10D ONLY if you are NOT a U.S. citizen.

10A. IMMIGRANT		10B. EXCHANGE VISITOR		10C. OTHER NON-IMMIGRANT		10D. FORM DS2019
"A" NUMBER	VISA TYPE	VISA NUMBER	VISA TYPE	VISA NUMBER	DO YOU HAVE A VALID DS2019? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DATE	ISSUE DATE	EXPIRATION DATE	ISSUE DATE	EXPIRATION DATE	DATE OF LAST VALIDATION (MM/DD/YYYY)	

**IV- THIS SECTION TO BE COMPLETED BY DESIGNATED EDUCATION OFFICER (DEO) OR DESIGNEE**

11A. The trainee has met all of the criteria of the Trainee Qualifications & Credentials Verification Letter (TQCVL).	<input type="checkbox"/> YES <input type="checkbox"/> NO	
11B. Incomplete items on the TQCVL have been addressed and resolved.	<input type="checkbox"/> YES <input type="checkbox"/> NO	
11C. Special attention has been given to the following items from the application forms.		
11D. Comments:		
11E. This applicant has been approved for appointment.	<input type="checkbox"/> YES <input type="checkbox"/> NO	
11F. Comments:		
12A. SIGNATURE OF FACILITY DESIGNATED EDUCATION OFFICER OR DESIGNEE	12B. TITLE	12C. DATE

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER
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**V- LICENSE, CERTIFICATION, OR REGISTRATION IN CURRENT CLINICAL PROFESSION**

13A. LIST ALL LICENSES, CERTIFICATIONS AND REGISTRATIONS, INCLUDING THE DRUG ENFORCEMENT AGENCY (DEA), THAT YOU HAVE NOW OR HAVE HAD AS A HEALTH PROFESSIONAL, I.E. MEDICAL, NURSING, PHARMACY, ETC.	13B. STATE ISSUING LICENSE	13C. LICENSE, CERTIFICATION OR REGISTRATION NUMBER	13D. EXPIRATION DATE (MM/DD/YYYY)

**VI- LICENSE, CERTIFICATION, OR REGISTRATION IN OTHER/PREVIOUS CLINICAL PROFESSION(S)**

14A. LIST ALL LICENSES, CERTIFICATIONS, AND REGISTRATIONS, INCLUDING DEA, THAT YOU HAVE EVER HAD AS A HEALTH PROFESSIONAL, I.E. MEDICAL, NURSING, PHARMACY, ETC.	14B. STATE ISSUING LICENSE	14C. LICENSE, CERTIFICATION OR REGISTRATION NUMBER	14D. EXPIRATION DATE (MM/DD/YYYY)

15. ENTER YOUR NATIONAL PROVIDER IDENTIFIER (NPI)

**The following two questions apply to both your current health profession and any prior health profession.**

16. DO YOU HAVE PENDING, OR HAVE YOU EVER HAD ANY LICENSE, CERTIFICATION, OR REGISTRATION TO PRACTICE (INCLUDING DEA CERTIFICATE) REVOKED, SUSPENDED, DENIED, RESTRICTED, OR PLACED ON A PROBATIONARY STATUS, OR HAVE YOU EVER VOLUNTARILY RELINQUISHED A LICENSE, CERTIFICATION, OR REGISTRATION IN LIEU OF FORMAL ACTION?  YES - EXPLAIN IN PART XI  NO

17. DO YOU HAVE PENDING, OR HAVE YOU EVER HAD CLINICAL PRIVILEGES AT ANY HEALTH CARE INSTITUTION OR AGENCY REVOKED, SUSPENDED, DENIED, RESTRICTED, LIMITED, OR PLACED ON A PROBATIONARY STATUS, OR HAVE YOU EVER VOLUNTARILY RELINQUISHED CLINICAL PRIVILEGES IN LIEU OF FORMAL ACTION?  YES - EXPLAIN IN PART XI  NO

**VII - EDUCATION AND TRAINING AFTER HIGH SCHOOL THROUGH GRADUATE / PROFESSIONAL SCHOOL. (Continue in Part XI if necessary)**

18A. NAME OF SCHOOL	18B. ADDRESS (City, State, and Zip Code)	18C. START DATE (MM/YY)	18D. (EXPECTED) COMPLETION DATE (MM/YY)	18E. DIPLOMA, DEGREE, OR CERTIFICATE AWARDED OR IN PROGRESS	18F. MAJOR FIELD OF STUDY

**VIII - GRADUATES OF AN INTERNATIONAL MEDICAL SCHOOL**

19A. ARE YOU A GRADUATE OF AN INTERNATIONAL MEDICAL SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO	19B. EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG) CERTIFICATE NUMBER	19C. ECFMG CERTIFICATE DATE
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**IX- INTERNSHIP, RESIDENCY AND FELLOWSHIP TRAINING**

20A. NAME OF HOSPITAL OR INSTITUTION	20B. ADDRESS (City, State and ZIP Code)	20C. SPECIALTY	20D. START DATE (MM/YY)	20E. (EXPECTED) COMPLETION DATE (MM/YY)	20F. NUMBER OF MONTHS COMPLETED



LAST NAME, FIRST NAME, MIDDLE NAME

SOCIAL SECURITY NUMBER

**AUTHORIZATION FOR RELEASE OF INFORMATION**

In order for the Department of Veterans Affairs (VA) to assess and verify my educational background, professional qualifications and suitability for employment, I:

- Authorize VA to make inquiries about me to current and previous employers, educational institutions, state licensing boards, professional liability insurance carriers, other professional organizations or persons, agencies, organizations, or institutions listed by me as references, and to any other sources which VA may deem appropriate or be referred by those contacted;
- Authorize release of such information and copies of related records and documents to VA officials;
- Release from liability all those who provide information to VA in good faith and without malice in response to such inquiries;
- Authorize VA to disclose to such persons, employers, institutions, boards, or agencies identifying and other information about me to enable VA to make such inquiries; and
- Authorize VA to share any information about me with the affiliated institution or training program official.

SIGNATURE OF APPLICANT

DATE

**PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE**

Public reporting burden for this collection of information is estimated to average 30 minutes, including the time for reviewing instructions, searching existing data sources, gathering data, completing, and reviewing the information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to VA Clearance Officer (005R1B), 810 Vermont Avenue NW, Washington, DC 20420. Do not send applications to this address.

**AUTHORITY:** The information requested on this form and Authorization for Release of Information is solicited under Title 38, United States Code, Chapters 73 and 74.

**PURPOSES AND USES:** The information requested on the application is collected to determine your qualifications and suitability for appointment to a VA clinical training program. If you are appointed by VA, the information will be used to make pay and benefit determinations and in personnel administration processes carried out in accordance with established regulations and systems of records.

**ROUTINE USES:** Information on the form may be released without your prior consent outside the VA to another federal, state or local agency. It may be used to check the National Practitioner Health Integrity and Protection Data Bank (HIPDB) or the List of Excluded Individuals and Entities (LEIE) maintained by Health and Human Services (HHS), Office of Inspector General (OIG), or to verify information with state licensing boards and other professional organizations or agencies to assist VA in determining your suitability for a clinical training appointment. This information may also be used periodically to verify, evaluate, and update your clinical privileges, credentials, and licensure status, to report apparent violations of law, to provide statistical data, or to provide information to a Congressional office in response to an inquiry made at your request. Such information may be released without your prior consent to federal agencies, state licensing boards, or similar boards or entities, in connection with the VA's reporting of information concerning your separation or resignation as a professional staff member under circumstances which raise serious concerns about your professional competence. Information concerning payments related to malpractice claims and adverse actions which affect clinical privileges also may be released to state licensing boards and the National Practitioner Data Bank. Information will be stored in a confidential and secure VA database for purposes of processing your application and may be verified through a computer matching program. Information from this form may also be used to survey you regarding employment opportunities in VA and to solicit you perceptions about your clinical training experiences at VA and non-VA facilities.

**EFFECTS OF NON-DISCLOSURE:** See statement below concerning disclosure of your social security number. Completion of this form is mandatory for consideration of your application for a clinical training position in VA; failure to provide this information may make impossible the proper application of Civil Service rules and regulations and VA personnel policies and may prevent you from obtaining employment, employee benefits, or other entitlements.

**INFORMATION REGARDING DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER UNDER PUBLIC LAW 93-579 SECTION 7(b)**

Disclosure of your Social Security Number (SSN) is mandatory to obtain the employment and benefits that you are seeking. Solicitation of the SSN is authorized under provisions of Executive Order 9397 dated November 22, 1943. The SSN is used as an identifier throughout your Federal career. It will be used primarily to identify your records. The SSN also will be used by Federal agencies in connection with lawful requests for information about you from former employers, educational institutions, and financial or other organizations. The information gathered through the use of the number will be used only as necessary in personnel administration processes carried out in accordance with established regulations and published notices of systems of records, 'Applicants for Employment' under Title 38, U.S.C.-VA (02VA135), in the 2003 Compilation of Privacy Act Issuances. The SSN will also be used for the selection of persons to be included in statistical studies of personnel management matters. The use of the SSN is necessary because of the large number of Federal employees and applicants with identical names and birth dates whose identities can only be distinguished by the SSN.

# Declaration for Federal Employment\*

Form Approved:  
OMB No. 3206-0182

(\*This form may also be used to assess fitness for federal contract employment)

## Instructions

The information collected on this form is used to determine your acceptability for Federal and Federal contract employment and your enrollment status in the Government's Life Insurance program. You may be asked to complete this form at any time during the hiring process. Follow instructions that the agency provides. If you are selected, before you are appointed you will be asked to update your responses on this form and on other materials submitted during the application process and then to recertify that your answers are true.

All your answers must be truthful and complete. A false statement on any part of this declaration or attached forms or sheets may be grounds for not hiring you, or for firing you after you begin work. Also, you may be punished by a fine or imprisonment (U.S. Code, title 18, section 1001).

Either type your responses on this form or print clearly in dark ink. If you need additional space, attach letter-size sheets (8.5" X 11"). Include your name, Social Security Number, and item number on each sheet. We recommend that you keep a photocopy of your completed form for your records.

## Privacy Act Statement

The Office of Personnel Management is authorized to request this information under sections 1302, 3301, 3304, 3328, and 8716 of title 5, U. S. Code. Section 1104 of title 5 allows the Office of Personnel Management to delegate personnel management functions to other Federal agencies. If necessary, and usually in conjunction with another form or forms, this form may be used in conducting an investigation to determine your suitability or your ability to hold a security clearance, and it may be disclosed to authorized officials making similar, subsequent determinations.

Your Social Security Number (SSN) is needed to keep our records accurate, because other people may have the same name and birth date. Public Law 104-134 (April 26, 1996) asks Federal agencies to use this number to help identify individuals in agency records. Giving us your SSN or any other information is voluntary. However, if you do not give us your SSN or any other information requested, we cannot process your application. Incomplete addresses and ZIP Codes may also slow processing.

**ROUTINE USES:** Any disclosure of this record or information in this record is in accordance with routine uses found in System Notice OPM/GOVT-1, General Personnel Records. This system allows disclosure of information to: training facilities; organizations deciding claims for retirement, insurance, unemployment, or health benefits; officials in litigation or administrative proceedings where the Government is a party; law enforcement agencies concerning a violation of law or regulation; Federal agencies for statistical reports and studies; officials of labor organizations recognized by law in connection with representation of employees; Federal agencies or other sources requesting information for Federal agencies in connection with hiring or retaining, security clearance, security or suitability investigations, classifying jobs, contracting, or issuing licenses, grants, or other benefits; public and private organizations, including news media, which grant or publicize employee recognitions and awards; the Merit Systems Protection Board, the Office of Special Counsel, the Equal Employment Opportunity Commission, the Federal Labor Relations Authority, the National Archives and Records Administration, and Congressional offices in connection with their official functions; prospective non-Federal employers concerning tenure of employment, civil service status, length of service, and the date and nature of action for separation as shown on the SF 50 (or authorized exception) of a specifically identified individual; requesting organizations or individuals concerning the home address and other relevant information on those who might have contracted an illness or been exposed to a health hazard; authorized Federal and non-Federal agencies for use in computer matching; spouses or dependent children asking whether the employee has changed from a self-and-family to a self-only health benefits enrollment; individuals working on a contract, service, grant, cooperative agreement, or job for the Federal government; non-agency members of an agency's performance or other panel; and agency-appointed representatives of employees concerning information issued to the employees about fitness-for-duty or agency-filed disability retirement procedures.

## Public Burden Statement

Public burden reporting for this collection of information is estimated to vary from 5 to 30 minutes with an average of 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of the collection of information, including suggestions for reducing this burden, to the U.S. Office of Personnel Management, Reports and Forms Manager (3206-0182), Washington, DC 20415-7900. The OMB number, 3206-0182, is valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

# Declaration for Federal Employment\*

Form Approved:  
OMB No. 3206-0182

(\*This form may also be used to assess fitness for federal contract employment)

## GENERAL INFORMATION

1. **FULL NAME** (Provide your full name. If you have only initials in your name, provide them and indicate "Initial only". If you do not have a middle name, indicate "No Middle Name". If you are a "Jr.," "Sr.," etc. enter this under Suffix. First, Middle, Last, Suffix)

2. **SOCIAL SECURITY NUMBER**

3a. **PLACE OF BIRTH** (Include city and state or country)

3b. **ARE YOU A U.S. CITIZEN?**

YES  NO (If "NO", provide country of citizenship)

4. **DATE OF BIRTH** (MM / DD / YYYY)

5. **OTHER NAMES EVER USED** (For example, maiden name, nickname, etc)

6. **PHONE NUMBERS** (Include area codes)

Day

Night

## Selective Service Registration

If you are a male born after December 31, 1959, and are at least 18 years of age, civil service employment law (5 U.S.C. 3328) requires that you must register with the Selective Service System, unless you meet certain exemptions.

7a. Are you a male born after December 31, 1959?

YES

NO (If "NO", proceed to 8.)

7b. Have you registered with the Selective Service System?

YES (If "YES", proceed to 8.)

NO (If "NO", proceed to 7c.)

7c. If "NO," describe your reason(s) in item 16.

## Military Service

8. Have you ever served in the United States military?

YES (If "YES", provide information below)

NO

*If you answered "YES," list the branch, dates, and type of discharge for all active duty.*

*If your only active duty was training in the Reserves or National Guard, answer "NO."*

Branch	From (MM/DD/YYYY)	To (MM/DD/YYYY)	Type of Discharge

## Background Information

For all questions, provide all additional requested information under item 16 or on attached sheets. The circumstances of each event you list will be considered. However, in most cases you can still be considered for Federal jobs.

For questions 9, 10, and 11, your answers should include convictions resulting from a plea of *nolo contendere* (no contest), but omit (1) traffic fines of \$300 or less, (2) any violation of law committed before your 16th birthday, (3) any violation of law committed before your 18th birthday if finally decided in juvenile court or under a Youth Offender law, (4) any conviction set aside under the Federal Youth Corrections Act or similar state law, and (5) any conviction for which the record was expunged under Federal or state law.

9. During the last 7 years, have you been convicted, been imprisoned, been on probation, or been on parole? (Includes felonies, firearms or explosives violations, misdemeanors, and all other offenses.) *If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved.*  YES  NO

10. Have you been convicted by a military court-martial in the past 7 years? (If no military service, answer "NO.") *If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the military authority or court involved.*  YES  NO

11. Are you currently under charges for any violation of law? *If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved.*  YES  NO

12. During the last 5 years, have you been fired from any job for any reason, did you quit after being told that you would be fired, did you leave any job by mutual agreement because of specific problems, or were you debarred from Federal employment by the Office of Personnel Management or any other Federal agency? *If "YES," use item 16 to provide the date, an explanation of the problem, reason for leaving, and the employer's name and address.*  YES  NO

13. Are you delinquent on any Federal debt? (Includes delinquencies arising from Federal taxes, loans, overpayment of benefits, and other debts to the U.S. Government, plus defaults of Federally guaranteed or insured loans such as student and home mortgage loans.) *If "YES," use item 16 to provide the type, length, and amount of the delinquency or default, and steps that you are taking to correct the error or repay the debt.*  YES  NO

# Declaration for Federal Employment\*

Form Approved:  
OMB No. 3206-0182

(\*This form may also be used to assess fitness for federal contract employment)

## Additional Questions

14. Do any of your relatives work for the agency or government organization to which you are submitting this form? (Include: father, mother, husband, wife, son, daughter, brother, sister, uncle, aunt, first cousin, nephew, niece, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepfather, stepmother, stepson, stepdaughter, stepbrother, stepsister, half brother, and half sister.) If "YES," use item 16 to provide the relative's name, relationship, and the department, agency, or branch of the Armed Forces for which your relative works.  YES  NO
15. Do you receive, or have you ever applied for, retirement pay, pension, or other retired pay based on military, Federal civilian, or District of Columbia Government service?  YES  NO

## Continuation Space / Agency Optional Questions

16. Provide details requested in items 7 through 15 and 18c in the space below or on attached sheets. Be sure to identify attached sheets with your name, Social Security Number, and item number, and to include ZIP Codes in all addresses. If any questions are printed below, please answer as instructed (these questions are specific to your position and your agency is authorized to ask them).

## Certifications / Additional Questions

**APPLICANT:** If you are applying for a position and have not yet been selected, carefully review your answers on this form and any attached sheets. When this form and all attached materials are accurate, read item 17, and complete 17a.

**APPOINTEE:** If you are being appointed, carefully review your answers on this form and any attached sheets, including any other application materials that your agency has attached to this form. If any information requires correction to be accurate as of the date you are signing, make changes on this form or the attachments and/or provide updated information on additional sheets, initialing and dating all changes and additions. When this form and all attached materials are accurate, read item 17, complete 17b, read 18, and answer 18a, 18b, and 18c as appropriate.

17. I certify that, to the best of my knowledge and belief, all of the information on and attached to this Declaration for Federal Employment, including any attached application materials, is true, correct, complete, and made in good faith. I understand that a false or fraudulent answer to any question or item on any part of this declaration or its attachments may be grounds for not hiring me, or for firing me after I begin work, and may be punishable by fine or imprisonment. I understand that any information I give may be investigated for purposes of determining eligibility for Federal employment as allowed by law or Presidential order. I consent to the release of information about my ability and fitness for Federal employment by employers, schools, law enforcement agencies, and other individuals and organizations to investigators, personnel specialists, and other authorized employees or representatives of the Federal Government. I understand that for financial or lending institutions, medical institutions, hospitals, health care professionals, and some other sources of information, a separate specific release may be needed, and I may be contacted for such a release at a later date.

- 17a. Applicant's Signature: \_\_\_\_\_ Date \_\_\_\_\_  
(Sign in ink)
- 17b. Appointee's Signature: \_\_\_\_\_ Date \_\_\_\_\_  
(Sign in ink)

<b>Appointing Officer:</b> Enter Date of Appointment or Conversion MM / DD / YYYY
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18. Appointee (Only respond if you have been employed by the Federal Government before): Your elections of life insurance during previous Federal employment may affect your eligibility for life insurance during your new appointment. These questions are asked to help your personnel office make a correct determination.

- 18a. When did you leave your last Federal job? \_\_\_\_\_  
DATE: MM/DD/YYYY
- 18b. When you worked for the Federal Government the last time, did you waive Basic Life Insurance or any type of optional life insurance?  YES  NO  DO NOT KNOW
- 18c. If you answered "YES" to item 18b, did you later cancel the waiver(s)? If your answer to item 18c is "NO," use item 16 to identify the type(s) of insurance for which waivers were not canceled.  YES  NO  DO NOT KNOW

SON: 1622 SOI: VAP2



**INFORMATION FOR SUBMISSION OF FINGERPRINTS**

Fingerprints are required prior to being issued a PIV Card and/or authorized systems (computer) access. If a background investigation National Agency Check with Written Inquiries (NACI) is required, systems access will not be authorized until ALL completed forms have been submitted to HRMS.

**This form must be completed in its entirety prior to being fingerprinted.**

Courtesy FP SON: \_\_\_\_\_ SOI: \_\_\_\_\_

**Part 1: To be completed by applicant**

Name: \_\_\_\_\_ (Last, First, Middle) Weight: \_\_\_\_\_ Lbs.

Other legal names used: \_\_\_\_\_ (Last name, First name) DOB: \_\_\_\_\_ (yyyymmdd)

Male: \_\_\_\_\_ Female: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ (City, State, Country)

Specific Ethnicity: \_\_\_\_\_ Country of Citizenship: \_\_\_\_\_ (If other than the United States)

Eye Color: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Hair Color: \_\_\_\_\_ Position/Job Title: \_\_\_\_\_

Height: \_\_\_\_\_' \_\_\_\_\_" Email address: \_\_\_\_\_

**Part 2: To be completed by referring service**

This individual will be assigned to \_\_\_\_\_ Service

\_\_\_\_\_  
*Printed Name of Approving Service Officer*                      *Signature of Approving Service Officer*                      *Date*

**REASON FOR FINGERPRINTING/TYPE OF APPOINTMENT**

VA/HRMS	Volunteer	WOC	
		Research	Non-Research
<input type="checkbox"/> Renewal	<input type="checkbox"/> Volunteer, SAC	<input type="checkbox"/> NCIRE, NACI	<input type="checkbox"/> Student affiliation: _____
<input type="checkbox"/> Pre-employment	<input type="checkbox"/> Volunteer, NACI	<input type="checkbox"/> UCSF, NACI	<input type="checkbox"/> Intern affiliation: _____
<input type="checkbox"/> Courtesy FP		<input type="checkbox"/> Other, NACI from: _____	<input type="checkbox"/> Resident affiliation: _____
			Non-Affiliated School: _____
			<input type="checkbox"/> SAC
			<input type="checkbox"/> NACI

**Part 3: To be completed by HRMS**

Signature WOC Coordinator: \_\_\_\_\_ Date: \_\_\_\_\_

Fingerprinted by: \_\_\_\_\_ Date: \_\_\_\_\_

## Consent for FBI Fingerprint Check

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I authorize the VA to release this information to the Office of Personnel Management (OPM) and to the FBI to conduct a check of fingerprints in FBI files. Information received as a result of the fingerprint check will only be provided to those with a need to know.

The information you give us is for the purpose of determining your suitability for Federal employment, study, volunteer service, etc. We will protect it from unauthorized disclosure. The collection, maintenance, and disclosure of this information are governed by the Privacy Act.

This information is required in order to work, train, and volunteer, or otherwise to provide or to receive service with the VA.

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Signature :

Date :

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### Privacy Act Statement

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The Privacy Act Statement of 1974 requires that when we ask you for information, we state our legal right to do so, why we are asking for the information, and how it will be used. We must also tell you what could happen if you do not provide it and whether your response is voluntary, required to obtain a benefit or mandatory.

Our legal right to ask for the information is 5 USC 301, and Executive Order 9397. We are asking for this information to investigate your background and determine your suitability for employment.

Disclosure of the information may be made to Federal, state and local agencies, and judicial authorities as authorized by law. Violations or potential violations of law, whether civil, criminal or regulatory in nature may be reported to appropriate agencies that have the responsibility for investigating or prosecuting such violations or are charged with enforcing or implementing such laws.

Your failure to complete the pre-appointment/post-appointment information on this form may mean that the required information cannot be obtained to determine your suitability and/or conduct an investigation. Without this information, a determination as to your suitability for Federal employment cannot be made and may result in you not being considered for employment; or a determination may be made that you are unsuitable for your position.

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**Complete the form below:  
include your name, your DEA number, and your signature**

**VA DEA Cards**

**PLEASE PRINT AND SIGN YOUR NAME**

**Name (print):** \_\_\_\_\_

**Name (signature):** \_\_\_\_\_

**Service:** \_\_\_\_\_

DEA Suffix Number: VA000 (Resident/Physician retain the number for VA Rx)

**DEA Personal:** \_\_\_\_\_

**NATIONAL PROVIDER IDENTIFIER (NPI #)** \_\_\_\_\_

**Example Card Below:**

**Name (print):** \_\_\_\_\_ Jane Doe \_\_\_\_\_

**Name (signature):** \_\_\_\_\_ Jane Doe \_\_\_\_\_

**Service:** \_\_\_\_\_ Internal Medicine \_\_\_\_\_

DEA Suffix Number: VA000 (Resident/Physician retain the number for VA Rx)

**DEA Personal:** \_\_\_\_\_

**NATIONAL PROVIDER IDENTIFIER (NPI #) ##### (10 Digit Number)**