

NEW WOC PACKET INSTRUCTIONS

PLEASE READ BEFORE FILLING OUT ANY DOCUMENTS!!!

Enclosed you will find all documents required to apply for your WOC appointment.

- ❖ **EMAIL ME TO SCHEDULE AN APPOINTMENT TO HAVE THE APPLICATION PROCESSED.**
- ❖ **ALL OF THE MANDATORY TRAINING MUST BE SUBMITTED WITH THE APPLICATION.**
- ❖ **There is a document in the application that gives you each website to complete the training.** The Human Protection Training is only needed if you will be working on a Human Research Study.

Prior to beginning any work on VA property, WOC's are required to have in their possession a **valid VA photo ID**. This form of identification cannot be obtained until the WOC paperwork has been completely processed.

Please note: Fill out all forms and sign where applicable. All paperwork must be completed and turned in to the WOC Coordinator before it can be sent to HR for processing. **Please bring all application paperwork to your appointment. Incomplete paperwork will not be accepted.**

- ❖ **Fill out the Physician, Nurse or Associated health application only if applicable. If a license (MD, RN, Etc...) is *not* required to do the Research work, you do not need to fill out the application.**
- ❖ You must complete ***both*** federal employment applications enclosed, Declaration of Federal Employment (OF 306) and the Optional Application for Federal Employment (OF 612) **which is not optional.**
- ❖ **For all Non U.S. Citizens, you **must** attach a copy of your **Passport or Visa and, one of the following: Employment authorization ID card, I-94, or your I-20. Please give your PI the example of the Non Citizen Memorandum which is located in the application. This memo is MANDATORY.****

If you have further questions or need to make an appointment you may contact Shelley, the best way is by email.

PHONE#376-1611x4204 **ROOM#**E556-1, FLOOR#5, Near Pulmonary

EMAIL ADDRESS: shelley.jenkins@med.va.gov

FAX# **Outside of the VA:** 376-1611 (three pauses) 5676

Inside of the VA: Just dial 5676

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Mandatory WOC Trainings

1. Ethics Video, Rent from the VA library, 4th floor.
Fill out the (Class Details Form)

TO PRINT CERTIFICATE:

When you are finished with the training, click on the **4th icon at the left hand bottom of the page** (looks like a printer) **Click Print Score**. It will be your Test Score Report.

2. Cyber Security
3. **VHA** Privacy Training (HIPPA)
4. Human Research Curriculum
5. VA Research Data Security And Privacy

The Website for the Ethics Video, Cyber Security, VHA Privacy Training & Research Data Security/Privacy is:

<http://www.vcampus.com/vcekpvalo/>

The Website for the Overview of Good Clinical Practice is:

<https://www.citiprogram.org/default.asp>

This training must be completed by all Human Studies personnel annually.

Please print& keep your Certificates

Please note that all new and renewal WOC applicants must turn in all trainings listed above with their WOC application. The Overview of GCP is the only training that is done if applicable. The VA EES System is no longer offering the Overview of Good Clinical Practice. All other trainings must be completed. The application will not be accepted without them.

Class Details

North Florida/South Georgia Veterans Health System

Course type/name: Films/Videos/Books In-Service
 Non-System Training/Programs

Start Date: **Delivery Method:** Film/Video/Book Classroom/Workshop **Cont. Ed. Type *if applicable***
 Correspondence Independent Study CEU
End Date: Equipment Demo Individual One-On-One CME
 Cross-Training Video Conference/Satellite Other:
Class Hours: Lecture/Speaker TV
 Internet/On-line **CE Units:**

Patient Safety Hours*: **Instructor:**

Class Location:

Accredited By:

Class Title:

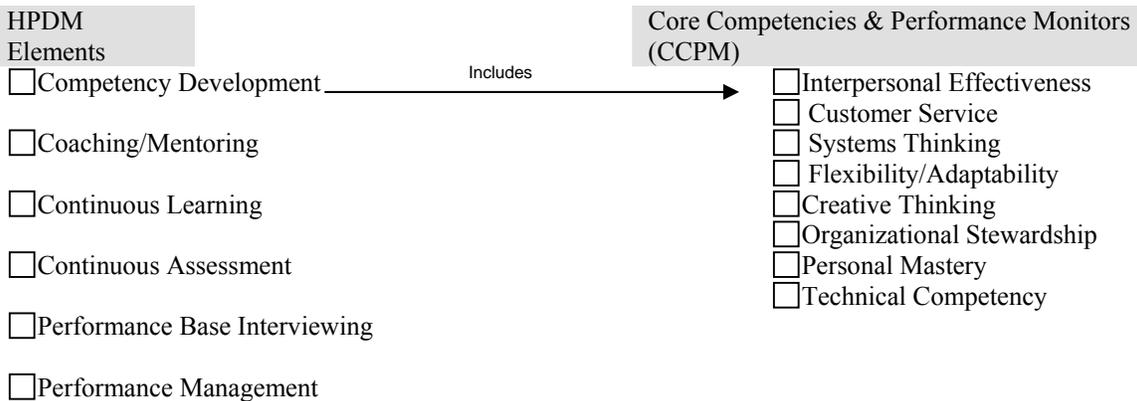
Notes:

Selected Content Categories that apply to this class – This information is used for various reports for JCAHO, competencies, etc.; appropriate selection is imperative for data integrity. See back for definitions.

- | | |
|---|--|
| <input type="checkbox"/> Clinical Knowledge
<input type="checkbox"/> Customer Service and Satisfaction
<input type="checkbox"/> Environment of Care
<input type="checkbox"/> External Review and Accreditation Development/Shared Decision
<input type="checkbox"/> Information Management and Technology Training
<input type="checkbox"/> Miscellaneous
<input type="checkbox"/> Non-Clinical Knowledge | <input type="checkbox"/> *Patient Safety Training
<input type="checkbox"/> Performance Improvement
<input type="checkbox"/> Performance Measurement
<input type="checkbox"/> Planning and Organizational Making
<input type="checkbox"/> Team Work – related/Empowerment

<input type="checkbox"/> Total Quality Improvement |
|---|--|

Selected HPDM/CCPM Categories that apply to this case – This information is used for various reports for JCAHO, competencies, etc.; appropriate selection is imperative for data integrity. See back for definitions.



Submitted by: _____ **Date:** _____

Department of Sample Memorandum

Date:

From: Prinicpal Investigators name goes here

Subj: Non-Citizen WOCs name goes here

To: ACOS, Human Resource(keep this the same)

1. In this paragraph, the Prinicpal Investigator (PI) indicates that the WOC above is working for him/her and is quailified to do the job. **“Our recruitment efforts have not produced any qualified U.S. Citizens for this position”**. (this statement must be added at the end of this paragraph)

Prinicpal Investigators signature

CONCUR DO NOT CONCUR (This highlighted area must be included at the bottom of the page)

Charles S. Wingo, MD, ACOS/Research

WITHOUT COMPENSATION POSITION
POSITION DESCRIPTION

Employee Name: _____

Principal Investigator Name: _____

Position Title: _____

Jobsite Location: (please check location below)

- BRRC**
- RORC**
- Hospital**

Major Duties/Responsibilities of this Position: (Please check any of the duties that apply)

- Laboratory:** Experiments, Tissue/cell analysis, Tissue/cell culturing, Blood and tissue sample collection and processing
- Administrative:** Data collection, Data analysis, Data maintenance/organizing
- Other:** _____

Principal Investigator Signature
extension

Date signed

Phone

Your Principal Investigator's signature, date signed and phone extension is required to complete this form. This form will not be accepted if not completed.

VA-WOC APPOINTEE INTELLECTUAL PROPERTY AGREEMENT

This agreement is made between _____ and the Department of Veterans Affairs (VA) in consideration of my without compensation (WOC) appointment by the VA Medical Center at the **Gainesville, Florida** (VAMC) and performing VA-Approved Research (as defined below) utilizing VA resources. This agreement is not intended to be executed by WOC appointees exclusively performing clinical services, attending services, or educational activities at the VAMC.

1. I hold a WOC appointment at the (VAMC) for the purpose of performing research projects, evaluated and approved by the VA Research and Development Committee (VA-Approved Research) ,at that VAMC.
2. By signing this agreement, I understand that, except as provided herein, I am adding no employment obligations to the VA beyond those created when I executed the WOC appointment.
3. I have read and understand the VHA Intellectual Property Handbook 1200. 18 (Handbook) [available at www.vard.org] which provides guidance and instruction regarding invention disclosures, patenting and the transfer of new scientific discoveries.
4. Notwithstanding that I am an employee or appointee at the **University of Florida**. I will disclose to VA any invention that I make while acting within my VA-WOC appointment in the performance of VA-Approved Research utilizing VA resources at the VAMC or in VA-approved space.
5. I understand that the VA Office of General Counsel (OGC) will review the invention disclosure and will decide whether VA can and will assert an ownership interest. Every effort will be made to issue a decision within 40 days of receipt of a complete file. OGC will base its decision on whether VA has made a significant contribution to the invention, to include my use of VA facilities, VA equipment, VA materials, VA supplies, and VA personnel, as well as assessment of the potential of the invention.
6. If VA asserts an ownership interest based on my inventive contribution, then, subject to Paragraph 7 below, I agree to assign certain ownership rights I may have in such invention to the VA. I agree to cooperate with VA, when requested, in drafting the patent applications(s) for such invention and will thereafter sign any documents, recognizing VA's ownership, as required by the U.S. Patent and Trademark Office at the time the patent application is filed.
7. VA recognizes that I am employed or appointed at the entity named in paragraph 4 and have obligations to disclose and assign certain invention rights to it. If that entity asserts an ownership interest, VA will cooperate with it to manage the development of the invention as appropriate.
8. If a Cooperative Technology Administration Agreement (CTAA) exists between the VA and the mentioned entity in paragraph 4, this Agreement will be implemented in accordance with the provisions of that CTAA.

Date

Signature

Date

Charles S. Wingo, MD., ACOS/Research

Gainesville & Lake City VA Medical Centers Scope of Practice for All Research Staff

EMPLOYEE'S NAME	TYPE OF RESEARCH (HUMAN, ANIMAL, OTHER)
PRINCIPAL INVESTIGATOR (PI) / PRIMARY SUPERVISOR	VA PHONE EXTENSION (REQUIRED)

The Scope of Practice is specific to the duties and responsibilities of each research team member. As such he/she is specifically authorized to conduct research involving Human Subjects with the responsibilities outlined below. All non-M.D. Investigators, Co-Investigators, Sub-Investigators, Study Coordinator and Research Assistants (including WOC's who perform independent clinical activities) must complete this scope of practice form and send a position description (PD) or functional statement. **The team member's supervisor must sign and date this scope of practice.**

PROCEDURES:

A Research Staff member may be authorized to perform the following duties/procedures on a regular and ongoing basis. They may be performed without specific prior discussion/instructions from the Principal Investigator. **The Principal Investigator initials what is granted or not granted.**

_____ This initial certifies that the employee listed above has no human contact according to the criteria listed below. Numbers 1-15 is **Not granted**.

Routine Duties	<u>Granted</u>	<i>OR</i>	<u>Not Granted</u>
1. Screens patients to determine study eligibility criteria by reviewing patient medical information or interviewing subjects.	_____		_____
2. Develops recruitment methods to be utilized in the study.	_____		_____
3. Performs venipuncture to obtain specific specimens required by study protocol (requires demonstrated and documented competencies).	_____		_____
4. Initiates submission of regulatory documents to UF IRB, VA R&D committee and sponsor.	_____		_____
5. Prepares study initiation activities.	_____		_____
6. Provides education and instruction of study medication use, administration, storage, side effects and notifies adverse drug reactions to study site.	_____		_____

	<u>Granted</u>	OR	<u>Not Granted</u>
7. Provides education regarding study activities to patient, relatives and Medical Center staff as necessary per protocol.	_____		_____
8. Maintains complete and accurate data collection in case report forms and source documents.	_____		_____
9. Initiates and/or expedites requests for consultation, special tests or studies following the Investigator's approval.	_____		_____
10. Obtains and organizes data such as tests results, diaries/cards or other necessary information for the study.	_____		_____
11. Demonstrates proficiency with VISTA/CPRS computer system by scheduling subjects research visits, documenting progress notes, initiating orders, consults, etc.	_____		_____
12. Accesses patient medical information while maintaining patient confidentiality .	_____		_____
13. Is authorized to obtain informed consent from research subject and is knowledgeable to perform the informed consent "process".	_____		_____
14. Initiates intravenous (IV) therapy and Administers IV solutions and medications	_____		_____
15. Collects and handles various types of human specimens	_____		_____

PRINCIPAL INVESTIGATOR STATEMENT:

My Employee's Scope of Practice was reviewed and discussed with him/her on the date below. After reviewing his/her education, clinical competency, qualifications, research practice involving human subjects, peer reviews, and individual skills, I certify that he/she possesses the skills to safely perform the aforementioned duties/procedures. Both the research staff member and I are familiar with all duties/procedures granted or not granted in this Scope of Practice. We agree to abide by the parameters of this Scope of Practice, all-applicable hospital policies and regulations.

This Scope of Practice will be reviewed every year and amended as necessary to reflect changes in the research staff member's duties/ responsibilities, utilization guidelines and/or hospital policies.

Principal Investigator/ Supervisor Signature

Date

Research Employee's Signature

Date

**GAINESVILLE AND LAKE CITY VA MEDICAL CENTERS
CLINICAL STUDIES CENTER
EDUCATION VERIFICATION FORM**

As part of the credentialing process it is necessary to verify educational credentials for each degree earned. All degrees must be entered, e.g. BS, Masters, PhD. **All applicable licenses must be listed and copies of licenses attached.** To assist us in completing this process, please provide the following information:

Employee Name	SERVICE & LOCATION	VA PHONE EXTENSION
	Research	X
HOME ADDRESS:	SSN# - -	DATE OF BIRTH (M/D/Y) / /
EMAIL ADDRESS:		
(1) DEGREE/TRAINING (LIST EACH DEGREE SEPARATELY)		DATE EDUCATION COMPLETED
University/Program Attended		CITY / STATE / COUNTRY
(2) DEGREE/TRAINING (LIST EACH DEGREE SEPARATELY)		DATE EDUCATION COMPLETED
UNIVERSITY/PROGRAM ATTENDED		CITY / STATE / COUNTRY
(1) LICENSE/REGISTRATION STATE	ISSUE DATE	EXPIRATION DATE
(2) LICENSE/REGISTRATION STATE	ISSUE DATE	EXPIRATION DATE
BOARD CERTIFICATION	ISSUE/AWARD DATE	EXPIRATION DATE
<p>In order for the Malcom Randall VA Health System Medical Center to access and verify my educational background, I hereby authorize the VA to make inquiries and consult with all educational institutions, State Licensing boards, or other similar government and non-governmental entities who have information bearing on my ethical and professional qualifications and competence to carry out the privileges I have requested. I authorize release of such information and copies of related records and or documents to VA officials. I release from liability all those who provide information to the Department of Veteran Affairs in good faith and without malice in response to such inquiries.</p>		
_____	_____	_____
Signature	Title	Printed Name
		Date

PATIENT CONTACT STATEMENT

Principal Investigator (**Please Print**)

Employee Name (**Please Print**)

Your Job Title **at VA**

Your Occupation/Profession

License or Certificate Number/Type (nurses, therapists, etc.)

IF YOU HAVE A LICENSE OR CERTIFICATE, YOU MUST PROVIDE A COPY OF IT AND FILL OUT VA FORM 5-4682 (available from this office).

(Work) _____ (Home) _____
Phone number where you can be reached

Your e-mail address

PLEASE CHECK THE ONE STATEMENT BELOW THAT APPLIES:

This WOC employee will have **at the most** only minor clerical contact with patients/human subjects. YES _____

This WOC employee will have **more than** minor clerical contact with patients/human subjects. YES _____

Principal Investigator's Signature

Date

Check this box if you do not
work with Animals, then sign & Date.
Leave the rest of the form blank.

Employee Name (please Print)

Principle Investigator (Please Print)

**Department of
Veterans Affairs**

MEMORANDUM

Date: January 20, 2004

From: ACOS/Research (151)

Subj: Experience of VA & WOC Employees Working with Animals

To: Research Investigators with VA & WOC Staff

1. In order to document the experience of your VA/WOC employee related to working with animals, we are requesting that you complete the questions listed below, and have you and the VA/WOC employee sign this memo. Please return to the Research Office E-579-1.

(Investigator Signature/Date)

(VA/WOC Employee Signature/Date)

1. The VA/WOC employee listed above will be working with the following species:

____ Dogs ____ Cats ____ Rats ____ Mice ____ Rabbits ____ Frogs
____ Guinea Pigs Other (Identify) _____

2. The DVAMC Policies, Procedures and Reporting on IACUC Evaluation of Animal Welfare Concerns information sheet is located in my lab.

_____ YES _____ NO

3. The protocol title of this study is _____,
_____, VA protocol # _____ and
UF protocol # _____.

4. The VA/WOC employee will be involved with:

Surgical preparation _____ surgical procedures _____
Post surgery care _____ routine care (special feeding, observations) _____
Other (identify) _____

5. The VA/WOC employee has experience working with animals as a result of:

Attending animal workshops (dates attended) _____
(Attach copies of workshop certificates)

Undergraduate/Graduate school _____

Conducted previous research (# of years) _____

Total # of years experience _____

Memo

To:

From: Marjorie Spence, ARNP

Date:

Re: Significant Biological Agent or **Animal Contact** Health Surveillance Questionnaire

- 1. Please complete the annual medical survey attached. The questionnaire will be placed in your Employee Health Record. This information is required under VHA Program Guide 1200.7 (Research and Development Occupational Health and Safety for Veterinary Medical Units Program Guide).**
- 2. Please page Marjorie Spence on VA# 1820 or ext. 5183 if you have any questions about the forms. Please send the completed forms to Lisa Mearkle, Research Service 151, as soon as possible. You will be contacted if any of your immunizations need to be updated. Thank you for your timely support of this program.**

**Marjorie Spence ARNP
Occupational Health Nurse**

CONFIDENTIAL MEDICAL INFORMATION

SIGNIFICANT BIOLOGICAL AGENT OR ANIMAL CONTACT
HEALTH SURVEILLANCE QUESTIONNAIRE

Date: _____

SS#: _____

Service: RESEARCH

Email address: _____

Principal Investigator/Supervisor: _____

Name: _____ Birth Date: _____

Previous Evaluation at Employee Health? Yes No

Status (Check all that apply):

- UF Faculty
- VA Staff
- Student
- Animal Handler
- Veterinarian
- Research Technician
- Other _____

1. What species of animals or types of biological agents will you be handling?

2. How often (never, rarely, sometimes, always) do you wear disposable gloves, a gown, a mask, a cap, or protective eyewear as part of assigned duties?

3. Do you smoke, eat, or drink in animal holding areas or procedure areas?

4. Do you work with chemicals in the workplace and have you had any symptoms associated with working with these chemicals?

5. MEDICAL HISTORY

Do you have any ongoing medical problems? If yes, explain.

6. Have you had (check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Recurrent Bronchitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Heart Murmur & Valve Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gastrointestinal Disorder | <input type="checkbox"/> Loss of Consciousness |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chronic Back or Joint Pain |
| Asthma | ↑ Hay Fever | ↑ Allergic Skin Problems |
| Sinusitis | | Eczmea |

If yes, please explain.

7. Are you currently pregnant, contemplating becoming pregnant within the next year?

- Yes No

***I prefer not to answer this question for personal privacy reasons and hereby assume personal responsibilities for any adverse consequences attendant to failure to provide this information. (Please sign):**

* _____
signature

* _____
date

8. Have you been told by a physician that you have an immune compromising medical condition or are taking medications that impair your immune system (steroids, immunosuppressive drugs, or chemotherapy)?

- Yes No

If Yes, Please list medications.

9. Drug Allergies:

Are you allergic to?

- | | | | | |
|---------------------------------------|--------------------------------------|----------------------------------|---|---------------------------------|
| <input type="checkbox"/> Dog | <input type="checkbox"/> Primates | <input type="checkbox"/> Alfalfa | <input type="checkbox"/> Goats | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Hog | <input type="checkbox"/> Guinea Pigs | <input type="checkbox"/> Latex | <input type="checkbox"/> Birds (feathers) | |
| <input type="checkbox"/> Rat or Mouse | <input type="checkbox"/> Cattle | <input type="checkbox"/> Weeds | <input type="checkbox"/> Sheep (wool) | |
| <input type="checkbox"/> Cat | <input type="checkbox"/> Rabbits | <input type="checkbox"/> Grasses | <input type="checkbox"/> Trees | |

10. If any allergic symptoms occur during or after contact with a laboratory animal species (sneezing spells, runny or stuffy nose, watery or "itchy" eyes, coughing, wheezing, or shortness of breath, skin rashes or hives, difficulty

breathing), and if so, which species is involved, and how frequently does each symptom occur (never, monthly, weekly, daily).

11. Current Prescribed Medications Taken on a Regular Basis:

12. Systemic Illnesses (i.e., diabetes, chronic bronchitis, cancer, etc.):

13. Briefly describe what type of contact you have with lab animals (i.e., clean out cages, do organ biopsies on frogs, etc.). PLEASE be sure to state how frequently you work with the animals (i.e., daily, weekly, etc.)

<u>Type of Contact</u>	<u>Frequency</u>
_____	_____
_____	_____
_____	_____

Signature

date

RECORD OF IMMUNIZATION

Indicate the date of most recent vaccination (or blood test to document immunity). Mark “?” if you do not recall the date. Mark “ND” (for never done) if test or vaccination has never been done.

Measles _____	Hepatitis A _____	CMV _____
Mumps _____	Hepatitis B _____	“Q” Fever _____
Rubella _____	Rabies _____	BCG _____
Vaccinia (smallpox) _____		
Yellow Fever _____		
Toxoplasmosis _____		

Date of last tetanus booster: _____

Date of last rabies vaccine (if applicable): _____

Date of last rabies titer (if applicable): _____

Tuberculosis Skin Testing

Date of last PPD skin test: _____

Positive, **Negative**

If POSITIVE, date of last Chest X-Ray: _____

If POSITIVE in the past, are you having any of the following symptoms (check box)?:

Fever

Chronic Cough

Bloody Sputum

Weight Loss

Shortness of Breath

Have you ever contracted a disease from animals, or experienced an animal related injury (including bites, scratches, needlesticks, etc)? **If yes, please explain below:**

Do you work with species of, or biological material from, non-human primates?

Yes

No

Are you involved with recombinant DNA technology? **Yes** **No. If yes, does the research involve techniques in which viable, recombinant DNA-containing micro-organisms are used to infect animals that then require Biosafety Level 3 containment?** **Yes** **No**

Date of Last Rabies Vaccine (if applicable): _____

Research Employee Safety Orientation Agreement

JCAHO and VA hospital policy requires that *all* new **employees** (including **WOCs**) and *all* new **investigators** of the Research Service attend this Safety Orientation Training within 90 days of appointment.

This training is held on the third Tuesday of each month (unless otherwise noted) from 8:00 to 10:00 a.m. in the Research Service Conference Room E-526, 5th floor.

By signing this statement, _____ has been made aware that
(Principle Investigator)

_____ will have three consecutive opportunities to attend the
(WOC name)

Mandatory Research Safety Orientation Training before he/she is unable to continue any VA research. Non-compliance will result in the revocation of the WOC appointment.

(Principle Investigator Signature/date)

(WOC Signature/date)

Revised: 6/2007

NEW EMPLOYEE SAFETY ORIENTATION CERTIFICATION

Employee Name (Please Print)

Principal Investigator (Please Print)

WOC Position: _____

Phone numbers:
(Work) _____ *(Home)* _____

E-mail address: _____

PLEASE READ AND SIGN THIS SIGNATURE PAGE AND GIVE IT TO THE PROGRAM CLERK.

I have received the Research Service New Employee Orientation & Safety Booklet and I understand that it is my responsibility to read and familiarize myself with this information.

The safety information presented in this booklet is to be reviewed and discussed with the Research Safety Officer, Mr. Mack Lawson, at the mandatory safety/orientation training meeting. The information in this booklet should be saved as a quick reference to safety matters. If you have further questions, refer to the Research Service Safety Manual that is available in each principal investigator's laboratory and in the Research Service office.

PLEASE READ AND SIGN THE FOLLOWING STATEMENT

I certify that I have been made aware of the orientation/safety items detailed in items I through IX of the Research Service New Employee Orientation/Safety Training Booklet.

Employee Signature

Date

Research Safety Officer

Date

Research Scope of Practice for CPRS Access
North Florida/South Georgia Veterans Health System

Employee's Name _____ / _____
(Please Print) (Signature)

Principal/Co-Investigator _____ / _____
(Please Print) (Signature)

The Signatures of both Employee and Principal Investigator indicates that the employee has seen the Research CPRS DVD, and is now requesting CPRS Training.

All levels of CPRS access (I, II & III) have the following capabilities:

1. Access patients' medical records under the auspices of an IRB and R&D approved research protocol for review of medical information including but not necessarily limited to progress notes, orders, diagnostic studies etc..
2. Schedule appointments for subjects enrolled in an IRB and R&D approved research protocol.
3. Enter progress notes in CPRS as directed by the principal investigator (e.g. documentation of informed consent, documenting patient visits, etc..)

Check the appropriate access desired:

Level I – Student Class: CPRS access for chart review, scheduling, and progress note entry. **Note:** “Student Class” requires that progress notes be cosigned by the Principal Investigator or Co-Principal Investigator.

Level II – Clinical/Coordinator Limited Class: CPRS access for chart review, scheduling, progress note entry and order entry. **Note:** “Clinician/Coordinator Limited Class” requires the progress notes to be co-signed by the Principal Investigator or Co-Principal Investigator. The clinician/coordinator may not sign orders under this limited access level.

Level III – Clinician/Coordinator/Researcher Unrestricted Class: CPRS access for chart review, scheduling, progress note entry and order entry. **Note:** Clinician/Coordinator Unrestricted Class is for progress note entry that does not require signature by the Principal Investigator. This access is also for mid-level practitioners (e.g. physician assistant or nurse practitioner) with an established scope of practice with physician oversight, or the researcher is a physician credentialed by the Chief of Staff's office.

COMPUTER ACCESS APPLICATION
NF/SG VETERANS HEALTH SYSTEM

DIVISION: _____ **SERVICE:** _____

APPLICANT: _____
(Full Name- First - Middle - Last)

SSN: _____ **JOB TITLE:** _____ **Contract Employee? Yes** ___ **No** ___

(To be completed by the Package Coordinator)

PRIMARY MENU: _____

SECONDARY MENU: _____

SECURITY KEYS: _____

FILEMAN ACCESS: _____

Information Manager: _____

NT Account? Yes ___ **No** ___ **Exchange Account? Yes** ___ **No** ___

SERVICE CHIEF:

I request that the person listed above be given access to the computer system. The level of access will be determined by the job duties of this individual. Information security (as outlined in Memorandum No. 00-13) has been discussed with the individual.

SERVICE CHIEF/SUPERVISOR

SIGNATURE: _____ **DATE:** _____

Please FAX to: IRMS, Lake City, (386) 719-3609

IRM SERVICE:

ENTERED BY _____ **DATE** _____

EXPIRATION DATE. December 1, 2009.

FOLLOW-UP RESPONSIBILITY. Facility Chief Information Officer (IRM).

Assignment over 120 days

Providing Direct Patient Services

Yes

No

FINGERPRINT RECORD PREP SHEET

Yes

No

<i>PLEASE PRINT CLEARLY</i>	
NAME (LAST, FIRST MIDDLE)	
SS#	
DOB Yr/Month/Date	
ALIAS	
SEX	
RACE	
EYE COLOR	
HAIR COLOR	
HEIGHT (FT/IN)	
WEIGHT (LBS)	
PLACE OF BIRTH (COUNTRY/STATE)	
CITIZENSHIP	
SERVICE OR DEPT.	
POSITION	
ADDRESS	
STREET	PHONE #
CITY	STATE ZIP CODE

Candidate is (check one):

- Applicant Current Employee Volunteer Contractor
- On-station Fee staff Unpaid/WOC employee
- WOC/Unpaid student/trainee/resident/fellow
- University student/trainee/resident/fellow (disbursement agreement)

DATE PRINTED/COMPLETED: _____

PRINTED/COMPLETED BY: _____

GUIDE FOR ORIENTATION OF NEW EMPLOYEES

INSTRUCTIONS

This form is for use in orienting new VA employees. It covers the first two phases of the orientation process, viz: (I) at the employee is inducted, and (II) at the time of report to the work site. Phase III (Group Orientation) ordinarily should not be given sooner than 3 or even 6 weeks after appointment. These checklists are not intended to be all-inclusive, but to serve as a convenient reminder of the important matters that should be covered. Those items not applicable

or appropriate to your type of station need not to be used. Space is provided for inserting other necessary or desirable items. Check off the topics discussed with the employee. Before the employee reports for duty, the personnel office should fill in on both parts of the form the employee's name, title, etc., and send the Phase II portion to the supervisor as an advance notification. Stations having a standard checklist for Phase I may use it in place of this sheet:

NAME, TITLE, AND GRADE OF EMPLOYEE	EOD DATE
------------------------------------	----------

ORGANIZATION (*Service, division, etc.*)

CHECK	PHASE I - IN THE PERSONNEL OFFICE	
	1. PREPARE PROPER ACCOMMODATIONS FOR THE INTERVIEW. A quiet place, private if possible. Neat and orderly surroundings.	8. EXPLAIN AVAILABLE BENEFITS AND SERVICES. Medical, educational, training, recreational, housing, transportation, etc. Federal Employees' Group Life Insurance, Health Benefits Plans, etc.
	2. WELCOME EMPLOYEE AND PUT HIM OR HER AT EASE. Use a friendly approach. Offer a comfortable chair. Show a genuine interest.	9. HAND OUT "EMPLOYMENT FOLDER." Explain its purpose. Show and briefly introduce enclosed material. Suggest reading the material before attending group orientation session.
	3. INDICATE THE PURPOSE OF THE INTERVIEW. To explain orientation program, of which this is a part. To discuss immediate needs and problems.	10. SCHEDULE EMPLOYEE FOR STATION SAFETY TRAINING.
	4. GIVE INFORMATION ABOUT GROUP ORIENTATION MEETING. Time and place. A handout of subjects to be covered, if available. Relationship to first two phases of the orientation process.	11. OTHER (<i>Add items as appropriate</i>).
	5. DESCRIBE THE WORK ASSIGNMENT. Name and location of the organizational unit. Position title and grade. Brief rundown of duties typical of the position. Name and title of immediate supervisor.	12. ENCOURAGE EMPLOYEE TO ASK QUESTIONS. Answer them as fully as you can.
	6. EXPLAIN MISSION OF VA AND OF STATION. Importance of services rendered. Opportunity to contribute to accomplishment of these missions.	13. INTRODUCE EMPLOYEE TO STATION OFFICIALS. Station director and assistant director, if feasible. Other appropriate top officials in the organization.
	7. GENERAL INFORMATION ABOUT CONDITIONS OF EMPLOYMENT. Nature of appointment. Salary, including "pay lag," pay plan, withholding, retirement, other deductions, etc.	14. ESCORT EMPLOYEE TO SUPERVISOR. Introduce employee. Ask supervisor to follow through on orientation, using Phase II checklist.

SIGNATURE AND TITLE OF PERSON(S) CONDUCTING ORIENTATION	DATE

GUIDE FOR ORIENTATION OF NEW EMPLOYEES

INSTRUCTIONS

This checklist is for use by the supervisor(s) in orienting a new employee reporting for duty at the work unit. The list is intended not to be all-inclusive, but to serve as a convenient reminder of the important matters that should be covered. Those items not applicable or appropriate to your type of situation need not be used. Space is provided for inserting other necessary or desirable items. Some topics may best be discussed with the employee by the division or service

chief; others may be more suitable for discussion by the immediate supervisor. Check off the items covered in the interview(s). The form should be signed and returned to the personnel office within 15 days after the employee's entrance on duty. (Note: Both sheets may then be destroyed. If preferred, they may be held for a locally determined time for such purposes as review by the Training Development Committee and then destroyed.)

NAME, TITLE, AND GRADE OF EMPLOYEE	EOD DATE
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ORGANIZATION (*Service, division, etc.*)

CHECK	PHASE II - AT THE WORK SITE	
1. GET READY TO ORIENT THE NEW EMPLOYEE.	Review experience, education, training.	6. (Continued)
	Have current job description or list of duties and responsibilities available for discussion.	Use of telephone.
	Have work place, equipment, and supplies ready.	Other practices and procedures, e.g., uniforms, smoking, etc.
	Prepare a quiet, private place for the interview, if possible.	7. INSTRUCT EMPLOYEE IN DUTIES, OR ASSIGN TO A QUALIFIED INSTRUCTOR.
2. WELCOME EMPLOYEE AND PUT HIM/HER AT EASE.	Use a friendly approach. Offer a comfortable chair.	Discuss duties and responsibilities of job.
	Indicate your work relationship to the employee.	Explain quality and quantity requirements.
	Inquire about housing, transportation, and parking situation.	Assign employee to work place.
	Discuss background and interests.	Give step-by-step instruction (JIT four-step method, if appropriate).
3. EXPLAIN THE WORK OF THE UNIT.	Its organization and functions.	Indicate availability of help when needed.
	Indicate employee's position in the unit.	Provide learning aids, i.e., samples of work, forms, manuals, procedures, etc.
	Explain relation of employee's work to that of others.	Explain use and care of whatever tools, equipment, and supplies, are required.
	Explain to whom employee reports and who, if any, reports to employee	Stress security or confidential aspects of job, if any.
4. SHOW EMPLOYEE THE LAYOUT AND AVAILABLE FACILITIES.	Explain layout of office or work area.	8. SAFETY ORIENTATION.
	Show elevators, rest room, water fountain, and similar facilities.	Stress importance of working safely.
	Discuss station and other eating facilities.	Potential hazards and safety procedures.
5. INTRODUCE EMPLOYEE TO OTHER UNIT SUPERVISORS AND CO-WORKERS.	Indicate to each the new employee's position.	Personal protective equipment and its use.
	Mention briefly the duties of each person introduced.	Location of: emergency phone numbers, fire alarm boxes, and extinguishers.
	Identify time clerk and personnel clerk.	Appropriate actions to be taken if you are injured or if someone is hurt.
	Arrange for a co-worker to lunch with employee the first day (or, better still, go yourself).	Disaster instructions and evacuation plans and procedures.
6. EXPLAIN UNIT RULES AND REGULATIONS.	Hours of work, punctuality, good attendance.	9. OTHER (Add items as appropriate).
	Lunch and rest periods, if any.	Discussed position specific competencies and had employee sign competency form.
	Leave, including when and to whom requests should be made.	Ensure your service provides and documents HIPPA/Privacy training within 30 days of employment.
		10. FOLLOW-UP.
		Check progress often during first few days.
		Encourage questions and answer them fully.
		Make corrections tactfully, as necessary. Give encouragement.

SIGNATURE AND TITLE OF SUPERVISOR(S) CONDUCTING ORIENTATION	DATE
	DATE



OPTIONAL APPLICATION FOR FEDERAL EMPLOYMENT - OF 612

You may apply for most jobs with a resume, this form, or other written format. If your resume or application does not provide all the information requested on this form and in the job vacancy announcement, you may lose consideration for a job.

1 Job title in announcement		2 Grade(s) applying for	3 Announcement number
4 Last name	First and middle names		5 Social Security Number
6 Mailing address			7 Phone numbers (include area code) Daytime () Evening ()
City	State	ZIP Code	

WORK EXPERIENCE

8 Describe your paid and nonpaid work experience related to the job for which you are applying. Do **not** attach job descriptions.

1) Job title (if Federal, include series and grade)

From (MM/YY)	To (MM/YY)	Salary \$	per	Hours per week
Employer's name and address				Supervisor's name and phone number ()
Describe your duties and accomplishments				

2) Job title (if Federal, include series and grade)

From (MM/YY)	To (MM/YY)	Salary \$	per	Hours per week
Employer's name and address				Supervisor's name and phone number ()
Describe your duties and accomplishments				

GENERAL INFORMATION

Optional Form 612 (September 1994) (EG)
U.S. Office of Personnel Management

You may apply for most Federal jobs with a resume, the attached *Optional Application for Federal Employment* or other written format. If your resume or application does not provide all the information requested on this form and in the job vacancy announcement, you may lose consideration for a job. Type or print clearly in dark ink. Help speed the selection process by keeping your application brief and sending only the requested information. If essential to attach additional pages, include your name and Social Security Number on each page.

- For information on Federal employment, including job lists, alternative formats for persons with disabilities, and veterans' preference, call the U.S. Office of Personnel Management at **912-757-3000**, **TDD 912-744-2299**, by computer modem **912-757-3100**, or via the Internet at <http://www.usajobs.opm.gov>.
- If you served on active duty in the United States Military and were separated under honorable conditions, you may be eligible for veterans' preference. To receive preference if your service began after October 15, 1976, you must have a Campaign Badge, Expeditionary Medal, or a service-connected disability. Veterans' preference is not a factor for Senior Executive Service jobs or when competition is limited to status candidates (current or former career or career-conditional Federal employees). Most Federal jobs require United States citizenship and also that males over age 18 born after December 31, 1959, have registered with the Selective Service System or have an exemption.
- The law prohibits public officials from appointing, promoting, or recommending their relatives.
Federal annuitants (military and civilian) may have their salaries or annuities reduced. All employees must pay any valid delinquent debts or the agency may garnish their salary.
- Send your application to the office announcing the vacancy. If you have questions, contact that office.
-

THE FEDERAL GOVERNMENT IS AN EQUAL OPPORTUNITY EMPLOYER

PRIVACY ACT AND PUBLIC BURDEN STATEMENTS

■ The Office of Personnel Management and other Federal agencies rate applicants for Federal jobs under the authority of sections 1104, 1302, 3301, 3304, 3320, 3361, 3393, and 3394 of title 5 of the United States Code. We need the information requested in this form and in the associated vacancy announcements to evaluate your qualifications. Other laws require us to ask about citizenship, military service, etc.

■ We request your Social Security Number (SSN) under the authority of Executive Order 9397 in order to keep your records straight; other people may have the same name. As allowed by law or Presidential directive, we use your SSN to seek information about you from employers, schools, banks, and others who know you. Your SSN may also be used in studies and computer matching with other Government files, for example, files on unpaid student loans.

■ If you do not give us your SSN or any other information requested, we cannot process your application, which is the first step in getting a job. Also, incomplete addresses and ZIP Codes will slow processing.

■ We may give information from your records 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 violations of law or regulation; Federal agencies for statistical reports and studies; officials of labor organizations recognized by law in connection with representing employees; Federal agencies or other sources requesting information for Federal agencies in connection with hiring or retaining, security clearances, security or suitability investigations, classifying jobs, contracting, or issuing licenses, grants, or other benefits; public and private organizations including news media that grant or publicize employee recognition

and awards; and the Merit Systems Protection Board, the Office of Special Counsel, the Equal Employment Opportunity Commission, the Federal Labor Relations Authority, the National Archives, the Federal Acquisition Institute, and congressional offices in connection with their official functions.

■ We may also give information from your records to: prospective nonfederal employers concerning tenure of employment, civil service status, length of service, and date and nature of action for separation as shown on personnel action forms of specifically identified individuals; 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 nonfederal agencies for use in computer matching; spouses or dependent children asking whether the employee has changed from self-and-family to 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 employee about fitness-for-duty or agency-filed disability retirement procedures.

■ We estimate the public reporting burden for this collection will vary from 20 to 240 minutes with an average of 40 minutes per response, including time for reviewing instructions, searching existing data sources, gathering data, and completing and reviewing the information. You may send comments regarding the burden estimate or any other aspect of the collection of information, including suggestions for reducing this burden, to U.S. Office of Personnel Management, Reports and Forms Management Officer, Washington, DC 20415-0001.

■ Send your application to the agency announcing the vacancy.

9 May we contact your current supervisor?

YES [] NO [] ► If we need to contact your current supervisor before making an offer, we will contact you first.

EDUCATION

10 Mark highest level completed. Some HS [] HS/GED [] Associate [] Bachelor [] Master [] Doctoral []

11 Last high school (HS) or GED school. Give the school's name, city, State, ZIP Code (if known), and year diploma or GED received.

12 Colleges and universities attended. Do **not** attach a copy of your transcript unless requested.

Name	Total Credits Earned		Major(s)	Degree - (if any)	Year Received
	Semester	Quarter			
1) _____ City _____ State _____ ZIP Code _____					
2) _____					
3) _____					

OTHER QUALIFICATIONS

13 **Job-related** training courses (give title and year). **Job-related** skills (other languages, computer software/hardware, tools, machinery, typing speed, etc. **Job-related** certificates and licenses (current only). **Job-related** honors, awards, and special accomplishments (publications, memberships in professional/honor societies, leadership activities, public speaking, and performance awards.) Give dates, but do not send documents unless requested.

GENERAL

14 Are you a U.S. citizen? YES [] NO [] ► Give the country of your citizenship. _____

15 Do you claim veterans' preference? NO [] YES [] ► Mark your claim of 5 or 10 points below.
5 points [] ► Attach your DD 214 or other proof. 10 points [] ► Attach an *Application for 10-Point Veterans' Preference* (SF 15) and proof required.

16 Were you ever a Federal civilian employee? NO [] YES [] ► For highest civilian grade give:
Series _____ Grade _____ From (MM/YY) _____ To (MM/YY) _____

17 Are you eligible for reinstatement based on career or career-conditional Federal status? NO [] YES [] ► If requested, attach SF 50 proof.

APPLICANT CERTIFICATION

18 I certify that, to the best of my knowledge and belief, all of the information on and attached to this application is true, correct, complete and made in good faith. I understand that false or fraudulent information on or attached to this application 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.

SIGNATURE

DATE SIGNED

Declaration for Federal Employment

Form Approved:
O.M.B. No. 3206-0182

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 a 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:
O.M.B. No. 3206-0182

GENERAL INFORMATION

1 FULL NAME <i>(First, middle, last)</i> ▶	2 SOCIAL SECURITY NUMBER ▶
3 PLACE OF BIRTH <i>(Include City and State or Country)</i> ▶	4 DATE OF BIRTH <i>(MM/DD/YY)</i> ▶
5 OTHER NAMES EVER USED <i>(For example, maiden name, nickname, etc.)</i> ▶ ▶	6 PHONE NUMBERS <i>(Include Area Codes)</i> 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", skip 7b and 7c. If "YES", go to 7b.*
- 7b. Have you registered with the Selective Service System? YES NO *If "NO", go 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 *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 *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 10 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.) <i>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.</i> | YES | NO |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you been convicted by a military court-martial in the past 10 years? <i>(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.</i> | YES | NO |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Are you now under charges for any violation of law? <i>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.</i> | YES | NO |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? <i>If "YES", use item 16 to provide the date, an explanation of the problem, reason for leaving, and the employer's name and address.</i> | YES | NO |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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.) <i>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.</i> | YES | NO |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Declaration for Federal Employment

Form Approved:
O.M.B. No. 3206-0182

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)

Appointing Officer:
Enter Date of Appointment or Conversion
MM/DD/YYYY

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

REFERENCES (Continued)

27A. NAME	27B. ADDRESS (Number, Street, City, State and ZIP Code)	27C. AREA CODE/PHONE NO.	27D. BUSINESS OR OCCUPATION

ITEM NO.	PLACE AN "X" IN APPROPRIATE SPACE. IF "YES" EXPLAIN DETAILS ON SEPARATE SHEET	YES	NO
28.	Do you receive or do you have a pending application for retirement or retainer pay, pension, or other compensation based upon military, Federal civilian, or District of Columbia service?	<input type="checkbox"/>	<input type="checkbox"/>
29.	Does the Department of Veterans Affairs employ any relative of yours (by blood or marriage)? If "YES" give separately such relative's (1) full name; (2) relationship; (3) VA position and employment location.	<input type="checkbox"/>	<input type="checkbox"/>
30.	ARE YOU NOW, OR HAVE YOU EVER BEEN, INVOLVED IN ADMINISTRATIVE OR JUDICIAL PROCEEDINGS IN WHICH MALPRACTICE ON YOUR PART IS OR WAS ALLEGED? (If "YES" give details including name of action or proceedings, date filed, court or reviewing agency, and the status or disposition of case concerning allegations, together with your explanation of the circumstances involved.) (As a provider of health care services, the VA has an obligation to exercise reasonable care in determining that applicants are properly qualified. It is recognized that many allegations of malpractice are proven groundless. Any conclusion concerning your answer as it relates to your qualifications will be made only after a full evaluation of the circumstances involved.)	<input type="checkbox"/>	<input type="checkbox"/>

NOTE: A conviction or a discharge does not necessarily mean you cannot be appointed. The nature of the conviction or discharge and how long ago it occurred is important. Give all the facts so that a decision can be made. If your answer to question 33, 34 or 35 is "YES" give for each offense: (1) date; (2) charge; (3) place; (4) court and (5) action taken. When answering item 33 or 34, you may omit (1) traffic fines for which you paid a fine of \$100.00 or less; (2) any offense committed before your 18th birthday which was finally adjudicated in a juvenile court or under a youth offender law; (3) any conviction the record of which has been expunged under Federal or State law; and (4) any conviction set aside under the Federal Youth Corrections Act or similar State authority.

31.	Within the last five years have you been discharged from any position for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
32.	Within the last five years have you resigned or retired from a position after being notified you would be disciplined or discharged, or after questions about your clinical competence were raised?	<input type="checkbox"/>	<input type="checkbox"/>
33.	Have you ever been convicted, forfeited collateral, or are you now under charges for any felony or any firearms or explosives offense against the law? (A felony is defined as any offense punishable by imprisonment for a term exceeding one year, but does not include any offense classified as a misdemeanor under the laws of a State and punishable by a term of imprisonment of two years or less.)	<input type="checkbox"/>	<input type="checkbox"/>
34.	During the past seven years have you been convicted, imprisoned, on probation or parole, or forfeited collateral, or are you now under charges for any offense against the law not included in 33 above?	<input type="checkbox"/>	<input type="checkbox"/>
35.	While in the military service were you ever convicted by a general court-martial?	<input type="checkbox"/>	<input type="checkbox"/>
36.	If you were in the military service in one of these health occupations, did you ever receive a non-judicial punishment (Article 15)?	<input type="checkbox"/>	<input type="checkbox"/>
37.	Are you delinquent on any Federal debt? (Include delinquencies arising from Federal taxes, loans, overpayment of benefits, and other debts to the U.S. Government, plus defaults on any Federally guaranteed or insured loans such as student and home mortgage loans.) If "Yes" explain on a separate sheet the type, length, and amount of the delinquency or default and steps you are taking to correct errors or repay the debt. Give any identification numbers associated with the debt and the address of the Federal agency involved.	<input type="checkbox"/>	<input type="checkbox"/>

IX - SIGNATURE OF APPLICANT

NOTE: A false statement on any part of your application may be grounds for not hiring you, or for terminating you after you begin work. Also, you may be punished by fine or imprisonment (U.S. Code, Title 18, Section 1001).

▶ CERTIFICATION: I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL OF MY STATEMENTS ARE TRUE, CORRECT, COMPLETE, AND MADE IN GOOD FAITH.

38A. SIGNATURE OF APPLICANT (Sign in dark ink)	38B. DATE (Month,Day,Year)
--	----------------------------

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 concerning such information about me to my previous employer(s), current employer, educational institutions, State licensing boards, professional liability insurance carriers, national practitioner data bank, American Medical Association, Federation of State Medical Boards, other professional organizations and/or persons, agencies, organizations or institutions listed by me as references, and to any other appropriate sources to whom VA may be referred by those contacted or deemed appropriate;
- Authorize release of such information and copies of related records and/or 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; and
- 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.

SIGNATURE	DATE

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 30 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

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

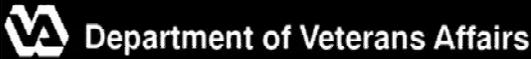
PURPOSES AND USES: The information requested on the application is collected primarily to determine your qualifications and suitability for employment. If you are employed by the VA, the information will be used to make pay and benefit determinations and, as necessary, in personnel administration processes carried out in accordance with established regulations and published notices of systems of records.

ROUTINE USES: Information on the form or the form itself may be released without your prior consent outside the VA to another Federal, State or local agency, to the National Practitioner Data Bank which is administered by the Department of Health and Human Services, to State licensing boards, and/or appropriate professional organizations or agencies to assist the VA in determining your suitability for hiring and for employment, to periodically verify, evaluate and update your clinical privileges and licensure status, to report apparent or potential violations of law, to provide statistical data upon proper request, or to provide information to a Congressional office in response to an inquiry made at your request. Such information may also 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. The information you supply may be verified through a computer matching program at any time.

EFFECTS OF NON-DISCLOSURE: See statement below concerning disclosure of your social security number. Disclosure of the other information is voluntary; however, failure to provide this information may delay or make impossible the proper application of Civil Service rules and regulations and VA personnel policies and thus may prevent you from obtaining employment, employees benefits, or other entitlements.

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

Disclosure of your SSN (social security number) is mandatory to obtain the employment and related benefits that you are seeking. Solicitation of the SSN is authorized under the provisions of Executive Order 9397, dated November 22, 1943. The SSN is used as an identifier throughout your Federal career from the time of application through retirement. 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 your 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. The SSN also will be used for the selection of persons to be included in statistical studies of personnel management matters. The use of the SSN is made necessary because of the large number of present and former Federal employees and applicants who have identical names and birth dates, and whose identities can only be distinguished by the SSN.



APPLICATION FOR NURSES AND NURSE ANESTHETISTS

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 to determine your eligibility for appointment in Veterans Health Administration. Type, or print in ink. If additional space is required, please attach a separate sheet and refer to items being answered by number.

1. NAME (Last, First, Middle)		2. APPLICATION FOR (Check one) <input type="checkbox"/> GENERAL PRACTICE <input type="checkbox"/> SPECIALTY (Identify below)	
3. PRESENT ADDRESS (Include ZIP Code)		4. TELEPHONE NUMBER (Include Area Code)	
		4A. RESIDENCE	4B. BUSINESS
5. DATE OF BIRTH	6. PLACE OF BIRTH	7. SOCIAL SECURITY NUMBER	
8A. 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 8B)		8B. COUNTRY OF WHICH YOU ARE A CITIZEN	
9A. HAVE YOU EVER FILED APPLICATION FOR APPOINTMENT IN THE VA <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" complete items 9B and 9C)		9B. NAME OF OFFICE WHERE FILED	9C. DATE FILED
10. WHEN MAY INQUIRY BE MADE OF YOUR PRESENT EMPLOYER		11. DATE AVAILABLE FOR EMPLOYMENT	

I - ACTIVE MILITARY DUTY

12A. DATE FROM	12B. DATE TO	12C. SERIAL OR SERVICE NO.	12D. BRANCH OF SERVICE	12E. TYPE OF DISCHARGE <input type="checkbox"/> HONORABLE <input type="checkbox"/> Other (Explain on separate sheet)
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II - REGISTRATION AND CLINICAL PRIVILEGES

13A. LIST ALL STATES/TERRITORIES IN WHICH YOU ARE NOW OR HAVE EVER BEEN REGISTERED AS A NURSE (If necessary, continue on separate sheet)	13B. REGISTRATION NUMBER	13C. EXPIRATION DATE

14. ARE YOU FULLY REGISTERED IN EVERY STATE IN WHICH YOU ARE NOW REGISTERED (If restricted, limited or probational in any State(s), explain on separate sheet) <input type="checkbox"/> YES <input type="checkbox"/> NO	15. DO YOU HAVE PENDING OR HAVE YOU EVER HAD ANY REGISTRATION TO PRACTICE REVOKED, SUSPENDED, DENIED, RESTRICTED, LIMITED, OR ISSUED/PLACED ON A PROBATIONAL STATUS OR VOLUNTARILY RELINQUISHED <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" explain on separate sheet)	16. HAVE YOU EVER HELD A REGISTRATION TO PRACTICE THAT IS NO LONGER HELD OR CURRENT <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" explain on separate sheet)
17A. DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD CLINICAL PRIVILEGES AT ANY HEALTH CARE INSTITUTION, AGENCY OR ORGANIZATION <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" explain on separate sheet)	17B. NAME OF CURRENT OR MOST RECENT INSTITUTION, AGENCY OR ORGANIZATION WHERE HELD	17C. HAVE ANY OF YOUR STAFF APPOINTMENTS OR CLINICAL PRIVILEGES EVER BEEN DENIED, REVOKED, SUSPENDED, REDUCED, LIMITED, OR VOLUNTARILY RELINQUISHED <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" explain on separate sheet)

III - NURSE ANESTHETIST CERTIFICATION (To be completed by Nurse Anesthetists only)

18A. ARE YOU CERTIFIED AS A NURSE ANESTHETIST BY THE COUNCIL ON CERTIFICATION OF NURSE ANESTHETISTS (CCNA) <input type="checkbox"/> YES <input type="checkbox"/> NO	18B. WHAT IS THE DATE OF YOUR CERTIFICATION OR MOST RECENT RECERTIFICATION (GIVE MONTH AND YEAR)	18C. WHAT IS YOUR AMERICAN ASSOCIATION OF NURSE ANESTHETISTS (AANA) IDENTIFICATION NUMBER	18D. HAS YOUR CCNA CERTIFICATION EVER BEEN REVOKED <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" explain on separate sheet)
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IV - THIS SECTION TO BE COMPLETED BY FACILITY DIRECTOR OR DESIGNEE

CERTIFICATION: I certify that I have verified registration with State boards, and sighted visa or evidence of citizenship. Board certification has been verified (if appropriate).		
19. EVIDENCE HAS BEEN SIGHTED IN REGARDS TO:		
<input type="checkbox"/> CERTIFICATION AS A NURSE ANESTHETIST	<input type="checkbox"/> VISA	
<input type="checkbox"/> REGISTRATION FOR ALL STATES LISTED BY APPLICANT	<input type="checkbox"/> NATURALIZED CITIZENSHIP	
<input type="checkbox"/> CURRENT OR MOST RECENT CLINICAL PRIVILEGES		
<input type="checkbox"/> NO CURRENT OR PREVIOUS CLINICAL PRIVILEGES		
20A. SIGNATURE OF FACILITY DIRECTOR OR DESIGNEE	20B. TITLE	20C. DATE

V - PROFESSIONAL LIABILITY INSURANCE

21A. PRESENT PROFESSIONAL LIABILITY INSURANCE CARRIER	21B. DATE COVERAGE BEGAN	21C. NAME OF PRIOR CARRIER	21D. DATES OF COVERAGE		22. HAS ANY CARRIER EVER CANCELLED, DENIED OR REFUSED TO RENEW YOUR INSURANCE <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" explain on separate sheet)
			FROM	TO	

VI - QUALIFICATIONS

BASIC NURSING EDUCATION (Continue on separate sheet if necessary)

23A. NAME OF SCHOOL	23B. ADDRESS (City, State and ZIP Code)	23C. LENGTH OF PROGRAM	23D. DATE COMPLETED	23E. DIPLOMA OR DEGREE RECEIVED

ADDITIONAL EDUCATION (Continue on separate sheet if necessary)

24A. NAME OF SCHOOL	24B. ADDRESS (City, State and ZIP Code)	24C. MAJOR	24D. DATE COMPLETE	24E. CREDITS	24F. DEGREE

25. IS YOUR PROFESSIONAL BIOGRAPHY COMPILED <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" please forward a copy to the VA)	NOTE: IF YOUR COLLEGE OR UNIVERSITY STUDY IS NOT A PART OF YOUR PROFESSIONAL BIOGRAPHY, PLEASE SEND OFFICIAL TRANSCRIPT(S)
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VII - NURSING EXPERIENCE

26A. EMPLOYER	26B. ADDRESS (City, State and ZIP Code)	26C. POSITION	26D. FULL TIME	26E. PART-TIME AVERAGE HOURS PER WEEK	26F. DATES EMPLOYED	
					FROM	TO
			<input type="checkbox"/>	<input type="checkbox"/>		

NAME AND TITLE OF DIRECTOR OF NURSING OR OF OTHER DEPARTMENT TO WHICH YOU WERE ASSIGNED

			<input type="checkbox"/>	<input type="checkbox"/>		
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NAME AND TITLE OF DIRECTOR OF NURSING OR OF OTHER DEPARTMENT TO WHICH YOU WERE ASSIGNED

			<input type="checkbox"/>	<input type="checkbox"/>		
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NAME AND TITLE OF DIRECTOR OF NURSING OR OF OTHER DEPARTMENT TO WHICH YOU WERE ASSIGNED

VIII - GENERAL INFORMATION

27. NAMES UNDER WHICH YOU WERE EMPLOYED. IF DIFFERENT FROM NAME GIVEN IN ITEM 1.

28. LIST ALL PROFESSIONAL PUBLICATIONS, SCIENTIFIC PAPERS, HONORS, AWARDS, RESEARCH GRANTS, FELLOWSHIPS AND SPECIALTY CERTIFICATION (If additional space is required, attach separate sheet).

IX - REFERENCES

NOTE: LIST FOUR PERSONS LIVING IN THE UNITED STATES WHO ARE NOT RELATED TO YOU BY BLOOD OR MARRIAGE AND WHO HAVE BEEN IN A POSITION TO JUDGE YOUR PROFESSIONAL QUALIFICATIONS DURING THE PAST FIVE YEARS.

29A. NAME	29B. ADDRESS (Street, City, State and ZIP Code)	29C. AREA CODE/PHONE NO.	29D. BUSINESS OR OCCUPATION

ITEM NO.	PLACE AN "X" IN APPROPRIATE SPACE. IF "YES" EXPLAIN DETAILS ON SEPARATE SHEET OF PAPER	YES	NO
30.	Do you receive or do you have a pending application for retirement or retainer pay, pension, or other compensation based upon military, Federal civilian, or District of Columbia service?	<input type="checkbox"/>	<input type="checkbox"/>
31.	Does the Department of Veterans Affairs employ any relative of yours (by blood or marriage)? If "YES" give separately such relative's (1) full name; (2) relationship; (3) VA position and employment location.	<input type="checkbox"/>	<input type="checkbox"/>
32.	ARE YOU NOW, OR HAVE YOU EVER BEEN, INVOLVED IN ADMINISTRATIVE, PROFESSIONAL OR JUDICIAL PROCEEDINGS IN WHICH MALPRACTICE ON YOUR PART IS OR WAS ALLEGED? (If "YES" give details including name of action or proceedings, date filed, court or reviewing agency, and the status or disposition of case concerning allegations, together with your explanation of the circumstances involved.) (As a provider of health care services, the VA has an obligation to exercise reasonable care in determining that applicants are properly qualified. It is recognized that many allegations of professional malpractice are proven groundless. Any conclusion concerning your answer as it relates to professional qualifications will be made only after a full evaluation of the circumstances involved.)	<input type="checkbox"/>	<input type="checkbox"/>

NOTE: A conviction or a discharge does not necessarily mean you cannot be appointed. The nature of the conviction or discharge and how long ago it occurred is important. Give all the facts so that a decision can be made. If your answer to question 35, 36 or 37 is "YES" give for each offense: (1) date; (2) charge; (3) place; (4) court and (5) action taken. When answering item 35 or 36, you may omit (1) traffic fines for which you paid a fine of \$100.00 or less; (2) any offense committed before your 18th birthday which was finally adjudicated in a juvenile court or under a youth offender law; (3) any conviction the record of which has been expunged under Federal or State law; and (4) any conviction set aside under the Federal Youth Corrections Act or similar State authority.

33.	Within the last five years have you been discharged from any position for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
34.	Within the last five years have you resigned or retired from a position after being notified you would be disciplined or discharged, or after questions about your clinical competence were raised?	<input type="checkbox"/>	<input type="checkbox"/>
35.	Have you ever been convicted, forfeited collateral, or are you now under charges for any felony or any firearms or explosives offense against the law? (A felony is defined as any offense punishable by imprisonment for a term exceeding one year, but does not include any offense classified as a misdemeanor under the laws of a State and punishable by a term of imprisonment of two years or less.)	<input type="checkbox"/>	<input type="checkbox"/>
36.	During the past seven years have you been convicted, imprisoned, on probation or parole, or forfeited collateral, or are you now under charges for any offense against the law not included in 35 above?	<input type="checkbox"/>	<input type="checkbox"/>
37.	While in the military service were you ever convicted by a general court-martial?	<input type="checkbox"/>	<input type="checkbox"/>
38.	If you were in the military service in one of these health occupations, did you ever receive a non-judicial punishment (Article 15)?	<input type="checkbox"/>	<input type="checkbox"/>
39.	Are you delinquent on any Federal debt? (Include delinquencies arising from Federal taxes, loans, overpayment of benefits, and other debts to the U.S. Government, plus defaults on any Federally guaranteed or insured loans such as student and home mortgage loans.) If "Yes" explain on a separate sheet the type, length, and amount of the delinquency or default and steps you are taking to correct errors or repay the debt. Give any identification numbers associated with the debt and the address of the Federal agency involved.	<input type="checkbox"/>	<input type="checkbox"/>

X - SIGNATURE OF APPLICANT

NOTE: A false statement on any part of your application may be grounds for not hiring you, or for terminating you after you begin work. Also, you may be punished by fine or imprisonment (U.S. Code, Title 18, Section 1001).

Un+ CERTIFICATION:

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL OF MY STATEMENTS ARE TRUE, CORRECT, COMPLETE, AND MADE IN GOOD FAITH.

40A. SIGNATURE OF APPLICANT (Sign in dark ink)	40B. DATE (Month, Day, Year)
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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 the VA to make inquiries concerning such information about me to my previous employer(s), current employer, educational institutions, State licensing boards, professional liability insurance carriers, other professional organizations and/or persons, agencies, organizations or institutions listed by me as references, and to any other appropriate sources to whom the VA may be referred by those contacted or deemed appropriate;
- Authorize release of such information and copies of related records and/or documents to VA officials;
- Release from liability all those who provide information to the VA in good faith and without malice in response to such inquiries; and
- Authorize the VA to disclose to such persons, employers, institutions, boards or agencies identifying and other information about me to enable the VA to make such inquiries.

SIGNATURE	DATE

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