DEPARTMENT OF VETERANS AFFAIRS
Medical Center
1700 South Lincoln Avenue
Lebanon, PA 17042

In Reply Refer To: 595/121

Dear_____:

Welcome to the Department of Veterans Affairs. You will be assigned to our facility from _____to _____, as an _____ under authority of 38 U.S.C. 7405 (a) (1). During your period of affiliation with our facility, you are authorized to perform services as directed by_____.

In accepting this assignment you will receive no monetary compensation and you will not be entitled to those benefits normally given to regularly paid employees of the Veterans Health Administration, such as leave, retirement, etc.

If you agree to these conditions, please sign the enclosed **file copy** of this letter, complete the enclosed forms, and return them to:

VA Medical Center
Attn: _____
1700 S. Lincoln Avenue
Lebanon, PA 17042

This agreement may be terminated at any time by either party by written notice of such intent.

Sincerely,

Dennis J. Donahoe
Human Resources Manager

Enclosure

I agree to serve in the above capacity under the conditions indicated.

Signature:_____

Date:_____

OMB Number: 2900-0205
Estimated Burden: 30 minutes

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 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. Residency, fellowship and internship announcements for clinical training programs may require additional information. All applications must include the information required by the training program to which you are applying as well as information requested on all application forms.

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

1A. NAME (Last, First, Middle)	1B. OTHER NAMES USED (For example: maiden name, nickname, etc.)
2. PRESENT ADDRESS (Include ZIP Code)	3A. DAY TELEPHONE (include area code) 3B. EVENING TELEPHONE (include area code)

4. SOCIAL SECURITY NUMBER	5. PREFERRED EMAIL ADDRESS	6. DATE OF BIRTH (mm/dd/yyyy)	7. PLACE OF BIRTH (City, State, and Country (if not U.S.A.))

8A. PROGRAM/DISCIPLINE OF STUDY	8F. CURRENT COLLEGE/UNIVERSITY/SCHOOL: INCLUDE CITY AND STATE (Do not abbreviate)
8B. ARE YOU APPLYING FOR A VA ADVANCED FELLOWSHIP PROGRAM FOR PHYSICIAN RESIDENTS? ☐ YES ☐ NO 8C. ENTER YOUR NATIONAL PROVIDER IDENTIFIER (NPI)	8G. TARGET DEGREE LEVEL OF YOUR CURRENT TRAINING PROGRAM ☐ Certificate/Diploma ☐ Master's ☐ Post-doctoral (other than residents) ☐ Associate ☐ Post-master's fellowship ☐ Baccalaureate ☐ Doctoral ☐ Residency/Fellowship
8D. START DATE OF YOUR DEGREE PROGRAM OF STUDY (mm/yyyy) 8E. EXPECTED END DATE OF YOUR DEGREE PROGRAM OF STUDY (mm/yyyy)	
9A. VA TRAINING FACILITY (City, State)	10. CHECK APPROPRIATE BOXES IF YOU ARE ENROLLED IN A COLLEGE/UNIVERSITY THAT IS CLASSIFIED AS: ☐ Tribal College or University (TCU) ☐ Historical Black College and University (HBCU) ☐ Hispanic Serving Institution (HSI)
9B. VA TRAINING START DATE (mm/yyyy) ☐ UNKNOWN 9C. VA TRAINING END DATE (mm/yyyy) ☐ UNKNOWN	

II - FOR APPLICANTS CURRENTLY ON ACTIVE DUTY IN U.S. MILITARY DUTY

11A. ARE YOU NOW IN U.S. MILITARY? ☐ YES *(If YES, complete 11b, 11c* ☐ NO	11B. SERIAL OR SERVICE NO.	11C. BRANCH OF SERVICE

III - CITIZENSHIP

12A. CITIZENSHIP ☐ U.S. CITIZEN BY BIRTH ☐ NATURALIZED U.S. CITIZEN ☐ NOT A U.S. CITIZEN (Complete item 12B)

NOTE: Complete items 13A, 13B, 13C, or 13D ONLY if you are not a U.S. citizen.

12B. COUNTRY OF CITIZENSHIP

13A. IMMIGRANT	13B. EXCHANGE VISITOR		13C. OTHER NON-IMMIGRANT		13D. FORM DS2019
"A" NUMBER	VISA TYPE	VISA NUMBER	VISA TYPE	VISA NUMBER	DO YOU HAVE A VALID DS2019? ☐ YES ☐ 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

14A. The trainee has met all of the criteria of the Trainee Qualifications & Credentials Verification Letter (TQCVL). ☐ YES ☐ NO

14B. Incomplete items on the TQCVL have been addressed and resolved. ☐ YES ☐ NO

14C. Special attention has been given to the following items from the application forms.

14D. Comments:

14E. This applicant has been approved for appointment. ☐ YES ☐ NO

14F. Comments:

15A. SIGNATURE OF FACILITY DESIGNATED EDUCATION OFFICER OR DESIGNEE	15B. TITLE	15C. DATE

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER

V- LICENSE, CERTIFICATION, OR REGISTRATION IN CURRENT CLINICAL PROFESSION

16A. 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.	16B. LICENSE, CERTIFICATION OR REGISTRATION BODY	16C. STATE ISSUING LICENSE	16D. LICENSE, CERTIFICATION OR REGISTRATION NUMBER	16E. IS THE LICENSE, REGISTRATION, OR CERTIFICATION CURRENT? IF NO, EXPLAIN IN PART XI.	16F. EXPIRATION DATE
				☐ YES ☐ NO ☐ NOT REQUIRED	
				☐ YES ☐ NO ☐ NOT REQUIRED	
				☐ YES ☐ NO ☐ NOT REQUIRED	
				☐ YES ☐ NO ☐ NOT REQUIRED	

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

17A. LIST ALL LICENSES, CERTIFICATIONS, AND REGISTRATIONS, INCLUDING DEA, THAT YOU HAVE EVER HAD AS A HEALTH PROFESSIONAL, I.E. MEDICAL, NURSING, PHARMACY, ETC.	17B. LICENSE, CERTIFICATION OR REGISTRATION BODY	17C. STATE ISSUING LICENSE	17D. LICENSE, CERTIFICATION OR REGISTRATION NUMBER	17E. IS THE LICENSE, REGISTRATION, OR CERTIFICATION CURRENT? IF NO, EXPLAIN IN PART XI.	17F. EXPIRATION DATE
				☐ YES ☐ NO ☐ NOT REQUIRED	
				☐ YES ☐ NO ☐ NOT REQUIRED	
				☐ YES ☐ NO ☐ NOT REQUIRED	
				☐ YES ☐ NO ☐ NOT REQUIRED	

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

18. DO YOU HAVE PENDING OR HAVE YOU EVER HAD ANY LICENSE, CERTIFICATION, OR REGISTRATION TO PRACTICE (including DEA Certificate) REVOKED, SUSPENDED, DENIED, RESTRICTED, LIMITED, OR ISSUED/PLACED ON A PROBATIONAL STATUS OR VOLUNTARILY RELINQUISHED? ☐ YES - EXPLAIN IN PART XI ☐ NO

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

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

20A. NAME OF SCHOOL	20B. ADDRESS (City, State, and Zip Code)	20C. START DATE (mm/yy)	20D. DATE COMPLETED (mm/yy)	20E. DIPLOMA/DEGREE/ CERTIFICATE OR QUALIFICATIONS RECEIVED	20F. MAJOR FIELD OF STUDY

VIII - GRADUATES OF AN INTERNATIONAL MEDICAL SCHOOL

21A. ARE YOU A GRADUATE OF AN INTERNATIONAL MEDICAL SCHOOL? ☐ YES ☐ NO	21B. EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG) CERTIFICATE NUMBER	21C. ECFMG CERTIFICATE DATE

IX- INTERNSHIP, RESIDENCY AND FELLOWSHIP TRAINING

22A. NAME OF HOSPITAL OR INSTITUTION	22B. ADDRESS (City, State and ZIP Code)	22C. SPECIALTY	22D. COMPLETED (mm/yy)	22E. AMOUNT OF TIME APPROVED BY SPECIALTY BOARD

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER

ITEM	X - ADDITIONAL QUESTIONS PLACE AN 'x' IN APPROPRIATE SPACE. IF YES, EXPLAIN DETAILS IN PART XI.	YES	NO
23	If you have ever participated in the Medicare/Medicaid Program, were you convicted of and or investigated for making and/or using false, fictitious, or fraudulent statements, representations, writings or documents, regarding a material fact in connection with the delivery of or payment for health care benefits, items or services that would be in violation of the Criminal False Claims Act?	☐	☐
24	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 in Part XI, 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.	☐	☐
25	Do you need accommodations to perform the procedures and essential functions of the training position for which you have applied?	☐	☐

ITEM NO.	XI - REMARKS (Include additional information requested in items above. Be sure to indicate item number on Form to which the comment refers.)

XII - 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.

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).

26A. SIGNATURE OF APPLICANT (sign in dark ink)	26B. DATE (month, day, year)

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 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.

☐ Authorize VA to share any information about me with the affiliated institution and /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 per response, including the time for reviewing instructions, searching existing data sources, gathering data and 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 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 appointment to a residency, advanced fellowship, fellowship, internship or other type of clinical training appointment. If you are appointed 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. It may be used to check the National Practitioner Health Integrity and Protection Data Bank(HIPDB) or the List of Exclusions is maintained by Health and Human Services (HHS) Office of Inspector General (OIG) on the List of Excluded Individuals and Entities (LEIE), to State licensing boards, and/or appropriate professional organizations or agencies to assist the VA in determining your suitability for a clinical training appointment. This information may also be used to periodically verify, evaluate and update your clinical privileges, credentials 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 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 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 at any time. The information from this form may also be used to survey you regarding employment opportunities in VA and solicit you perceptions regarding your clinical training experience at VA and non-VA facilities.

EFFECTS OF NON-DISCLOSURE: See statement below concerning disclosure of your social security number. Your obligation to respond is mandatory and 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, "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 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.

APPOINTMENT AFFIDAVITS

_____ _____
(Position to which Appointed) *(Date Appointed)*

_____ _____ _____
(Department or Agency) *(Bureau or Division)* *(Place of Employment)*

I, _____, do solemnly swear (or affirm) that--

A. OATH OF OFFICE

I will support and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties of the office on which I am about to enter. So help me God.

B. AFFIDAVIT AS TO STRIKING AGAINST THE FEDERAL GOVERNMENT

I am not participating in any strike against the Government of the United States or any agency thereof, and I will not so participate while an employee of the Government of the United States or any agency thereof.

C. AFFIDAVIT AS TO THE PURCHASE AND SALE OF OFFICE

I have not, nor has anyone acting in my behalf, given, transferred, promised or paid any consideration for or in expectation or hope of receiving assistance in securing this appointment.

_____
(Signature of Appointee)

Subscribed and sworn (or affirmed) before me this____ day of _____ , 2____

at _____ _____
(City) (State)

_____
(Signature of Officer)

(SEAL)

Commission expires_____ _____
(If by a Notary Public, the date of his/her Commission should be shown) (Title)

Note - If the appointee objects to the form of the oath on religious grounds, certain modifications may be permitted pursuant to the Religious Freedom Restoration Act. Please contact your agency's legal counsel for advice.

Declaration for Federal Employment*

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

Form Approved:
OMB 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 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?	4. DATE OF BIRTH (MM / DD / YYYY)
☐ YES ☐ NO (If "NO", provide country of citizenship) ♦	♦
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*

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

Form Approved:
OMB 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: _____ (Sign in ink) Date _____

17b. Appointee's Signature: _____ (Sign in ink) Date _____

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? MM / DD / YYYY DATE:

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

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			B. Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any)* *(mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

ABUSE OF PATIENTS

1. **PURPOSE**: To inform employees of the Department of Veterans Affairs policy in cases of suspected abuse of patients by employees.

2. **POLICY**: An absolute requirement of the Department of Veterans Affairs is that patients will be shown every courtesy and that they will, at all times, be treated with kindness and sympathetic respect. Any employee who mistreats a patient, either verbally or physically, will be subject to appropriate disciplinary action. Disciplinary action will be initiated against any employee who witnesses any abuse or mistreatment of a patient and who fails to promptly report the incident to their immediate supervisor.

3. **DEFINITION**: Patient abuse is the maltreatment of a patient, which includes mental, physical, sexual and verbal abuse such as the following:

a. Any action or behavior that conflicts with a patient's rights, identified in VA Regulations 38 CFR 17.34a

b. Intentional omission of care

c. Willful violation of a patient's privacy

d. Intimidation, harassment or ridicule of a patient

e. Willful physical injury

It should be noted that one does not have to intend to abuse a patient to commit patient abuse.

4. **PROCEDURES**:

a. Any abuse will be immediately reported by the employee(s) that witnessed the incident to their immediate supervisor. The employee who first receives an allegation of patient abuse from a patient, member of the patient's family, or other source will also immediately report the allegation to their immediate supervisor. Any incident or allegation of a criminal nature will also be reported to the VA Police. The supervisor receiving the report will immediately notify the medical center's Patient Safety Manager at extension 4018 and the VA Police, as appropriate. Procedures outlined in the current memorandum, Patient Safety Improvement Program, will then be followed in reporting these type incidents; i.e., completion of VA Form 10-2633, Report of Special Incident Involving a Beneficiary.

b. The administrative penalty action for patient abuse is removal. However, a lesser penalty of admonishment, reprimand, suspension or demotion, may be imposed when mitigating or extenuating circumstances clearly warrant such lesser penalty or the nature of the abuse is minor.

Abuse of a minor nature constitutes such acts as teasing a patient, speaking harshly, rudely, or irritably to a patient; laughing at or ridiculing a patient; scolding a patient; and indifference to a patient.

c. When there is general or recurring abuse, full inquiry will be made into the methods and kinds of supervision exercised in the care and treatment of patients to determine to what extent the management of the facility is at fault. Those persons found to be responsible or guilty must be dealt with in the proportion to the degree of their responsibility or guilt.

d. Steps will be taken to ensure that all employees are kept fully informed of this policy, so that not only will all possible measures be taken to avoid abuse and mistreatment of patients but also to ensure that any responsible and guilty employees will be disciplined in line with VA policy as specified.

e. Every new employee will be required to acknowledge receipt of this policy statement and will certify that they have read and understand the medical center policy on abuse of patients. The certification will be filed in the employee's official personnel folder.

5. **RESPONSIBILITIES**:

a. **Supervisors** at all levels are responsible for assuring that prompt inquiry or investigation is conducted in instances of alleged abuse or mistreatment of a patient. Charges of abuse or mistreatment of a patient must be sustained against a VA employee if supported by the evidence developed.

b. **Chief, Education and Staff Development**, is responsible for scheduling, on the basis of need, initial and refresher training deemed appropriate in restraining hyperactive patients.

c. **Employees**. It is mandatory for all employees to fully support and strictly comply with this policy.

d. **VA Police** will investigate all incidents of patient abuse dealing directly with circumstances of a criminal nature.

6. **REFERENCES**:

VA Handbook 5021
VA Regulations, Title 38 CFR, 17.33a
Current Joint Commission Comprehensive Accreditation Manual for Hospitals

Attachment

Attachment

PENALTIES IN CASES OF ABUSE OF PATIENTS BY EMPLOYEES

TO: Human Resources Manager (121)

I hereby acknowledge receipt of a copy of the medical center policy on Penalties in Cases of Abuse of Patients by Employees. I have read and completely understand the requirements of this policy.

Employee signature_____

Care Line_____

Date_____

SEXUAL HARASSMENT

1. **PURPOSE**: To set forth medical center policy on sexual harassment.

2. **POLICY**: It is the policy of the Department of Veterans Affairs and this medical center that sexual harassment is unacceptable conduct in the workplace and will not be tolerated or condoned. Sexual harassment is a prohibited personnel practice when it results in discrimination for or against an employee on the basis of conduct not related to job performance.

3. **PROCEDURES:**

a. Definition. Sexual harassment is a form of employee mis-conduct, which seriously undermines the integrity of the employment relationship. Specifically, sexual harassment is unwelcomed sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when:

(1) Submission to such conduct is made either explicitly or implicitly a term or condition of employment;

(2) Submission to or rejection of such conduct by an individual is used as a basis for employment decisions affecting such individual;

(3) Such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive work environment; or

(4) In third-party situations, an individual is offended by the sexual interaction, conduct, or communications between others.

b. Furthermore, jokes, remarks, teasing, or questions that contain sexual overtones can also be a form of sexual harassment and are not acceptable in a professional work environment and will not be condoned.

c. Complaints. Employees shall process complaints of sexual harassment by discussing the matter with their supervisors or a supervisor above them in the line of authority. If the complaint is not satisfactorily resolved by their supervisors the employee may:

(1) File an EEO complaint based on sexual harassment.

(2) File a complaint under the negotiated contract grievance procedures or under the Department of Veterans Affairs administrative grievance procedures based on sexual harassment.

(3) File a complaint with the Special Counsel of the Merit Systems Protection Board if an adverse action is involved.

(4) File a complaint with the Special Counsel of the Merit Systems Protection Board if a prohibited personnel practice is involved or if there is a violation of the merit system principles. Human Resources will provide full information and assistance to any employee wanting to file a complaint or report an incident of sexual harassment.

4. **RESPONSIBILITIES:**

a. All **supervisors** will refrain from the use of implicit or explicit coercive sexual behavior to control, influence, or affect the career, salary, or job of an employee. Supervisors will expeditiously investigate and take corrective action whenever a complaint of sexual harassment is brought to their attention. Complaints of harassment will be examined impartially and resolved promptly.

b. All **employees** will refrain from participating in deliberate or repeated unsolicited verbal comments, gestures, or physical contact of a sexual nature. Employees are also responsible for discouraging any unwelcomed activities and for promptly reporting any incident of misconduct.

c. **Human Resources Manager**, will provide advice to supervisors and employees concerning any complaint of sexual harassment and assist in efforts to resolve and prevent incidents of sexual harassment.

5. **REFERENCES**:

MP-7, pt. I, ch. 3
VHA Directive 10-95-055, dated June 2, 1995