

Beckley VAMC Checklist

Name _____

College/ Affiliation _____

__PIV Form

__Two Forms of Identification

__10-28500 Application for Health Professions Trainees

__OF 306 Declaration for Federal Employment

__SF 61 Appointment Affidavit

__Form 1-9

__Drug Testing Authorization Form

__JIT ROB Form

__WOC Appointment Letter

__Influenza Form - Only if you do not take the vaccine

__COVID Vaccination Form

__COVID Card

__Mandatory Training Completed

__For Stipend (paid) students – Human Resources will contact.

Direct deposit information will be needed- Bank Routing and Account Number

****This form is not part of the HPT's onboarding scanned documents**

FINGERPRINT REQUEST FORM

Bring with you two (2) original IDs (Identity Source Documents) from the list below

<https://www.oit.va.gov/programs/piv/media/docs/IDMatrix.pdf>

Complete all fields on this form to the best of your ability

Applicant Category: Check One

<input type="checkbox"/>	EMPLOYEE	<input type="checkbox"/>	CONTRACTOR	<input checked="" type="checkbox"/>	HEALTH PROFESSIONS TRAINEE (VHA intern, resident, fellow, student)
<input checked="" type="checkbox"/>	AFFILIATE	<input type="checkbox"/>	VOLUNTEER	<input type="checkbox"/>	OTHER:

ENTER YOUR NAME EXACTLY AS IT APPEARS ON IDs

<u>Name: (Last, First, Middle)</u>		<u>Other Last Names Used</u>	
<u>SSN</u> (use of pseudo number is not permitted)	<u>Position Title</u>		<u>Telephone #</u>
<u>Date of Birth: (mm/dd/yyyy)</u>	<u>City/State and Country of Birth</u>		
<u>E-Mail Address</u>	<u>Country of Citizenship</u>		<u>Dual Citizen?</u>
<u>VA Work Location</u> Beckley VA	<u>Organization (VHA, VBA, NCA, VACO, etc.)</u> VHA		<u>Start Date</u>
<u>Contractors Only: Company Name</u>		<u>Company Address/Work Email</u>	
<u>Health Professions Trainees Only: School Name</u> <u>Training Program</u>			

FINGERPRINT LOCATION		FINGERPRINT DATE (mm/dd/yyyy)		PREVIOUS VA PIV CARD HOLDER (Yes/No)	
GENDER (M/F)	HEIGHT (inches)	WEIGHT (US pounds)	HAIR COLOR	EYE COLOR	RACE/ETHNICITY

Courtesy Prints for another Facility: ☐

Facility: _____

SOI# _____

SON# _____

Fingerprint Results Cleared: YES NO (Circle One)

Date/Initials of Clearance: _____



Department of Veterans Affairs

APPLICATION FOR HEALTH PROFESSIONS TRAINEES

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

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

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

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

II - U.S. MILITARY DUTY STATUS

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

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

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

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

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

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

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

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

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

15. ENTER YOUR NATIONAL PROVIDER IDENTIFIER (NPI) _____

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

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

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

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

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

VIII - GRADUATES OF AN INTERNATIONAL MEDICAL SCHOOL

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

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

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

SIGNATURE OF APPLICANT <i>(Sign in ink)</i>	DATE
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PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE

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

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

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

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

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

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

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

Declaration for Federal Employment*

Form Approved:
OMB No. 3206-0182

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

Instructions

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

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

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

Privacy Act Statement

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

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

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

Public Burden Statement

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

Declaration for Federal Employment*

Form Approved:
OMB No. 3206-0182

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

GENERAL INFORMATION

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

2. **SOCIAL SECURITY NUMBER**

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

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

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

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

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

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

Day

Night

Selective Service Registration

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

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

☐ YES

☐ NO (If "NO", proceed to 8.)

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

☐ YES (If "YES", proceed to 8.)

☐ NO (If "NO", proceed to 7c.)

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

Military Service

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

☐ YES (If "YES", provide information below) ☐ NO

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

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

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

Background Information

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

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

9. During the last 7 years, have you been convicted, been imprisoned, been on probation, or been on parole? (Includes felonies, firearms or explosives violations, misdemeanors, and all other offenses.) If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved.

☐ YES ☐ NO

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

☐ YES ☐ NO

11. Are you currently under charges for any violation of law? If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved.

☐ YES ☐ NO

12. During the last 5 years, have you been fired from any job for any reason, did you quit after being told that you would be fired, did you leave any job by mutual agreement because of specific problems, or were you debarred from Federal employment by the Office of Personnel Management or any other Federal agency? If "YES," use item 16 to provide the date, an explanation of the problem, reason for leaving, and the employer's name and address.

☐ YES ☐ NO

13. Are you delinquent on any Federal debt? (Includes delinquencies arising from Federal taxes, loans, overpayment of benefits, and other debts to the U.S. Government, plus defaults of Federally guaranteed or insured loans such as student and home mortgage loans.) If "YES," use item 16 to provide the type, length, and amount of the delinquency or default, and steps that you are taking to correct the error or repay the debt.

☐ YES ☐ NO

Declaration for Federal Employment*

Form Approved:
OMB No. 3206-0182

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

Additional Questions

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

Continuation Space / Agency Optional Questions

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

Certifications / Additional Questions

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

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

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

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

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

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)

(SEAL)

(Signature of Officer)

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.



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):

<input type="checkbox"/> 1. A citizen of the United States
<input type="checkbox"/> 2. A noncitizen national of the United States (See instructions)
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____
<input type="checkbox"/> 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)
<p>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.</p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>
<p>QR Code - Section 1 Do Not Write In This Space</p>

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



Employer Completes Next Page





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
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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		Additional Information		<div>QR Code - Sections 2 & 3</div> <div>Do Not Write in This Space</div>
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				

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. Rehire/Retiree (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
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (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. 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 		<ol style="list-style-type: none"> 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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 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: <ol style="list-style-type: none"> 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 		<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 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. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

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.

**Department of
Veterans Affairs**

Memorandum

From: VHA Office of Academic Affiliations (OAA)

Subj: Random Drug Testing Notification and Acknowledgement

To: Health Professions Trainee (HPT) in a Testing Designated Positions (TDP)

1. On September 15, 1986, President Reagan signed Executive Order 12564, Drug-Free Federal Workplace, establishing a policy against the use of illegal drugs by Federal employees, whether on or off duty. In accordance with the Executive Order, VA has established a Drug-Free Workplace Program to include random testing for the use of illegal drugs by employees (to include trainees) in sensitive positions.
2. This is to notify you that as an HPT in a sensitive position you may be subject to random drug testing. The testing procedures, including the collection of a urine specimen, will be conducted in accordance with Department of Health and Human Services (HHS) Guidelines for Drug Testing Programs.
 - a. The only VHA Training Programs exempt from Random Drug Testing per policy are:
Clinical Pastoral Education (Chaplain), Social Work, Dietetics, Occupational Therapy, Optometry, Audiology, Speech Pathology, Non-Clinical and Administrative
3. You can be assured that the quality of testing procedures is tightly controlled, that the test used to confirm use of illegal drugs is highly reliable and that the test results will be handled with maximum respect for individual confidentiality, consistent with safety and security.
4. As a trainee subject to random drug testing you should be aware of the following:
 - Counseling and rehabilitation assistance are available to all trainees through existing Employee Assistance Programs (EAP) at VA facilities (information on EAP can be obtained from your local Human Resources office).
 - You will be given the opportunity to submit supplemental medical documentation of lawful use of an otherwise illegal drug to a Medical Review Officer (MRO).
 - VA will initiate termination of VA appointment and/or dismissal from VA rotation proceedings against any trainee who is found to use illegal drugs on the basis of a verified positive drug test.
 - Termination and/or dismissal from VA rotation proceedings will be initiated against any trainee who refuses to be tested.
5. Random testing will begin no sooner than 30 days from the date you sign this acknowledgement.
6. Visit the US Office of Personnel Management (OPM) Work-Life webpage for information on Services Available for You, Guidance & Legislation as well as Substance User Disorder.
<https://www.opm.gov/policy-data-oversight/worklife/employee-assistance-programs/>

I acknowledge receiving and reading the notice which states that my position may be designated for random drug testing, and that, if selected, refusal to submit to testing will result in termination and/or dismissal from the VA.

Training Program and Affiliate

Print Name and Date Signed

Signature



Appendix A: Department of Veteran Affairs Information Security Rules of Behavior for Organizational Users

1. COVERAGE

- a. Department of Veterans Affairs (VA) Information Security Rules of Behavior (ROB) provides the specific responsibilities and expected behavior for organizational users and non-organizational users of VA systems and VA information as required by OMB Circular A-130, Appendix III, paragraph 3a(2)(a) and VA Handbook 6500, *Managing Information Security Risk: VA Information Security Program*.
- b. *Organizational users* are identified as VA employees, contractors, researchers, students, volunteers, and representatives of Federal, state, local or tribal agencies not representing a Veteran or claimant.
- c. *Non-organizational users* are identified as all information system users other than VA users explicitly categorized as organizational users. These include individuals with a Veteran/claimant power of attorney. Change Management Agents at the local facility are responsible for on-boarding power of attorney/private attorneys.
- d. VA Information Security ROB does not supersede any policies of VA facilities or other agency components that provide higher levels of protection to VA's information or information systems. The VA Information Security ROB provides the minimal rules with which individual users must comply. Authorized users are required to go beyond stated rules using "due diligence" and the highest ethical standards.

2. COMPLIANCE

- a. Non-compliance with VA ROB may be cause for disciplinary actions. Depending on the severity of the violation and management discretion, consequences may include restricting access, suspension of access privileges, reprimand, demotion and suspension from work. Theft, conversion, or unauthorized disposal or destruction of Federal property or information may result in criminal sanctions.
- b. Unauthorized accessing, uploading, downloading, changing, circumventing, or deleting of information on VA systems; unauthorized modifying VA systems, denying or granting access to VA systems; using VA resources for unauthorized use on VA systems; or otherwise misusing VA systems or resources is strictly prohibited.
- c. VA Information Security Rules of Behavior (ROB) does not create any other right or benefit, substantive or procedural, enforceable by law, by a party in litigation with the U.S. Government.

3. ACKNOWLEDGEMENT

- a. VA Information Security ROB must be signed before access is provided to VA information systems or VA information. The VA ROB must be signed annually by all users of VA information systems or VA information. This signature indicates agreement to adhere to the VA ROB. Refusal to sign VA Information Security ROB will result in denied access to VA information systems or VA information. Any refusal to sign the VA Information Security ROB may have an adverse impact on employment with VA.



- b. The ROB may be signed in hard copy or electronically. If signed using the hard copy method, the user should initial and date each page and provide the information requested under Acknowledgement and Acceptance For Other Federal Government Agency users, documentation of a signed ROB will be provided to the VA requesting official.

4. INFORMATION SECURITY RULES of BEHAVIOR

Access and Use of VA Information Systems

I Will:

- Comply with all federal VA information security, privacy, and records management policies. SOURCE: PM-1
- Have NO expectation of privacy in any records that I create or in my activities while accessing or using VA information systems. SOURCE: AC-8
- Use only VA-approved devices, systems, software, services, and data which I am authorized to use, including complying with any software licensing or copyright restrictions. SOURCE: AC-6
- Follow established procedures for requesting access to any VA computer system and for notifying my VA supervisor or designee when the access is no longer needed. SOURCE: AC- 2
- Only use my access to VA computer systems and/or records for officially authorized and assigned duties. SOURCE: AC-6
- Log out of all information systems at the end of each workday. SOURCE: AC-11
- Log off or lock any VA computer or console before walking away. SOURCE: AC-11
- Only use other Federal government information systems as expressly authorized by the terms of those systems; personal use is prohibited. SOURCE: AC-20
- Only use VA-approved solutions for connecting non-VA-owned systems to VA's network. SOURCE: AC-20

I Will Not:

- Attempt to probe computer systems to exploit system controls or to obtain unauthorized access to VA sensitive data. SOURCE: AC-6
- Engage in any activity that is prohibited by VA Directive 6001, Limited Personal Use of Government Office Equipment Including Information Technology. SOURCE: AC-8
- Have a VA network connection and a non-VA network connection (including a modem or phone line or wireless network card, etc.) physically connected to any device at the same time unless the dual connection is explicitly authorized. SOURCE: AC-17 (k)



- Host, set up, administer, or operate any type of Internet server or wireless access point on any VA network unless explicitly authorized by my Information System Owner, local Chief Information Officer (CIO) or designee, and approved by my Information Security Officer (ISO). SOURCE: AC-18

Protection of Computing Resources

I Will:

- Secure mobile devices and portable storage devices (e.g., laptops, Universal Serial Bus (USB) flash drives, smartphones, tablets, personal digital assistants (PDA)). SOURCE: AC-19

I Will Not:

- Swap or surrender VA hard drives or other storage devices to anyone other than an authorized OI&T employee. SOURCE: MP-4
- Attempt to override, circumvent, alter or disable operational, technical, or management security configuration controls unless expressly directed to do so by authorized VA staff. SOURCE: CM-3

Electronic Data Protection

I Will:

- Only use virus protection software, anti-spyware, and firewall/intrusion detection software authorized by VA. SOURCE: SI-3
- Safeguard VA mobile devices and portable storage devices containing VA information, at work and remotely, using FIPS 140-2 validated encryption (or its successor) unless it is not technically possible. This includes laptops, flash drives, and other removable storage devices and storage media (e.g., Compact Discs (CD), Digital Video Discs (DVD)). SOURCE: SC-13
- Only use devices encrypted with FIPS 140-2 (or its successor) validated encryption. VA owned and approved storage devices/media must use VA's approved configuration and security control requirements. SOURCE: SC-28
- Use VA e-mail in the performance of my duties when issued a VA email account. SOURCE: SC-8
- Obtain approval prior to public dissemination of VA information via e-mail as appropriate. SOURCE: SC-8

I Will Not:

- Transmit VA sensitive information via wireless technologies unless the connection uses FIPS 140-2 (or its successor) validated encryption. SOURCE: AC-18
- Auto-forward e-mail messages to addresses outside the VA network. SOURCE: SC-8
- Download software from the Internet, or other public available sources, offered as free trials, shareware; or other unlicensed software to a VA-owned system. SOURCE: CM-11



- Disable or degrade software programs used by VA that install security software updates to VA computer equipment, to computer equipment used to connect to VA information systems, or used to create, store or use VA information. SOURCE: CM- 10

Teleworking and Remote Access

I Will:

- Keep government furnished equipment (GFE) and VA information safe, secure, and separated from my personal property and information, regardless of work location. I will protect GFE from theft, loss, destruction, misuse, and emerging threats. SOURCE: AC-17
- Obtain approval prior to using remote access capabilities to connect non-GFE equipment to VA's network while within the VA facility. SOURCE: AC-17
- Notify my VA supervisor or designee prior to any international travel with a GFE mobile device (e.g. laptop, PDA) and upon return, including potentially issuing a specifically configured device for international travel and/or inspecting the device or reimaging the hard drive upon return. SOURCE: AC-17
- Safeguard VA sensitive information, in any format, device, system and/or software in remote locations (e.g., at home and during travel). SOURCE: AC-17
- Provide authorized OI&T personnel access to inspect the remote location pursuant to an approved telework agreement that includes access to VA sensitive information. SOURCE: AC-17
- Protect information about remote access mechanisms from unauthorized use and disclosure. SOURCE: AC-17
- Exercise a higher level of awareness in protecting GFE mobile devices when traveling internationally as laws and individual rights vary by country and threats against Federal employee devices may be heightened. SOURCE: AC-19

I Will Not:

- Access non-public VA information technology resources from publicly- available IT computers, such as remotely connecting to the internal VA network from computers in a public library. SOURCE: AC-17
- Access VA's internal network from any foreign country designated as such unless approved by my VA supervisor, ISO, local CIO, and Information System Owner. SOURCE: AC-17

User Accountability

I Will:

- Complete mandatory security and privacy awareness training within designated time frames, and complete any additional role-based security training required based on my role and responsibilities. SOURCE: AT-3



- I Understand that authorized VA personnel may review my conduct or actions concerning VA information and information systems, and take appropriate action. SOURCE: AU-1
- Have my GFE scanned and serviced by VA authorized personnel. This may require me to return it promptly to a VA facility upon demand. SOURCE: MA-2
- Permit only those authorized by OI&T to perform maintenance on IT components, including installation or removal of hardware or software. SOURCE: MA-5
- Sign specific or unique ROB's as required for access or use of specific VA systems. I may be required to comply with a non-VA entity's ROB to conduct VA business. While using their system, I must comply with their ROB. SOURCE: PL-4

Sensitive Information

I Will:

- Ensure that all printed material containing VA sensitive information is physically secured when not in use (e.g., locked cabinet, locked door). SOURCE: MP-4
- Only provide access to sensitive information to those who have a need- to-know for their professional duties, including only posting sensitive information to web-based collaboration tools restricted to those who have a need-to-know and when proper safeguards are in place for sensitive information. SOURCE: UL-2
- Recognize that access to certain databases has the potential to cause great risk to VA, its customers and employees due to the number and/or sensitivity of the records being accessed. I will act accordingly to ensure the confidentiality and security of these data commensurate with this increased potential risk. SOURCE: UL-2
- Obtain approval from my supervisor to use, process, transport, transmit, download, print or store electronic VA sensitive information remotely (outside of VA owned or managed facilities (e.g., medical centers, community based outpatient clinics (CBOC), or regional offices)). SOURCE: UL-2
- Protect VA sensitive information from unauthorized disclosure, use, modification, or destruction, and will use encryption products approved and provided by VA to protect sensitive data. SOURCE: SC-13
- Transmit individually identifiable information via fax only when no other reasonable means exist, and when someone is at the machine to receive the transmission or the receiving machine is in a secure location. SOURCE: SC-8
- Encrypt email, including attachments, which contain VA sensitive information. I will not encrypt email that does not include VA sensitive information or any email excluded from the encryption requirement. SOURCE: SC-8
- Protect Sensitive Personal Information (SPI) aggregated in lists, databases, or logbooks, and will include only the minimum necessary SPI to perform a legitimate business function. SOURCE: SC-28



- Ensure fax transmissions are sent to the appropriate destination. This includes double checking the fax number, confirming delivery, using a fax cover sheet with the required notification message included. SOURCE: SC-8

I Will Not:

- Disclose information relating to the diagnosis or treatment of drug abuse, alcoholism or alcohol abuse, HIV, or sickle cell anemia without appropriate legal authority. I understand unauthorized disclosure of this information may have a serious adverse effect on agency operations, agency assets, or individuals. SOURCE IP-1
- Allow VA sensitive information to reside on non-VA systems or devices unless specifically designated and authorized in advance by my VA supervisor, ISO, and Information System Owner, local CIO, or designee. SOURCE: AC-20
- Make any unauthorized disclosure of any VA sensitive information through any means of communication including, but not limited to, e-mail, instant messaging, online chat, and web bulletin boards or logs. SOURCE: SC-8

Identification and Authentication

I Will:

- Use passwords that meet the VA minimum requirements. SOURCE: IA-5 (1)
- Protect my passwords; verify codes, tokens, and credentials from unauthorized use and disclosure. SOURCE: IA-5 (h)

I Will Not:

- Store my passwords or verify codes in any file on any IT system, unless that file has been encrypted using FIPS 140-2 (or its successor) validated encryption, and I am the only person who can decrypt the file. I will not hardcode credentials into scripts or programs. SOURCE: IA-5 (1) (c)

Incident Reporting

I Will:

- Report suspected or identified information security incidents including anti-virus, antispyware, firewall or intrusion detection software errors, or significant alert messages (security and privacy) to my VA supervisor or designee immediately upon suspicion. SOURCE: IR-6



5. ACKNOWLEDGEMENT AND ACCEPTANCE

- a. I acknowledge that I have received a copy of these Rules of Behavior VA information Security Rules of Behavior.
- b. I understand, accept and agree to comply with all terms and conditions of VA Information Security Rules of Behavior.

Print or type your full name

Signature Date

Office Phone

Position Title



U.S. Department of Veterans Affairs

Veterans Health Administration
Beckley VA Medical Center

200 Veterans Avenue
Beckley, WV 25801
www.beckley.va.gov

Dear :

Welcome to the Beckley Veterans Affairs Medical Center. You will be assigned to our facility in a Without Compensation (WOC) basis as a _____ from _____ not to exceed _____ under authority of 38 U.S.C. 7405 (A)(1) or 5 U.S.C. 311. During your period of affiliation with our facility, you are authorized to perform services as directed by Leah Jones, DO, Designated Education Officer.

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 Department of Veterans Affairs, such as leave, retirement, etc. (a student volunteer is not a Federal Employee for any purposes other than injury compensation and law related to the Tort Claims Act). You may, if applicable, be eligible to receive the benefits indicated below. Cash cannot be paid in lieu of any of these benefits

☐ Quarters ☐ Subsistence ☐ Uniforms ☐ Laundering of Uniforms ☒ N/A

If you agree to these conditions, please sign the statement below and return the letter via email or in person to Education staff: john.marcum@va.gov and/or deborah.murdock@va.gov. This agreement may be terminated at any time by either party by written notice of such intent.

Also, please indicate your veteran status by checking the appropriate number below.

Sincerely,

Jason Hogie
Supervisory HR Specialist HR Strategic Business Partner

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

Veteran Status	
1. Vietnam Veteran*	<input type="checkbox"/>
2. Other Veteran	<input type="checkbox"/>
3. Non-Veteran	<input type="checkbox"/>
*For this purpose, a Vietnam Veteran is one with Service between August 5, 1964 and May 7, 1975.	

WOC Employee Signature:

Date: _____

School/Program:

August 10, 2020

VHA DIRECTIVE 1192.01
APPENDIX B

HEALTH CARE PERSONNEL INFLUENZA VACCINATION FORM

I am a VA: ___ Employee ___ Volunteer ___ Other (ex: Trainee, Resident, Intern, Fee Basis, or Researcher) Please indicate: _____

CHECK ONE STATEMENT BELOW AND COMPLETE AND SIGN THE LAST SECTION OF THIS FORM PRIOR TO SUBMISSION TO EMPLOYEE OCCUPATIONAL HEALTH:

☐ I received the seasonal influenza vaccine this flu season (any required documentation is attached).

☐ I have been granted a medical exemption from receiving the seasonal influenza vaccine this flu season. I have a contraindication for flu vaccine as defined by CDC. The reasons for contraindication must be recognized contraindications and precautions by the Centers for Disease Control and Prevention, found here: <https://www.cdc.gov/flu/prevent/whoshouldvax.htm>. This has been discussed and acknowledged by my personal physician. I understand that by declining to receive the vaccine by November 30 or within two weeks of beginning employment, I must wear a face mask according to requirements and guidelines within VHA Directive 1192.01, Seasonal Influenza Vaccination Program for VHA Health Care Personnel.

Printed Physician Name and Address

Physician Signature Date National Provider Identification Number

Supervisor Signature Date Supervisor Email

☐ I notified my immediate supervisor in writing that I have a deeply held religious belief that prevents me from receiving the seasonal influenza vaccine this influenza season. I understand that by declining to receive the vaccine by November 30 or within two weeks of beginning employment, I must wear a face mask according to requirements and guidelines within VHA Directive 1192.01, Seasonal Influenza Vaccination Program for VHA Health Care Personnel.

Supervisor Signature Date Supervisor Email



COVID-19 VACCINATION FORM

I am a VA: ☐ Employee ☐ Volunteer ☐ Other (ex: Trainee, Resident, Intern, Fee Basis, or Researcher)

Please indicate: _____

CHECK THE STATEMENT(S) FOR WHICH YOU MEET THE CRITERIA AND COMPLETE AND SIGN THE LAST SECTION OF THIS FORM PRIOR TO SUBMISSION TO YOUR SUPERVISOR. PLEASE READ THE DESCRIPTIONS BELOW TO LEARN THE CRITERIA TO REQUEST A MEDICAL OR RELIGIOUS EXCEPTION. YOU MAY SELECT MEDICAL EXCEPTION, RELIGIOUS EXCEPTION, OR SELECT BOTH IF YOU MEET THE CRITERIA FOR BOTH A MEDICAL AND RELIGIOUS EXCEPTION.

☐ FULLY VACCINATED *(Required documentation attached):*

I have received a complete COVID-19 vaccine series. Please complete the following information:

Type of vaccine administered:

- ☐ ASTRAZENECA/OXFORD
☐ JOHNSON AND JOHNSON (J&J)/JANSSEN
☐ MODERNA
☐ PFIZER
☐ OTHER

Date(s) of Administration: _____

Name of health care professional, clinical site, or vaccination event that administered the vaccine:

To verify the information entered, please attach a copy of the documents showing you received your vaccine(s). Acceptable forms of documentation include a copy of:

- The signed record of immunization from a health care provider or pharmacy.
- COVID-19 Vaccination Record Card (CDC Form MLS-319813_r, published on September 3, 2020).
- Record of immunization from a health care provider or pharmacy.
- Medical records documenting the vaccination; or
- Immunization records from a public health or state immunization information system.

☐ FULLY VACCINATED *(Attached is a VA Form 10-5345 to authorize Employee Occupational Health to release my COVID-19 vaccination record to verify my vaccination status):*

I have received a complete COVID-19 vaccine series and was vaccinated by the Veterans Health Administration (VHA). I authorize VHA to use and disclose my health information as related to the care and treatment for infection with COVID-19, including test results and vaccination status, to certain personnel of the Department of Veterans Affairs (VA) who have a need for the information in the performance of their duties, to promote the health and safety of the Federal workforce and the efficiency of the civil service.

☐ MEDICAL EXCEPTION:

I have a medical exception to receiving the COVID-19 vaccination and am requesting a reasonable accommodation. This submission will be used to notify my supervisor to initiate the reasonable accommodation process. Approval of the requested accommodation is subject to the outcome of the reasonable accommodation process. If the accommodation is approved, I acknowledge that according to requirements and guidelines within the VA Notice, Mandatory Coronavirus Disease 2019 (COVID-19) Vaccination Program for VA Employees, I must:

- Wear a face mask;
- Physically distance;
- Submit to COVID-19 testing;
- Be subject to Government-wide travel restrictions on official travel; and
- Any other mitigation strategies required as part of the accommodation.

☐ RELIGIOUS EXCEPTION:

I have a sincerely held religious belief that prevents me from receiving the COVID-19 vaccine and am requesting a reasonable accommodation. This submission will be used to notify my supervisor to initiate the reasonable accommodation process. Approval of the requested accommodation is subject to the outcome of the reasonable accommodation process. If the accommodation is approved, I acknowledge that according to requirements and guidelines within the VA Notice, Mandatory Coronavirus Disease 2019 (COVID-19) Vaccination Program for VA Employees I must:

- Wear a face mask;
- Physically distance;
- Submit to COVID-19 testing;
- Be subject to Government-wide travel restrictions on official travel; and
- Any other mitigation strategies required as part of the accommodation.

☐ **MEDICAL AND RELIGIOUS EXCEPTION (BOTH):**

I have both a medical and religious exception to receiving the COVID-19 vaccination and am requesting a reasonable accommodation. This submission will be used to notify my supervisor to initiate the reasonable accommodation process. Approval of the requested accommodation(s) is/are subject to the outcome of the reasonable accommodation process. If the accommodation(s) is/are approved, I acknowledge that according to requirements and guidelines within the VA Notice, Mandatory Coronavirus Disease 2019 (COVID-19) Vaccination Program for VA Employees, I must:

- Wear a face mask;
- Physically distance;
- Submit to COVID-19 testing;
- Be subject to Government-wide travel restrictions on official travel; and
- Any other mitigation strategies required as part of the accommodation.

NOTE: Declaring an exception for a medical condition or religious exception requires the supervisor to engage in the reasonable accommodation process in accordance with VA Handbook 5975.1 and VA Directive 5975.

Name (print): _____

Dept./Serv: _____

Employee Signature: _____ Date (MM/DD/YYYY): _____

VA employees provide this form to your supervisor.

Health Professions Trainees (HPTs) requesting medical or religious exceptions provide this form to the Designated Education Officer (DEO); and proof of vaccination is provided to the DEO via the Trainee Qualifications and Credentials Verification Letter (TQCVL). HPTs who request a medical or religious exception will follow the same reasonable accommodation process established for employees.

Privacy Act Statement:

Authority:

Pursuant to 5 U.S.C. chapters 11 and 79, and in discharging the functions directed under Executive Order 14043, Requiring Coronavirus Disease 2019 Vaccination for Federal Employees (Sept. 9, 2021), we are authorized to collect this information. The authority for the system of records notices (SORN) associated with this collection of information, OPM/GOVT-10, Employee Medical File System of Records, 75 Fed. Reg. 35099 (June 21, 2010), amended 80 Fed. Reg. 74815 (Nov. 30, 2015), for title 5 employees, and 08VA05, Employee Medical File System Records (Title 38)-VA, for title 38 employees, also includes 5 U.S.C. chapters 33 and 63 and Executive Order 12196, Occupational Safety and Health Program for Federal Employees (Feb. 26, 1980). Providing this information is mandatory, and we are authorized to impose penalties for failure to provide the information pursuant to applicable Federal personnel laws and regulations.

Purpose

This information is being collected and maintained to promote the safety of Federal workplaces and the Federal workforce consistent with the above-referenced authorities, Executive Order 13991, Protecting the Federal Workforce and Requiring Mask-Wearing (Jan. 20, 2021), the COVID-19 Workplace Safety: Agency Model Safety Principles established by the Safer Federal Workforce Task Force, and guidance from Centers for Disease Control and Prevention and the Occupational Safety and Health Administration.

Routine Uses

While the information requested is intended to be used primarily for internal purposes, in certain circumstances it may be necessary to disclose this information externally, for example to disclose information to: a Federal, State, or local agency to the extent necessary to comply with laws governing reporting of communicable disease or other laws concerning health and safety in the work environment; to adjudicative bodies (e.g., the Merit System Protection Board), arbitrators, and hearing examiners to the extent necessary to carry out their authorized duties regarding Federal employment; to contractors, grantees, or volunteers as necessary to perform their duties for the Federal Government; to other agencies, courts, and persons as necessary and relevant in the course of litigation, and as necessary and in accordance with requirements for law enforcement; or to a person authorized to act on your behalf. A complete list of the routine uses can be found in the SORNs associated with this collection of information.

Consequence of Failure to Provide Information:

Providing this information is mandatory. Unless granted a legally required exception, all covered Federal employees are required to be vaccinated against COVID-19 and to provide documentation concerning their vaccination status to their employing agency. Unless you have been granted a legally required exception, failure to provide this information may subject you to disciplinary action, including and up to removal from Federal service.

Certification

I sign this document under penalty of perjury that the above is true and correct, and that I am the person named above. I understand that a knowing and willful false statement on this form can be punished by fine or imprisonment or both (18 U.S.C. 1001). I understand that if I am a Federal employee or contractor making a false statement on this form could result in additional administrative action, including an adverse personnel action up to and including removal from my position or removal from a contract.

Student Resident Orientation Beckley VAMC (517)

1. VA's Mission Statement is to fulfill President Lincoln's promise: *"To care for him who shall have borne the battle, and for his widow, and his orphan"* by serving and honoring America's Veterans.
2. A VA Identification Badge along with school/residency photo ID is required to be worn above the waist while you are here doing your clinical/student rotation. Please introduce your role and who your supervising/attending preceptor is to the Veterans that you are caring for.
3. Parking is in the parking garage or side lots. Do not park on the top lot near the main entrance of Building 1 or the physician's lot.
4. Dress is business casual or as instructed by your academic institution. Flip Flops/open toe shoes are not permitted during clinical rotations.
5. In the event of an emergency, **call #911** and: identify yourself, your location, and what the emergency is, such as a medical emergency (code blue), rapid response, fire, etc.

Emergency Codes Designations:

- Code Red = Fire
 - Rapid Response = Medical Emergency
 - Code Black = Missing Patient
 - Code Blue= Cardiac Arrest
 - Code Green= Disaster
 - Code Yellow= Bomb Threat
6. **Fire emergencies: RACE = Rescue – Alarm – Contain - Extinguish (or Evacuate).** Make sure you review with your preceptor where the fire alarms, extinguishers, and fire exits are in the clinical or administrative area you are assigned to. Follow the instructions of your VA supervisor.
 7. Hand hygiene is the single most important measure to reduce the risks of transmitting germs from one person to another or from one site to another. Make sure that you wash your hands at least 15 seconds, including the areas between the fingers, above the knuckles and wrists, and under fingernails. Alcohol gels are also available but should not replace hand washing if your hands are soiled, if you are leaving an isolation room, or if you are dealing with *Clostridium difficile*.

COVID 19 Screening and Masks/precautions per VHA guidance.



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**Student Resident Orientation
Beckley VAMC (517)**

8. Our Employee Health Program is available to you if you are injured here at Beckley VAMC.
If you are injured, tell your preceptor and go to Employee Health/Emergency Department.
9. It is your responsibility to keep the computer access codes that you are given secure. Protect your computer codes by not sharing them with anyone. Log off whenever you walk away from the computer, even for a moment. Inactivity on the computer for more than ninety days will lock out your account.
 - Keep your accounts active with a minimal log in every 30 days.
10. **You can call the IT help desk at 4124 for reactivation of your account if needed.**
11. Copy and pasting documents or cloned documentations in the health record is forbidden.
12. You may not use thumb drives or any other personally owned USB device on VA computers.
13. It is important that you always protect patient sensitive confidential information. Do not print out patient information and leave it at the printer for others to read. Do not take photographs of health records or other VA private information.
14. Veteran Personal Identifiable Information and Patient Health information may not be stored or shared using Google Docs or any other similar file sharing site. As a trainee at the VA you must not store Veteran information on any non-VA site from any device, including: from your home; your affiliate institution; your mobile tablet; or cell-phone.
15. Documentation must be co-signed by a licensed provider **by end of day written** and not to exceed 48 hours of date written. Make sure your documentation is timely and accurate.
16. Whenever you are doing a rotation (whether monthly or longer) at Beckley VAMC or Outpatient Community Clinics, you must check in and check out with your preceptor as directed. Communicate with your preceptor if unable to present for a clinical rotation.
17. Veterans are twice as likely to die from suicide as Non-Veterans. The National VA Suicide **Hotline is 800-273-8255**. Warm Hand off with Crisis Line staff.
 - Seek assistance with a VA staff member. Key things to Ask:
Name, Location of the Veteran and do they have weapons, etc. to hurt themselves or others?
18. Cell Phones are to be stowed away during clinical rotations. If needed during rotations for research, etc. the phone must be placed on silent.
19. Please make sure on your last week of your rotation, contact the Education Department at extension 4659 or 2016 to obtain Clearance. This must be completed prior to or on your last day of your rotation.



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**Student Resident Orientation
Beckley VAMC (517)**

I fully understand the information. By signing this form, you agree that you have reviewed and will adhere to these requirements.

Signature: _____ Date: _____

Printed Name _____

Academic Affiliation: _____



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