VA | U.S. Department of Veterans Affairs
VA Loma Linda Healthcare System

Thank you for choosing to complete your clinical rotation at the Loma Linda VA. Below are all required forms required for VA Onboarding. **Once complete, packets must be submitted in-person to Human Resources any weekday between 7:00am – 3:00pm.** Please allow 30 minutes for review upon submission and additional time to complete fingerprinting. Human Resources is located at 25814 Business Center Drive. Redlands, CA 92373. (NOTE: Packets will not be accepted at Clinical Education)

Trainees unable to submit packets in person may send in their paperwork via CERTIFIED MAIL to: Attn: WOC Team (05) 25814 Business Center Drive. Redlands, CA 92373.

Please note that **the entire onboarding process takes up to 6 weeks to complete**.

Trainees must include 2 forms of ID with the completed packet:

- 2 forms of identification on List B+C, or 1 form of identification from list A (see list on last page)
- NON-CITIZENS:
  - Permanent Residents – bring your green card issued to you
  - Nonresident – Commonly I-94 and foreign passport
  - Please read list A for acceptable documents in your case

Please also include a copy of your COVID vaccination card or record (required).

Note: One week prior to your rotation start date you are required to report to HR to complete your Oath of Office. This may be done on a walk-in basis; HR is located at 25814 Business Center Drive in Redlands, CA 92373. HR is open for Walk-ins every weekday from 8:00am - 3:00pm (closed on Federal Holidays).

Please complete ALL fields below, review all pages for completeness, print and sign all highlighted areas (12 total signatures)

Full Legal Name: _____

Home Address:

_____

Program (list school and program): _____

Expected Start Date at VA: _____

__ 2 forms of ID included (acceptable forms of ID listed on last page)

__ COVID vaccination card or exemption included

For any questions or concerns about the onboarding process please reach out to:
VHALOMClinicalEducation@va.gov

FINGERPRINT RECORD PREP SHEET**PLEASE PRINT CLEARLY**

DATE:_____

SON: 4049 SOI: vam1

LAST NAME:_____FIRST NAME:_____MIDDLE NAME:_____

SSN:_____ DATE OF BIRTH (MM/DD/YYYY)_____ _____ ____

COUNTRY OF BIRTH:_____

STATE OF BIRTH _____City of Birth_____

DRIVER LICENSE NUMBER:_____ STATE ISSUED BY:_____

PASSPORT NUMBER:_____ (IF APPLICABLE) DUAL CITIZENSHIP: YES_____ NO_____

Country of Citizenship:_____

ALIEN REGISTRATION NUMBER:_____ (IF APPLICABLE)

NATURALIZATION CERTIFICATE NUMBER:_____ (IF APPLICABLE)

GENDER:_____ RACE:_____ EYE COLOR:_____ HAIR COLOR:_____

HEIGHT:_____ WEIGHT:_____LBS.

E-MAIL ADDRESS_____ PHONE NUMBER:_____

POSITION TITLE_____ **MUST FILLOUT**

APPLICANTS SIGNATURE:_____ DATE:_____

(BELOW IS FOR CONTRACTORS ONLY)

COMPANY NAME:_____ JOB TITLE:_____

SUPERVISOR'S NAME:_____

CONTRACTOR'S WORK ADDRESS:_____

_____

_____

I certify that to the best of my knowledge and belief, all the information provided is true, correct, complete, and made in good faith. I understand that false or fraudulent information on or attached to this form may be grounds for not hiring or firing me after I begin work and may be punishable by a fine or imprisonment. I understand that this information I give may be investigated.

FINGERPRINTS CAPTURE BY PIV PERSONNEL:_____ DATE:_____

VA Loma Linda Healthcare System
11201 Benton Street Loma Linda, CA 92357
(800) 741-8387-(909) 825-7084
www.lomalinda.va.gov

In Reply Refer To: 605-14A

APPOINTMENT LETTER FOR TRAINEES APPOINTED WITHOUT COMPENSATION (WOC)

Date: _____

Dear Trainee,

Welcome to the Department of Veterans Affairs. You will be assigned to our facility as a Trainee from _____ through_____ under the authority of Title 38 United States Code (U.S.C.) 7405(a) (1).

In accepting this training 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 (VHA), such as leave, health insurance, or retirement.

If you agree to these conditions, please sign the following statement. Either party may terminate this agreement any time by written notice of such intent.

Sincerely,

_____
Chief, Human Resources Management Service

_____
Medical Center Director

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

_____ _____
Signature Date

_____
Printed Name

_____
Home Address

_____
School and Program

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. 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)	7C. VA TRAINING END DATE (mm/yyyy)
VA 605 - Loma Linda, CA	☒ UNKNOWN	☒ UNKNOWN

II - U.S. MILITARY DUTY STATUS

8A. ARE YOU NOW IN U.S. MILITARY?	8B. ARE YOU IN THE RESERVES OR NATIONAL GUARD?	8C. BRANCH OF SERVICE
☐ YES *(If YES, complete 8c)* ☐ NO	☐ YES *(If YES, complete 8c)* ☐ NO	

III - CITIZENSHIP

9A. CITIZENSHIP	9B. COUNTRY OF CITIZENSHIP
☐ U.S. CITIZEN BY BIRTH ☐ NATURALIZED U.S. CITIZEN ☐ NOT A U.S. CITIZEN (Complete item 9B)	

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? ☐ 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

11A. The trainee has met all of the criteria of the Trainee Qualifications & Credentials Verification Letter (TQCVL). ☐ YES ☐ NO

11B. Incomplete items on the TQCVL have been addressed and resolved. ☐ YES ☐ 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. ☐ YES ☐ 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
, ,	

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? ☐ YES ☐ NO	19B. EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG) CERTIFICATE NUMBER	19C. ECFMG CERTIFICATE DATE

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
, ,	

X - ADDITIONAL QUESTIONS

ITEM	PLACE AN 'x' IN APPROPRIATE SPACE. IF YES, EXPLAIN DETAILS IN PART XI	YES	NO
21	AS A PARTICIPANT IN THE MEDICARE AND MEDICAID PROGRAMS, HAVE YOU EVER BEEN CONVICTED OF OR INVESTIGATED FOR MAKING FALSE, FICTITIOUS, OR FRAUDULENT STATEMENTS, REPRESENTATIONS, WRITINGS, OR DOCUMENTS REGARDING THE DELIVERY OF OR PAYMENT FOR HEALTH CARE BENEFITS, ITEMS OR SERVICES THAT WOULD BE IN VIOLATION OF THE CRIMINAL FALSE CLAIMS ACT?	☐	☐
22	ARE YOU NOW, OR HAVE YOU EVER BEEN, INVOLVED IN ADMINISTRATIVE, PROFESSIONAL, OR JUDICIAL PROCEEDINGS IN WHICH MALPRACTICE ON YOUR PART 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 outcome of the case concerning those allegations. Please also provide your explanation of what occurred. 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.	☐	☐
23	Do you need accommodations to perform the procedures and essential functions of the training position for which you have applied?	☐	☐

XI - REMARKS

ITEM NO.	(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).

24A. SIGNATURE OF APPLICANT *(Sign in ink)*	24B. DATE *(mm/dd/yyyy)*

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER
, ,	

AUTHORIZATION FOR RELEASE OF INFORMATION

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

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

SIGNATURE OF APPLICANT *(Sign in ink)*	DATE

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE

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

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

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

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

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

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

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

Declaration for Federal Employment*

Form Approved:
OMB No. 3206-0182

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

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. Were you born a male 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 your only active duty was training in the Reserves or National Guard, answer "NO."

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

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 charges, 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 relativeworks.* ☐ 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 received a tentative/conditional job offer or have not yet been selected, carefully review your answers on this form and any attached sheets.

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) (MM / DD / YYYY)

17b. Appointee's Signature: _____ Date: _____
(Sign in ink) (MM / DD / YYYY)

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

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

Department of Veterans Affairs _____ Loma Linda, CA
(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)

HR Assistant
(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 10/31/2022

►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 10/31/2022

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

OMB Control No. 3206-0166

Department of Veterans Affairs

APPLICANT'S STATEMENT OF SELECTIVE SERVICE REGISTRATION STATUS

NOTE: 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 be registered with the Selective Service System, unless you meet certain exemptions under the Selective Service law. If you are required to register but knowingly and willfully fail to do so, you are ineligible for appointment by executive agencies of the Federal Government.

CERTIFICATION OF REGISTRATION STATUS *(Check one)*

☐ I certify that I am registered with the Selective Service System.

☐ I certify that I have been determined by the Selective Service System to be exempt from the registration provisions of Selective Service law.

☐ I certify that I have not registered with the Selective Service System.

☐ I certify that I have not reached my 18th birthday and understand I am required by law to register at that time.

NON-REGISTRANTS UNDER AGE 26

If you are under age 26 and have not registered as required, you should register promptly at a United States Post Office or consular office if you are outside the United States.

NON-REGISTRANTS AGE 26 AND OVER

If you were born in 1960 or later, are 26 years of age or older, and were required to register but did not do so, you can no longer register under Selective Service law. Accordingly, you are not eligible for appointment to an executive agency unless you can prove to the Office of Personnel Management (OPM) that your failure to register was neither knowing or willful. You may request an OPM decision through the agency which was considering you for employment by returning this statement with your written request for an OPM determination together with any explanation and documentation you wish to furnish to prove that your failure to register was neither knowing nor willful.

PRIVACY ACT STATEMENT

Because information on your registration status is essential for determining whether you are in compliance with 5 U.S.C. 3328, failure to provide the information requested by the statement will prevent any further consideration of your application for appointment. This information is subject to verification with the Selective Service System and may be furnished to other Federal agencies for law enforcement or other authorized use in implementing this law.

FALSE STATEMENT NOTIFICATION

A false statement may be grounds for not hiring you if you have already begun work. Also, you may be punished by fine or imprisonment. (Section 1001 of Title 18, United States Code.)

LEGAL SIGNATURE OF APPLICANT *(Please use ink)*	DATE SIGNED *(Please use ink)*

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

Department of Veterans Affairs

EMPLOYEE EDUCATIONAL DATA

PRIVACY ACT STATEMENT: *The authority for collecting this information about you is 5 U.S.C. 7201. The information furnished will be used to update your education level to reflect the highest level achieved. The information you furnish is voluntary and will be used for workforce analysis and planning. Executive Order 9397 (November 22, 1943) authorizes use of your Social Security Number. That Order requires use of the SSN for the orderly administration of personnel records. Furnishing your Social Security Number as well as the other data is voluntary. Disclosure of this information may be made in accordance with the disclosure provisions of the Privacy Act of 1974 including the established routine uses for the OPM/GOVT-1, General Personnel Records system of records, or the 76VA05 system for Title 38 employees.*

INSTRUCTIONS - Please complete this form according to the instructions and if you have any questions, contact your Human Resources (HR) office. Return completed form to your HR office. *(Note: In order to keep your education record up-to-date, be sure to notify the HR office whenever you attain a higher level of education than the level you show on this form.)*

PART I - EDUCATION CODES

INSTRUCTION: Check the one box next to the code in Section A **or** B that best represents your highest education level. Then follow instructions in that section.

SECTION A - GENERAL EDUCATION LEVELS

- ☐ 1- Less than 8th grade or no formal education
- ☐ 2 - 8th grade
- ☐ A - Some high school -- did not graduate
- ☐ B - High school graduation or equivalency certificate, and no completion of any advanced job training.
- ☐ 3 - High school graduation and afterwards began additional job training program without completing.
- ☐ 5 - Less than one academic year of study (under 30 semester hours/ 45 quarter hours) in a college or university.
- ☐ C - One academic year of study (30-59 semester hours, 45-89 quarter hours) in a resident college or university.
- ☐ D - Two academic years of study (60-89 semester hours, 90-134 quarter hours) in a resident college or university.
- ☐ 7 - Four academic years of study (120 semester hours, 180 quarter hours, or more) but did **not** receive a bachelor's degree.
- ☐ L - Bar membership **without** law degree.
- ☐ E - Three academic years of study (90-119 semester hours, 135-179 quarter hours) in a resident college or university.

If you checked one of the boxes above go to PART II, otherwise continue in Section B.

SECTION B - HIGHER EDUCATION CERTIFICATE OR DEGREE

- ☐ 4 - Completed high school and afterwards completed additional job training program.
- ☐ 6 - Associate degree (including nursing and all other associate degrees.)
- ☐ F - Nursing diploma
- ☐ G - Bachelor's degree in Nursing
- ☐ H - Bachelor's degree in Engineering or Architecture
- ☐ I - Bachelor's degree in Accounting or Finance
- ☐ J - Bachelor's degree, all other fields
- ☐ 8 - Bachelor's degree and less than 15 semester hours, 23 quarter hours of graduate study
- ☐ N - One academic year of graduate study (15 semester hours, 23 quarter hours) but no master's degree
- ☐ K - Law degree (J.D. or LL.B.) **without** bar membership
- ☐ L - Bar membership **with** law degree
- ☐ M- Law degree (J.D. or LL.B) **with** bar membership
- ☐ O - Master's degree in Hospital Administration
- ☐ # - Master's degree in Nursing
- ☐ P - All other master degrees
- ☐ Q - Some academic work beyond master's degree but no higher degree
- ☐ R - Doctor of Dental Medicine
- ☐ S - Doctor of Dental Surgery
- ☐ T - Doctor of Medicine
- ☐ U - Doctor of Osteopathy
- ☐ V - Doctor of Veterinary Medicine
- ☐ 9 - All other professional degrees (including podiatry, D.P. or D.P.M., and optometry, O.D.)
- ☐ * - Doctoral degree in Nursing
- ☐ W - Doctor of Philosophy
- ☐ X - Ph.D. in Psychology
- ☐ Y- Other doctoral degrees
- ☐ Z - Doctoral degree and performed some academic work beyond

If you checked one of the boxes in Section B, then more specific information is needed. Please review the supplemental *(which is either attached or may be provided later by your HR office)* and select the most appropriate field of study from the programs listed and record the corresponding 6-digit program code in Part II.

PART II - EMPLOYEE INFORMATION

1. WHAT IS YOUR ONE DIGIT EDUCATION CODE FROM SECTION A OR SECTION B ABOVE?	COMPLETE IF YOU SELECTED FROM SECTION B	
EDUCATION CODE	2A. WHAT YEAR DID YOU COMPLETE YOUR HIGHEST LEVEL OF EDUCATION? YEAR OF COMPLETION	2B. ENTER THE SIX DIGIT PROGRAM CODE 511102 PROGRAM CODE
3. LAST NAME - FIRST NAME - MIDDLE INITIAL OF EMPLOYEE *(Print or type)* , ,		4. SOCIAL SECURITY NO.
5. SERVICE OR DIVISION VA 605 Loma Linda		
6. EMPLOYEE'S SIGNATURE		7. DATE

U.S. Office of Personnel Management Guide to Personnel Data Standards	**ETHNICITY AND RACE IDENTIFICATION** (Please read the Privacy Act Statement and instructions before completing form.)	
Name (Last, First, Middle Initial) , ,	Social Security Number	Birthdate (Month and Year)
Agency Use Only		

Privacy Act Statement

Ethnicity and race information is requested under the authority of 42 U.S.C. Section 2000e-16 and in compliance with the Office of Management and Budget's 1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. Providing this information is voluntary and has no impact on your employment status, but in the instance of missing information, your employing agency will attempt to identify your race and ethnicity by visual observation.

This information is used as necessary to plan for equal employment opportunity throughout the Federal government. It is also used by the U. S. Office of Personnel Management or employing agency maintaining the records to locate individuals for personnel research or survey response and in the production of summary descriptive statistics and analytical studies in support of the function for which the records are collected and maintained, or for related workforce studies.

Social Security Number (SSN) is requested under the authority of Executive Order 9397, which requires SSN be used for the purpose of uniform, orderly administration of personnel records. Providing this information is voluntary and failure to do so will have no effect on your employment status. If SSN is not provided, however, other agency sources may be used to obtain it.

Specific Instructions: The two questions below are designed to identify your ethnicity and race. **Regardless of your answer to question 1, go to question 2.**

Question 1. Are You Hispanic or Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

❒ Yes ❒ No

Question 2. Please select the racial category or categories with which you most closely identify by placing an "X" in the appropriate box. Check as many as apply.

RACIAL CATEGORY (Check as many as apply)	DEFINITION OF CATEGORY
❒ American Indian or Alaska Native	A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
❒ Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
❒ Black or African American	A person having origins in any of the black racial groups of Africa.
❒ Native Hawaiian or Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
❒ White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Standard Form 181
Revised August 2005
Previous editions not usable

42 U.S.C. Section 2000e-16

NSN 7540-01-099-3446

SELF-IDENTIFICATION OF DISABILITY

(see instructions and Privacy Act information on reverse)

Last Name, First Name, and MI	Date of Birth (mm/yy)	Social Security Number	ENTER CODE HERE——————— >
, ,			

Definition:

An Individual with a disability: A person who (1) has a physical impairment or mental impairment (psychiatric disability) that substantially limits one or more of such person's major life activities; (2) has a record of such impairment; or (3) is regarded as having such an impairment. This definition is provided by the Rehabilitation Act of 1973, as amended (29 U.S.C. 701 et. seq.).

Purpose:

Self-identification of disability status is essential for effective data collection and analysis. The information you provide will be used for statistical purposes only and will not in any way affect you individually. While self-identification is voluntary, your cooperation in providing accurate information is critical.

Part I. Targeted/Severe Disabilities

Hearing

18 - Total deafness in both ears (with or without understandable speech)

Vision

21 - Blind (inability to read ordinary size print, not correctable by glasses, or no usable vision, beyond light perception)

Missing Extremities

30 - Missing extremities (missing one arm or leg, both hands or arms, both feet or legs, one hand or arm and one foot or leg, one hand or arm and both feet or legs, both hands or arms and one foot or leg, or both hands or arms and both feet or legs)

Partial Paralysis

69 - Partial paralysis (because of a brain, nerve or muscle impairment, including palsy and cerebral palsy, there is some loss of ability to move or use a part of the body, including both hands; any part of both arms or legs; one side of the body, including one arm and one leg; and/or three or more major body parts)

Complete Paralysis

79 - Because of a brain, nerve or muscle impairment, including palsy and cerebral palsy, there is a complete loss of ability to move or use a part of the body, including both hands; one or both arms or legs; the lower half of the body; one side of the body, including one arm and one leg; and/or three or more major body parts

Other Impairments

82 - Epilepsy
90 - Severe intellectual disability
91 - Psychiatric disability
92 - Dwarfism

Part II. Other Disabilities

Hearing Conditions

15 - Hearing impairment/hard of hearing

Vision Conditions

22 - Visual impairments (e.g., tunnel or monocular vision or blind in one eye)

Physical Conditions

26 - Missing extremities (one hand or one foot)
40 - Mobility impairment (e.g., cerebral palsy, multiple sclerosis, muscular dystrophy, congenital hip defects, etc.)
41 - Spinal abnormalities (e.g., spina bifida, scoliosis)
44 - Non-paralytic orthopedic impairments: chronic pain, stiffness, weakness in bones or joints, some loss of ability to use part or parts of the body
51 - HIV Positive/AIDS
52 - Morbid obesity
61 - Partial paralysis of one hand, arm, foot, leg, or any part thereof
70 - Complete paralysis of one hand
80 - Cardiovascular/heart disease with or without restriction or limitation on activity; a history of heart problems w/complete recovery
83 - Blood diseases (e.g., sickle cell anemia, hemophilia)
84 - Diabetes
86 - Pulmonary or respiratory conditions (e.g., tuberculosis, asthma, emphysema, etc.)
87 - Kidney dysfunction (e.g., required dialysis)
88 - Cancer (present or past history)
93 - Disfigurement of face, hands, or feet (such as those caused by burns or gunshot wounds) and noticeable gross facial birthmarks
95 - Gastrointestinal disorders (e.g., Crohn's Disease, irritable bowel syndrome, colitis, celiac disease, dysphexia, etc.)
98 - History of alcoholism

Speech/Language/Learning Conditions

13 - Speech impairment - includes impairments of articulation (unclear language sounds), fluency (stuttering), voice (with normal hearing), dysphasia, or history of laryngectomy

94 - Learning disability - a disorder in one or more of the processes involved in understanding, perceiving, or using language or concepts (spoken or written) (e.g., dyslexia, ADD/ADHD)

Other Options

01 - I do not wish to identify my disability status. (Please read the notes on the next page.) (Note: Your personnel officer may use this code if, in his or her judgment, you used an incorrect code.)
05 - I do not have a disability.
06 - I have a disability, but it is not listed on this form.

VA U.S. Department of Veterans Affairs

AUTHORIZATION FOR RELEASE OF INFORMATION

PROTECTED UNDER THE FAIR CREDIT REPORTING ACT (TITLE 15, SECTION 1681)

STATEMENT OF AUTHORIZATION AND CLARIFICATION OF PURPOSE

I Authorize the Department of Veterans Affairs (VA), and authorized agents, to obtain my credit reports from any consumer or credit reporting agency for employment purposes.

The Fair Credit Reporting Act, as amended (15 U.S.C. § 1681, et seq.) allows VA to get one or more credit reports on you for employment. Should a decision to take any adverse action against you be made, based either in whole or in part on the credit report, you should know that the consumer or credit reporting agency that provided the report has played no role in the decision to take action.

VA is requesting an investigation to determine your fitness to work for, or on behalf of, the Federal Government. The information in this authorization will be given to the consumer or credit reporting agency so that the agency will release information about you and your credit history. This information may be disclosed to other Federal Agencies to fulfill official responsibilities, to the extent that the disclosure is permitted by law.

I Understand that the information released by records custodians and sources of information is for official use by the Department of Veterans Affairs, all affiliated agencies and departments, to determine suitability and/or fitness for employment on the behalf of the Federal Government.

Copies of this authorization that show my signature are as valid as the original release signed by me. This authorization is valid for ***(5)*** years from the date signed or upon the termination of my affiliation with the Department of Veterans Affairs, whichever is sooner.

SIGNATURE OF EMPLOYEE *(Sign in ink)*	TYPE OR PRINT LEGIBLY FULL NAME	DATE SIGNED

OTHER NAMES USED	HOME TELEPHONE NUMBER *(Include Area Code)*

CURRENT ADDRESS *(Include Street, City, State, and ZIP Code)*

,

I Will Not:

- Comment on VA mission-related legal matters unless I am the VA official spokesperson for the matter and have management approval to do so.
- In my capacity as a VA representative, comment or provide information on any matter about which I do not have actual, up-to-date knowledge.
- Post information protected by the Privacy Act of 1974, 38 USC 5701, 5705, or 7332, the Health Insurance Portability and Accountability Act (HIPAA) Rules, or VA policy on any non-VA websites, without legal authority and prior approval by authorized official;
- Use my VA title or indicate that I represent VA when acting outside of my official capacities.
- Use profanity; make libelous statements; or use privately-created works without the express, written permission of the author.
- Quote more than short excerpts of another person's work unless the source is properly credited.

5. ACKNOWLEDGEMENT AND ACCEPTANCE

a. I acknowledge that I have received a copy of the VA Information Security Rules of Behavior for Non-Organizational Users.

b. I understand, accept, and agree to comply with all terms and conditions of the VA Information Security Rules of Behavior for Non-Organizational Users.

c. These provisions are consistent with and do not supersede, conflict with, or otherwise alter the employee obligations, rights, or liabilities created by existing statute or Executive order relating to (1) classified information, (2) communications to Congress, (3) the reporting to an Inspector General of a violation of any law, rule, or regulation, or mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health or safety, or (4) any other whistleblower protection. The definitions, requirements, obligations, rights, sanctions, and liabilities created by controlling Executive orders and statutory provisions are incorporated into this agreement and are controlling.

Print or type your full name _____ **Signature** _____ **Date** _____

Office Phone _____ **Position Title** _____

Department of Veterans Affairs

COVID-19 VACCINATION

DATE *(MM/DD/YYYY)*: _____

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

If other, 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 full COVID-19 vaccine series (any required documentation is attached).

☐ I have been granted a medical exemption from receiving the COVID-19 vaccine.

I have a contraindication for the COVID-19 vaccine as defined by Centers for Disease Control and Prevention (CDC). The reasons for contraindication must be recognized contraindications and precautions by the CDC, found here: https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fvaccines%2Fcovid-19%2Finfo-by-product%2Fclinical-considerations.html, located under Interim Clinical Considerations for Use or Vaccine Indications. This has been discussed and acknowledged by my personal physician. I understand that by declining to receive the vaccine within eight weeks of publication of this directive, or within eight weeks of beginning employment, I must wear a face mask according to requirements and guidelines within VHA Directive 1193, COVID-19 Vaccination Program for VHA Health Care Personnel.

_____
Printed Physician Name and Address

_____	_____	_____
Physician Signature	Date *(MM/DD/YYYY)*	National Provider Identification Number
Supervisor Signature	Date *(MM/DD/YYYY)*	Supervisor Email

☐ I notified my immediate supervisor in writing that I have a deeply held religious belief that prevents me from receiving the COVID-19 vaccine.

I understand that by declining to receive the vaccine within eight weeks of publication of this directive, or within eight weeks of beginning employment, I must wear a face mask according to requirements and guidelines within VHA Directive 1193, COVID-19 Vaccination Program for VHA Health Care Personnel.

_____	_____	_____
Supervisor Signature	Date *(MM/DD/YYYY)*	Supervisor Email

I have read and fully understand the information on this form and have been given the opportunity to have my questions answered. I understand that violation of the directive may result in disciplinary action up to and including removal from Federal service.

Name (print): _____ Last 4 SS#: _____

Dept./Serv: Clinical Education Date *(MM/DD/YYYY)*: _____

Employee Signature: _____

Employees and volunteers provide this form to the VHA facility Employee Occupational Health Office. Secure electronic submission is permissible.

Health Professions Trainees requesting medical or religious exemptions 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).

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
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		**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		

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

Refer to the instructions for more information about acceptable receipts.