Clinical Trainee Onboarding Case File

Instructions: All trainees at the Hershel "Woody" Williams VA Medical Center must complete the following paperwork in its entirety. Completed documents should be saved for trainees' personal records and to decrease burden in the event that corrections are needed. Once completed and saved, please print all documents (**single sided**), sign where indicated by the "★" symbol, and return all documents to the Learning Resources Department at the Hershel "Woody" Williams VA Medical Center.

If you are unsure what information to type into a particular field, hover the cursor over that field for detailed instructions.

REQUIRED INFORMATION FOR VA TRAINEES:

**** Complete all required fields (those highlighted in red) on pages 1-7 before signing and submitting****

****Boxes outlined in red are required; all others are optional or dependent on individual response****

Today's Date (MM/DD/YYYY) : 02/26/2021

Full current legal name including middle name: Indicate Jr, Sr, II, etc, if applicable:

LAST:_____ FIRST:_____ MIDDLE:_____

Affiliate Educational Institution: _____

Trainee Type: _____

Program of Study or Residency: _____

Program Start Date: _____ Program Completion Date: _____

Supervisor/Service Chief: _____ *See Instructions Below

* GRADUATE MEDICAL EDUCATION Trainees, please select the chief of the appropriate service (Medicine, Surgery, or Psychiatry).
MEDICAL STUDENTS and NURSE PRACTITIONER trainees, select "Chief of Staff."
NURSING STUDENTS and SURGICAL TECHNOLOGY STUDENTS, select "Associate Director of Patient Care Services."
DIETETICS trainees should select "Chief of Nutrition and Food Services."
SPEECH PATHOLOGY and PHYSICAL THERAPY trainees should select "Chief of Physical Medicine and Rehabilitation."
RADIOLOGY, ULTRASOUND, and other IMAGING trainees should select "Chief of Imaging."
OPTOMETRY Trainees should select "Chief of Optometry."
BIO MEDICAL ENGINEERING Trainees should select "Chief of BioMedical Engineering."
AUDIOLOGY Trainees should select "Chief of Audiology."
All PHARMACY Trainees should select "Chief of Pharmacy."
PSYSCHOLOGY Trainees should select "Chief of Psychology."
SOCIAL WORK Trainees should select "Chief of Social Work."

If you are still unsure of who the Supervisor/Service Chief should be, please contact your academic program advisor for instructions.

BACKGROUND:

Date of Birth (MM/DD/YYYY): _____/_____/_____

Place of Birth (city, state, country – full information):_____

Foreign National (Check one): Yes____ No____

Race: _____

Full Social Security Number: _____-_____-_____
Gender (check one): Male ◯ Female ◯ Height (feet/inches): ____'____" Weight (pounds):_____
Eye color: _____ Hair color: _____
Personal e-mail address:_____
Permanent address (City, State, Country, Zip, etc):_____
_____
Full maiden name (last, first, middle): _____
List all previous names, aliases, nick names, etc:_____
So we can contact you: Other e-mail address _____
Personal Cell or Home phone: _____

Have you **ever** had computer access at this VA or any another VA? ◯ YES, List Below ◯ NO

Provide Facility and User ID for TMS: _____
Do you currently have a TMS account at another VA? ☐ YES ☐ NO
(TMS.va.gov is the internet site where you complete the required training) If so, list the name of the VA and your TMS ID. _____

U.S. Military Duty Status

Are you a male born after December 31, 1959? ☐ YES ☐ NO

(IF YES) Have you registered with the Selective Service System? ☐ YES ☐ NO

Are you now in the U.S. Military? ☐ YES ☐ NO Have you ever served in the U.S. Military? ☐ YES ☐ NO

Are you in the Reserves or National Guard? ☐ YES ☐ NO

Branch of Service?_____ Start Date (MM/DD/YYYY):_____

End Date (MM/DD/YYYY):_____ Type of Discharge:_____

☐ 1-Vietnam Veteran*
☐ 2-Other Veteran
☐ 3-Non-Veteran

* For this purpose, a Vietnam Veteran is one with Service between August 5, 1964 and May 7, 1975.

Pursuant to the Privacy Act of 1974, the information about your veteran status is requested under Title 38 United States Code and will be used to help identify veteran status of all VA trainees for statistical and program planning purposes. It will not be used for any other purpose. Disclosure of the information sought is voluntary. Failure to furnish this information will have no adverse effect on any benefit to which you may be entitled.

Select one of the citizen choices below

U.S. Citizen by Birth? ☐ Naturalized U.S. Citizen? ☐ Not a U.S. Citizen? ☐ (complete below)

If Not a U.S. Citizen complete the following

"A" Number: _____ VISA Type: _____VISA #_____

Issue Date (MM/DD/YYYY): _____ Expiration Date (MM/DD/YYYY):_____

Do you have a Valid DS2019? ◯ YES ◯ NO Date of last validation (MM/DD/YYYY) _____

Country of Citizenship? _____

(A) Is your primary and native written and spoken language English? (i.e., have you been raised to adulthood where English was the primary language?)

☐ Yes ☐ No

(B) Have you completed 8 years of education in a school where the basic curriculum is conducted in English? This may include graduate/post-graduate training

☐ Yes ☐ No

If yes, give name and location (city and state) of school(s):

_____

_____

_____

LICENSURE

Are you or have you ever been a Licensed Health Professional?

☐ YES (Complete Below) ☐ NO (SKIP TO EDUCATION)

National Provider Identifier (NPI) #: _____

ARE YOU CURRENLTY LICENSED ? ◯ YES ◯ NO

List all licenses, certifications, and registrations, including the DEA, that you have had as a Health Professional.

License currently held: _____

State Issued: _____

License Number: _____

Expiration Date: _____

IF YOU CURRENTLY HOLD AN ADDITIONAL LICENSE COMPLETE BELOW

License currently held: _____

State Issued: _____

License Number: _____

Expiration Date: _____

HAVE YOU PREVIOUSLY HELD A LICENSE AS A HEALTH PROFESSIONAL? ◯ YES ◯ NO

License currently held: _____

State Issued: _____

License Number: _____

Expiration Date (MM/DD/YYYY):_____

IF ANY ADDITIONAL PAST LICENSES COMPLETE THE FOLLOWING

License currently held: _____

State Issued: _____

License Number: _____

Expiration Date: _____

HAVE YOU EVER HAD A LICENSE REVOKED? ◯ YES ◯ NO

HAVE YOU EVER HAD YOUR CLINICAL PRIVILEGES REVOKED OR VOLUNTARILY RELINQUISHED CLINCIAL PRIVELAGES IN LIEU OF FORMAL ACTION? ◯ YES ◯ NO

EDUCATION

Education and Training after Highschool through Graduate/Professional School (Continue if Necessary)

1.Name of School:_____

Address of School:_____

Start Date (MM/YY):_____ (Expected) Completion Date (MM/YY):_____

Degree or Certificate: _____ Major of Study:_____

2.Name of School:_____

Address of School:_____

Start Date(MM/YY):_____ Expected) Completion Date (MM/YY):_____

Degree or Certificate: _____ Major of Study:_____

3.Name of School:_____

Address of School:_____

Start Date (MM/YY):_____ (Expected) Completion Date (MM/YY):_____

Degree or Certificate: _____ Major of Study:_____

ARE YOU A GRADUATE OF AN INTERNATIONAL MEDICAL SCHOOL? ◯ YES (COMPLETE BELOW) ◯ NO

EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES CERTIFICATE (ECFMG)

NUMBER:_____ ECFMG CERTIFICATE DATE: _____

INTERNSHIP, RESIDENCY AND FELLOWSHIP TRAINING

Have you had any previous internships, residencies, or fellowships? ◯ YES ◯ NO

1.Name of Hospital or Institution: _____

Address (City, State, Zip):_____

Specialty:_____ Start Date (MM/YY):_____ End Date (MM/YY):_____

Number of Months Completed:_____

2.Name of Hospital or Institution: _____

Address (City, State, Zip):_____

Specialty:_____ Start Date (MM/YY):_____

End Date (MM/YY):_____ Number of Months Completed:_____

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?

◯ YES ◯ NO

ARE YOU NOW, OR HAVE YOU EVER BEEN, INVOLVED IN ADMINISTRATIVE, PROFESSIONAL, OR JUDICIAL PROCEEDINGS IN WHICH MALPRACTICE ON YOUR PART WAS ALLEGED?

◯ YES (GIVE DETAILS BELOW) ◯ NO

DO YOU NEED ACCOMODATIONS TO PERFORM THE PROCEDURES AND ESSENTIAL FUNCTIONS OF THE TRAINING POSITION FOR WHICH YOU HAVE APPLIED? ◯ YES ◯ NO

DURING THE LAST 7 YEARS, HAVE YOU BEEN CONVICTED, BEEN IMPRISONED, BEEN ON PROBATION, OR BEEN ON PAROLE? ◯ YES ◯ NO

HAVE YOU BEEN CONVICTED BY A MILITARY COURT-MARTIAL IN THE LAST 7 YEARS? ◯ YES ◯ NO

ARE YOU CURRENTLY UNDER CHARGES FOR ANY VIOLATION OF THE LAW? ◯ YES ◯ NO

IF YES, PROVIDE VIOLATION, PLACE, AND NAME AND ADDRESS OF POLICE DEPT OR COURT INVOLVED IN THE CONTINUATION SECTION BELOW.

DURING THE LAST 5 YEARS , HAVE YOU BEEN FIRED FROM ANY JOB FOR AY REASON, DID YOU QUIT AFTER BEING TOLD 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? ◯ YES ◯ NO

ARE YOU DELIQUENT ON ANY FEDERAL DEBT? (INCLUDES DELINQUINCIES 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.) ◯ YES ◯ NO

IF YES PROVIDE TYPE, LENGTH AND AMOUTN OF DELIQUENCY OR DEFAULT, AND STEPS YOU ARE TAKING TO REPAY IN THE CONTINUATION SECTION BELOW.

DO ANY OF YOUR RELATIVES WORK FOR THE AGENCY OR GOVERNMENT ORGANIZATION TO WHICH YOU ARE SUBMITTING THIS FORM? ◯ YES ◯ NO

IF YES, PROVIDE DETAILS IN THE CONTINUATION SECTION BELOW

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 SECTION:

If you will be parking at the VA, please include the following information:

Driver's License Number:

State Issuing License:

Vehicle Information:

License Tag #: License Tag State:

Make: Model: Color: Year:

AUTHORIZATION FOR RELEASE OF INFORMATION

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

☐ Authorize VA to make inquiries 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.

===STOP===

You will now need to save this document. After saving, if you have completed the form correctly the red "NOT VALID" box below will turn green and read "VALID."

1.Save a copy of this document without signatures in original pdf form.
2.Verify that all information on pages 8-22 is correct.
3. Print pages 8-22, **SINGLE SIDED**, and sign in all required fields. Use the "★" symbol along the left margin as a reference for required signatures.
4. Add a copy of the "**Mandatory Training for Trainees**" TMS Certificate to the documents below and submit to the Learning Resources Department at the Hershel "Woody" Williams VA Medical Center.
5. Print an additional copy of the last page, "**Fingerprint Record Prep Sheet**," and bring with you when you report for fingerprinting.

NOT VALID

DEPARTMENT OF VETERANS AFFAIRS
Hershel "Woody" Williams VA Medical Center
Huntington, WV 25704

Dear ____

Welcome to the Department of Veterans Affairs. You will be assigned to our facility as ____________________________________ from_____________through __________ under authority of 38 U.S.C., 4114(a)(1)(A). During your period of affiliation with our facility, you are authorized to perform services as directed by the _______________________________

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

If you agree to these conditions, please sign the statement below and return the letter in the enclosed postage-free envelop. This agreement may be terminated at any time by either party by written notice of such intent.

US Citizen - Director's approval not required

Non US Citizen - Director's approval required

Sincerely yours,

☐ Approved ☐ Disapproved

Charlene L. McCollum
VISN5 Chief Human Resources Officer
VA Capitol Health Care Network, VISN 5

J. Brian Nimmo, MS, FACHE
Medical Center Director

Enclosure

- -

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

Signature: _____________________________ Print Name:______________________

Date: ______________________ Name of Training Institution:__________________________

Veteran Status – please check as appropriate

☐ 1-Vietnam Veteran*
☐ 2-Other Veteran
☐ 3-Non-Veteran

* For this purpose, a Vietnam Veteran is one with Service between August 5, 1964 and May 7, 1975.

Pursuant to the Privacy Act of 1974, the information about your veteran status is requested under Title 38 United States Code and will be used to help identify veteran status of all VA trainees for statistical and program planning purposes. It will not be used for any other purpose. Disclosure of the information sought is voluntary. Failure to furnish this information will have no adverse effect on any benefit to which you may be entitled.

FL 10-294
MAR 1990(RS)

Attachment A

QUALIFICATIONS REVIEW FOR WOC POSITIONS

Name:_____

Address: _____

_____

Position Applying For: _____

Citizenship ☐ ☐ U.S.

☐ Other (Please Specify Country)_____

Answer **one** of the following:

(A) Is your primary and native written and spoken language English? (i.e., have you been raised to adulthood where English was the primary language?)

☐ Yes ☐ No

(B) Have you completed 8 years of education in a school where the basic curriculum is conducted in English? This may include graduate/post-graduate training

☐ Yes ☐ No

If yes, give name and location (city and state) of school(s):

_____

_____

_____

Signature (SIGN IN INK) Date Signed

_____

PRIVACY ACT NOTICE: The information requested is voluntary and is solicited under authority of Title 38 and Public Law 95-201. It will be used to evaluate your qualifications for a specific position. If you decline to provide the information requested, it may not be possible to evaluate your qualifications fully.

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)
Huntington, WV	☐ 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 02/26/2021	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 dark ink)	24B. DATE (mm/dd/yyyy)
SIGN HERE	02/26/2021

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER

AUTHORIZATION FOR RELEASE OF INFORMATION

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

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

SIGNATURE OF APPLICANT	DATE
SIGN HERE	02/26/2021

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*

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

Form Approved:
OMB No. 3206-0182

Instructions

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

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

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

Privacy Act Statement

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

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

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

Public Burden Statement

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

Declaration for Federal Employment*

Form Approved:
OMB No. 3206-0182

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

GENERAL INFORMATION

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

♦

2. SOCIAL SECURITY NUMBER	3a. PLACE OF BIRTH (Include city and state or country)
♦	♦

3b. ARE YOU A U.S. CITIZEN?	4. DATE OF BIRTH (MM / DD / YYYY)
☐ YES ☐ NO (If "NO", provide country of citizenship) ♦	♦
5. OTHER NAMES EVER USED (For example, maiden name, nickname, etc)	**6. PHONE NUMBERS** (Include area codes)
♦	Day ♦
♦	Night ♦

Selective Service Registration

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

7a. Are you a male born after December 31, 1959? ☐ YES ☐ NO (If "NO", proceed to 8.)

7b. Have you registered with the Selective Service System? ☐ YES (If "YES", proceed to 8.) ☐ NO (If "NO", proceed to 7c.)

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

Military Service

8. Have you ever served in the United States military? ☐ YES (If "YES", provide information below) ☐ NO

If you answered "YES," list the branch, dates, and type of discharge for all active duty.
If your only active duty was training in the Reserves or National Guard, answer "NO."

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

Background Information

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

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

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

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

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

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

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

Declaration for Federal Employment*

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

Form Approved:
OMB No. 3206-0182

Additional Questions

14. Do any of your relatives work for the agency or government organization to which you are submitting this form? (Include: father, mother, husband, wife, son, daughter, brother, sister, uncle, aunt, first cousin, nephew, niece, father-in-law,mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepfather, stepmother, stepson, stepdaughter, stepbrother, stepsister, half brother, and half sister.) *If "YES," use item 16 to provide the relative's name,relationship, and the department, agency, or branch of the Armed Forces for which your relative works.* ☐ YES ☐ NO

15. Do you receive, or have you ever applied for, retirement pay, pension, or other retired pay based on military, Federal civilian, or District of Columbia Government service? ☐ YES ☐ NO

Continuation Space / Agency Optional Questions

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

Certifications / Additional Questions

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

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

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

17a. Applicant's Signature: SIGN HERE _____ (Sign in ink) Date 02/26/2021

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

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

18. **Appointee (Only respond if you have been employed by the Federal Government before):** Your elections of life insurance during previous Federal employment may affect your eligibility for life insurance during your new appointment. These questions are asked to help your personnel office make a correct determination.

18a. When did you leave your last Federal job? MM / DD / YYYY DATE:

18b. When you worked for the Federal Government the last time, did you waive Basic Life Insurance or any type of optional life insurance? ☐ YES ☐ NO ☐ DO NOT KNOW

18c. If you answered "YES" to item 18b, did you later cancel the waiver(s)? If your answer to item 18c is "NO," use item 16 to identify the type(s) of insurance for which waivers were not canceled. ☐ YES ☐ NO ☐ DO NOT KNOW

APPOINTMENT AFFIDAVITS

_____ _____

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

Department of Veterans Affairs | Veterans Health Admin. | Huntington, WV

(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 Huntington (City) WV (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.

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

SIGN HERE

_____ _____

Print Name Signature and Date Signed

CLINICAL TRAINEE REGISTRATION FORM
VA Medical Center Huntington, WV

This information will be kept confidential. All fields are required.

Legal Name *First*	*Middle*	*Last*	*Suffix*
Address			
Home Email Address		**Social Security Number**	
Are you a foreign national? Yes ☐ No ☐	**Date of Birth**	**Gender** ◯ Male ◯ Female	**Birth Place (*City and State*)**
RACE:			
Eye Color	**Hair Color**	**Height** ft in	**Weight** lbs

Education Information

Program Start Date	**Program End Date**
Program of Study	**School Name**
Position	
Service or Department Assigned/Requested	

Have you **ever** had computer access at this VA or any another VA? ◯ YES, List Below ◯

Provide Facility and User ID for TMS: _____

Do you currently have a TMS account at another VA? ☐ YES ☐ NO

(TMS.va.gov is the internet site where you complete the required training) If so, list the name of the VA and your TMS ID. _____

U.S. Citizen by Birth? ☐ Naturalized U.S. Citizen? ☐ Not a U.S. Citizen? ☐

"A" Number: _____ VISA Type: _____VISA #_____

Issue Date (MM/DD/YYYY): _____ Expiration Date (MM/DD/YYYY):_____

Do you have a Valid DS2019? ◯ YES ◯ NO Date of last validation (MM/DD/YYYY) _____

Country of Citizenship? _____

CLINICAL TRAINEE TMS REGISTRATION FORM
VA Medical Center Huntington, WV

This information will be kept confidential. All fields are required.

Legal Name *First* *Middle* *Last* *Suffix*

Home Email Address

Other Email:

Education Information

Program Start Date	**Program End Date**
Program of Study	**School Name**
Positior	
Service or Department Assigned/Requested	

Have you **ever** had computer access at this VA or any another VA? ◯ YES, List Below ◯

Provide Facility and User ID for TMS: _____

Do you currently have a TMS account at another VA? ☐ YES ☐ NO

(TMS.va.gov is the internet site where you complete the required training) If so, list the name of the VA and your TMS ID. _____

POLICE SERVICE
VA MEDICAL CENTER
HUNTINGTON, WV 25704

PARKING REGISTRATION

INFORMATION IS REQUESTED TO UPDATE PARKING INFORMATION OR ISSUING OF NEW PARKING PERMITS. PLEASE PRINT LEGIBLY.

NAME: (Last)_____**(First)**_____**(MI)**_____

(Last 4) Social Security Number:_____

FEMALE ◯ **MALE** ◯ **DATE OF APPLICATION:**_____

DRIVER'S LICENSE #_____ **STATE ISSUING LICENSE:**_____

ASSIGNED SERVICE:_____ **OFFICE PHONE:**_____

License Tag #	State	Make	Model	Color	Year

SIGNATURE: _____**DATE:**_____

DECAL #	ISSUE DATE	LOST/STOLEN/ETC. DISPOSITION
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

7/2010

VA – FINGERPRINT RECORD PREP SHEET

(PLEASE PRINT CLEARLY)

Name: _____/ _____/ _____
Last First Middle

STATE of Birth: _____ Country of Birth (if outside US): _____

Date of Birth: _____/ _____/ _____ Phone # / Ext:_____
YEAR (####) Month (##) Day (##)

Sex: ◯ Male ◯ Female ☐ Other Country of Citizenship (if outside US): _____

Race: ☐ Asian ☐ Black ☐ Native American ☐ Unknown ☐ Caucasian/Latino

Eye Color: _____ Hair Color: _____ Height: _____'_____" Weight: _____
Ft In lbs

Social Security Number: _____ - _____ - _____

Check One:
☐Employee ☐Pre-Employ ☐Resident ☐Student ☐Volunteer ☐WOC ☐Contractor ☐Courtesy

Service (Department): _____PIV Sponsor:_____

Check One: ☐ Full-Time ☐ Part-Time ☐ Temporary ☐ Intermittent ☐ FEE

*****IF PRE-EMPLOYMENT or Student who will be at facility longer than 6 months COMPLETE BELOW:**

City of Birth:_____

County of Birth:_____

Email Address:_____

Job Title:_____

*****OFFICIAL USE ONLY – To be completed by PIV Office Representative**
Notes:

eQIP **Date Sent: _____ Initials:_____ Logged:_____**

Date Fingerprinted: _____ Person Capturing Fingerprints: _____

CASE #:

NI_____ FLAG_____ UNCLASS_____ OTHER:

Revision: 6/2017