VASTLHCS Student clinical rotation packet for Nursing Service
FOR CURRENT VA EMPLOYEES ONLY

Step 1: ****Read this page first and please follow the instructions carefully****

Submission of completed forms is the responsibility of the student and the affiliated school. All forms must be complete and not missing required information, including required signatures.

Incomplete forms could cause delay in the approval process for the student. Students are not allowed to start clinicals until all forms are completed, received and fingerprints have cleared.

PLEASE SUBMIT THE APPLICATION PACKET 4-6 WEEKS BEFORE YOU ARE SCHEDULED TO START CLINICAL ROTATION.
Please note- student clinical rotation boarding requirements can be a lengthy process!

Step 2: Complete the required forms.

The forms are included in this link. Please utilize this checklist to ensure you have all necessary forms completed prior to turning them in. Your completed student packet should include the original "ink" copies of the following:

- ☐ **-VAF 10-2850D, Application for Health Professions Trainees**
- ☐ **-OF 306 Declaration for Federal Employment**
- ☐ **-Without Compensation Letter (leave the " start/end dates blank")**
- ☐ **-Without Compensation Checklist**
- ☐ **-Documentation for non-US born persons if applicable, as described below**.**

**If you were not born in the U.S., we will need a photocopy of documentation showing you are legal to be in this country for this period of time (for example a Naturalization Certificate, Student Visa, or Resident Alien Card). This would include students who were born on military bases outside of the U.S.

Step 3: Turn in your paperwork.

Option 1: Place completed documents in a sealed envelope with your (legible) name and school name in the upper left hand corner. **Send through "Point to Point" mail.**
The envelope should be addressed to:
Melinda Crain
Nursing Education 118/JC

Option 2: Hand deliver paperwork to Melinda Crain, John Cochran, bldg. 1-T (behind medical center) Rm 104

Step 4: Check your email frequently. (The address that you provided on your applications and VA email)

Important information related to your VA clinical rotation including missing paperwork and when you are cleared to start your rotation will be communicated by email from Melinda Crain.

Failure to respond to notifications regarding issues with student paperwork can cause a delay in the approval process. Please try to complete missing or incomplete requirements as soon as possible.

Step 5: If you have questions regarding the student boarding process, please email Melinda Crain at Melinda.Crain@va.gov

Answers to frequently asked questions:

When will I be able to start my rotation?

The student boarding process can be very lengthy. Typically it can take up to 4-6 weeks. Please turn in your completed application documents in a timely manner. Please double check to be sure that all items are completed, with signatures prior to turning the documents in. This can help prevent delays due to incomplete paperwork. Students do not have authorization to start their rotation until all paperwork is completed and all forms are signed by authorized VA officials. Your VA student liaison, Melinda Crain, will notify both you and your preceptor when all requirements are met and your paperwork has been signed. You will receive email notification when you have been "cleared" to start. ***You should not start your clinical rotation prior to receiving this notification***

I need to extend my clinical time at the VA. What do I need to do?

As soon as you discover that you will need more time to complete the rotation (and this has already been approved by your school), you will need to contact Melinda Crain by email for instructions. You will need to fill out all paperwork again. Do not delay as it can still be a lengthy process to get the extension approved.

I have completed my student clinical rotation, what do I need to do?

You will receive an email about a week prior to the end of your scheduled student rotation end date. It will contain instructions regarding wrapping up the student clinical rotation. If you finish your clinical rotation early, please contact Melinda Crain via email so that you can complete this sooner.

OMB Number: 2900-0205
Estimated Burden: 30 minutes

Department of Veterans Affairs

APPLICATION FOR HEALTH PROFESSIONS TRAINEES

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

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

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

1A. NAME (Last, First, Middle)

1B. OTHER NAMES USED (For example: maiden name, nickname, etc.)

2. PRESENT ADDRESS (Include ZIP Code)

3A. DAY TELEPHONE (include area code)

3B. EVENING TELEPHONE (include area code)

4. SOCIAL SECURITY NUMBER

5. PREFERRED EMAIL ADDRESS

6. DATE OF BIRTH (mm/dd/yyyy)

7. PLACE OF BIRTH (City, State, and Country (if not U.S.A.))

8A. PROGRAM/DISCIPLINE OF STUDY

8B. ARE YOU APPLYING FOR A VA ADVANCED FELLOWSHIP PROGRAM FOR PHYSICIAN RESIDENTS? ☐ YES ☐ NO

8C. ENTER YOUR NATIONAL PROVIDER IDENTIFIER (NPI)

8D. START DATE OF YOUR DEGREE PROGRAM OF STUDY (mm/yyyy)

8E. EXPECTED END DATE OF YOUR DEGREE PROGRAM OF STUDY (mm/yyyy)

8F. CURRENT COLLEGE/UNIVERSITY/SCHOOL: INCLUDE CITY AND STATE (Do not abbreviate)

8G. TARGET DEGREE LEVEL OF YOUR CURRENT TRAINING PROGRAM

☐ Certificate/Diploma ☐ Master's ☐ Post-doctoral (other than residents)
☐ Associate ☐ Post-master's fellowship
☐ Baccalaureate ☐ Doctoral ☐ Residency/Fellowship

9A. VA TRAINING FACILITY (City, State)

9B. VA TRAINING START DATE (mm/yyyy) ☐ UNKNOWN

9C. VA TRAINING END DATE (mm/yyyy) ☐ UNKNOWN

10. CHECK APPROPRIATE BOXES IF YOU ARE ENROLLED IN A COLLEGE/UNIVERSITY THAT IS CLASSIFIED AS:

☐ Tribal College or University (TCU)
☐ Historical Black College and University (HBCU)
☐ Hispanic Serving Institution (HSI)

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

11A. ARE YOU NOW IN U.S. MILITARY?
☐ YES *(If YES, complete 11b, 11c* ☐ NO

11B. SERIAL OR SERVICE NO.

11C. BRANCH OF SERVICE

III - CITIZENSHIP

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

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

12B. COUNTRY OF CITIZENSHIP

13A. IMMIGRANT	13B. EXCHANGE VISITOR		13C. OTHER NON-IMMIGRANT		13D. FORM DS2019
"A" NUMBER	VISA TYPE	VISA NUMBER	VISA TYPE	VISA NUMBER	DO YOU HAVE A VALID DS2019? ☐ YES ☐ NO
DATE	ISSUE DATE	EXPIRATION DATE	ISSUE DATE	EXPIRATION DATE	DATE OF LAST VALIDATION (mm/dd/yyyy)

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

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

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

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

14D. Comments:

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

14F. Comments:

15A. SIGNATURE OF FACILITY DESIGNATED EDUCATION OFFICER OR DESIGNEE

15B. TITLE

15C. DATE

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER

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

16A. LIST ALL LICENSES, CERTIFICATIONS, AND REGISTRATIONS, INCLUDING THE DRUG ENFORCEMENT AGENCY (DEA), THAT YOU HAVE NOW OR HAVE HAD AS A HEALTH PROFESSIONAL, I.E. MEDICAL, NURSING, PHARMACY, ETC.	16B. LICENSE, CERTIFICATION OR REGISTRATION BODY	16C. STATE ISSUING LICENSE	16D. LICENSE, CERTIFICATION OR REGISTRATION NUMBER	16E. IS THE LICENSE, REGISTRATION, OR CERTIFICATION CURRENT? IF NO, EXPLAIN IN PART XI.	16F. EXPIRATION DATE
				☐ YES ☐ NO ☐ NOT REQUIRED	
				☐ YES ☐ NO ☐ NOT REQUIRED	
				☐ YES ☐ NO ☐ NOT REQUIRED	
				☐ YES ☐ NO ☐ NOT REQUIRED	

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

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

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

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

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

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

VIII - GRADUATES OF AN INTERNATIONAL MEDICAL SCHOOL

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

IX- INTERNSHIP, RESIDENCY AND FELLOWSHIP TRAINING

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

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER

X - ADDITIONAL QUESTIONS

ITEM	PLACE AN 'x' IN APPROPRIATE SPACE. IF YES, EXPLAIN DETAILS IN PART XI.	YES	NO
23	If you have ever participated in the Medicare/Medicaid Program, were you convicted of and or investigated for making and/or using false, fictitious, or fraudulent statements, representations, writings or documents, regarding a material fact in connection with the delivery of or payment for health care benefits, items or services that would be in violation of the Criminal False Claims Act?	☐	☐
24	ARE YOU NOW, OR HAVE YOU EVER BEEN, INVOLVED IN ADMINISTRATIVE, PROFESSIONAL OR JUDICIAL PROCEEDINGS IN WHICH MALPRACTICE ON YOUR PART IS OR WAS ALLEGED? If YES, give details in Part XI, including name of action or proceedings, date filed, court or reviewing agency, and the status or disposition of case concerning allegations, together with your explanation of the circumstances involved. As a provider of health care services, the VA has an obligation to exercise reasonable care in determining that applicants are properly qualified. It is recognized that many allegations of professional malpractice are proven groundless. Any conclusion concerning your answer as it relates to professional qualifications will be made only after a full evaluation of the circumstances involved.	☐	☐
25	Do you need accommodations to perform the procedures and essential functions of the training position for which you have applied?	☐	☐

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).

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

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER

AUTHORIZATION FOR RELEASE OF INFORMATION

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

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

SIGNATURE OF APPLICANT	DATE

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE

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

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

PURPOSES AND USES: The information requested on the application is collected primarily to determine your qualifications and suitability for appointment to a residency, advanced fellowship, fellowship, internship or other type of clinical training appointment. If you are appointed by the VA, the information will be used to make pay and benefit determinations and, as necessary, in personnel administration processes carried out in accordance with established regulations and published notices of systems of records.

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

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

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

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

Declaration for Federal 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

GENERAL INFORMATION

1. **FULL NAME** *(First, middle, last)*
◆

2. **SOCIAL SECURITY NUMBER**
◆

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

4. **DATE OF BIRTH** *(MM/DD/YYYY)*
◆

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

6. **PHONE NUMBERS** *(Include area codes)*
Day ◆
Night ◆

Selective Service Registration

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

7a. Are you a male born after December 31, 1959? ☐ YES ☐ NO *If "NO" skip 7b and 7c. If "YES" go to 7b.*

7b. Have you registered with the Selective Service System? ☐ YES ☐ NO *If "NO" go to 7c.*

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

Military Service

8. Have you ever served in the United States military? ☐ YES *Provide information below* ☐ NO

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

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

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

Background Information

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

For questions 9,10, and 11, your answers should include convictions resulting from a plea 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 10 years, have you been convicted, been imprisoned, been on probation, or been on parole? (Includes felonies, firearms or explosives violations, misdemeanors, and all other offenses.) *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 10 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 now under charges for any violation of law? *If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved.* YES ☐ NO ☐

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

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

Declaration for Federal Employment

Form Approved:
OMB No. 3206-0182

Additional Questions

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

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

Continuation Space / Agency Optional Questions

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

Certifications / Additional Questions

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

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

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

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

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

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

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

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

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

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

DEPARTMENT OF VETERANS AFFAIRS
Medical Center
#1 Jefferson Barracks Drive
St. Louis, MO 63125-4199

Date: _____

In Reply Refer to: 657/SCSL

Applicant Name:

Applicant Address:

Applicant City,
State, Zip:

Dear Applicant,

Welcome to the Department of Veterans Affairs. You will be assigned to our facility as

- ☐ Student Nurse
- ☐ Student Nurse Practitioner
- ☐ Student Practical Nurse
- ☐ Student Surgical Technician

with start date _____(mm/dd/yyyy) and end date _____(mm/dd/yyyy)

During your period of affiliation with our facility, you are authorized to perform services as directed by the Nursing Service Line.

In accepting this assignment you will receive no monetary compensation and you will not be entitled to those benefits normally given to regularly paid employees of the Department of Veterans Affairs, such as leave, retirement, etc. You will, however, be eligible to receive the benefits indicated below. Cash cannot be paid in lieu of any of these benefits.

☐ Quarters ☐ Subsistence ☐ Uniforms ☐ Laundering of Uniforms

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

Please indicate your veteran status by circling the appropriate number below.

Sincerely yours,

MARIE E. LEWIS
Human Resources Manager
Enclosure

MELINDA CRAIN, MSN, RN, ACNP-BC
Nursing Instructor

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

Circle Applicant Veteran Status

*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*

Applicant Signature _____

Date _____

CHECKLIST FOR WOC APPOINTMENTS

Complete all items inserting N/A if not applicable.

NAME: _____ SSN: _____
Last, First, MI

DOB: _____ VETERAN STATUS: ☐ VIETNAM
☐ OTHER ( )
☐ NON-VETERAN

CITIZENSHIP: ☐ U. S. ☐ Other - Specify: _____

(If not a U.S. citizen, attach documentation to verify efforts to recruit qualified citizen and show Visa status.)

POSITION TO WHICH CANDIDATE WILL BE APPOINTED:
☐ Student Nurse
☐ Student Nurse Practitioner
☐ Student Practical Nurse
☐ Student Surgical Technician

BRIEF DESCRIPTION OF DUTIES:: Clinical Experience

RENEWAL? ☐ Yes ☐ No **(If yes, DO NOT complete beyond this point.)**

APPLICATION FORM ATTACHED:

- ☐ OF 612, Optional Application for Federal Employment
- ☐ VA Form 10-2850, Application for Physicians, Dentists, Podiatrists and Optometrists
- ☐ VA Form 10-2850a, Application for Nurses and Nurse Anesthetists
- ☐ VA Form 10-2850c, Application for Associated Health Occupations
- ☐ OTHER (Identify)

CREDENTIALING COMPLETED? ☒ Yes ☐ No

CLINICAL PRIVILEGES? ☐ Yes ☒ No

IF CANDIDATE IS A STUDENT, HAS HE/SHE BEEN INFORMED OF ELIGIBILITY FOR DIRECT-HIRE APPOINTMENT WITH THE VA WITHIN ONE YEAR OF GRADUATION?
☒ Yes ☐ No

IS THE STUDENT ATTENDING AN AFFILIATED UNIVERSITY?
☐ Yes If so, check one ☐ SLU ☐ WU Other

TO BE COMPLETED BY HUMAN RESOURCES MANAGEMENT SERVICE

DRUG TEST SCHEDULED? ☐ Yes ☐ Not Required

PHYSICAL SCHEDULED? ☐ Yes ☐ Not Required

ALL NECESSARY APPROVAL OBTAINED? ☐ Yes ☐ No

MEETS TECHNICAL REQUIREMENTS - reviewed by:

_____ _____
Human Resources Specialist Date