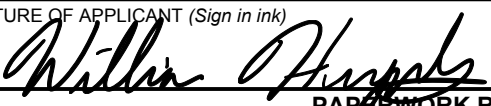
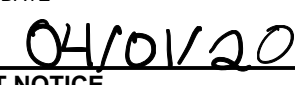


Department of Veterans Affairs		APPLICATION FOR HEALTH PROFESSIONS TRAINEES			
SEE LAST PAGE FOR PAPERWORK REDUCTION ACT, PRIVACY ACT AND INFORMATION ABOUT DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER					
INSTRUCTIONS: Please submit this application furnishing all information in sufficient detail to enable 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)	
		<input type="checkbox"/> UNKNOWN		<input type="checkbox"/> 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	
<input type="checkbox"/> YES (If YES, complete 8c) <input type="checkbox"/> NO		<input type="checkbox"/> YES (If YES, complete 8c) <input type="checkbox"/> NO			
III - CITIZENSHIP					
9A. CITIZENSHIP				9B. COUNTRY OF CITIZENSHIP	
<input type="checkbox"/> U.S. CITIZEN BY BIRTH <input type="checkbox"/> NATURALIZED U.S. CITIZEN <input type="checkbox"/> NOT A U.S. CITIZEN (Complete item 9B)					
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	
"A" NUMBER	VISA TYPE	VISA NUMBER	VISA TYPE	VISA NUMBER	DO YOU HAVE A VALID DS2019?
					<input type="checkbox"/> YES <input type="checkbox"/> NO
DATE	ISSUE DATE	EXPIRATION DATE	ISSUE DATE	EXPIRATION DATE	DATE OF LAST VALIDATION (MM/DD/YYYY)
IV- THIS SECTION TO BE COMPLETED BY DESIGNATED EDUCATION OFFICER (DEO) OR DESIGNEE					
11A. The trainee has met all of the criteria of the Trainee Qualifications & Credentials Verification Letter (TQCVL).					<input type="checkbox"/> YES <input type="checkbox"/> NO
11B. Incomplete items on the TQCVL have been addressed and resolved.					<input type="checkbox"/> YES <input type="checkbox"/> NO
11C. Special attention has been given to the following items from the application forms.					
11D. Comments:					
11E. This applicant has been approved for appointment.					<input type="checkbox"/> YES <input type="checkbox"/> NO
11F. Comments:					
12A. SIGNATURE OF FACILITY DESIGNATED EDUCATION OFFICER OR DESIGNEE			12B. TITLE		12C. DATE

LAST NAME, FIRST NAME, MIDDLE NAME			SOCIAL SECURITY NUMBER		
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?					
<input type="checkbox"/> YES - EXPLAIN IN PART XI <input type="checkbox"/> 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?					
<input type="checkbox"/> YES - EXPLAIN IN PART XI <input type="checkbox"/> NO					
VII - EDUCATION AND TRAINING AFTER HIGH SCHOOL THROUGH GRADUATE / PROFESSIONAL SCHOOL (Continue in Part XI if necessary)					
18A. NAME OF SCHOOL	18B. ADDRESS (City, State, and Zip Code)	18C. START DATE (MM/YY)	18D. (EXPECTED) COMPLETION DATE (MM/YY)	18E. DIPLOMA, DEGREE, OR CERTIFICATE AWARDED OR IN PROGRESS	18F. MAJOR FIELD OF STUDY
VIII - GRADUATES OF AN INTERNATIONAL MEDICAL SCHOOL					
19A. ARE YOU A GRADUATE OF AN INTERNATIONAL MEDICAL SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO	19B. EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG) CERTIFICATE NUMBER			19C. ECFMG CERTIFICATE DATE	
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
AUTHORIZATION FOR RELEASE OF INFORMATION	
<p>In order for the Department of Veterans Affairs (VA) to assess and verify my educational background, professional qualifications and suitability for employment, I:</p> <p><input type="checkbox"/> 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;</p> <p><input type="checkbox"/> Authorize release of such information and copies of related records and documents to VA officials;</p> <p><input type="checkbox"/> Release from liability all those who provide information to VA in good faith and without malice in response to such inquiries;</p> <p><input type="checkbox"/> 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</p> <p><input type="checkbox"/> Authorize VA to share any information about me with the affiliated institution or training program official.</p>	
SIGNATURE OF APPLICANT (<i>Sign in ink</i>)	DATE
	
PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE	
<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>	
INFORMATION REGARDING DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER UNDER PUBLIC LAW 93-579 SECTION 7(b)	
<p>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.</p>	