U.S. Department of Veterans Affairs
Veterans Health Administration
VA Northeast Ohio Healthcare System

VA Northeast Ohio Healthcare System
U.S. Department of Veterans Affairs
10701 East Blvd Cleveland, OH 44106
Education Office - Mail Code 14
216-791-3800 Ext: 64110
VHACleEduApps@va.gov

APPOINTMENT LETTER FOR TRAINEES PAID THROUGH A DISBURSEMENT AGREEMENT

Date:

Dear Trainee:

Welcome to the Department of Veterans Affairs (VA) and _____. You will be given a without compensation appointment at our facility as a Resident Physician from July 1, 2022 (Start Date) to June 30, 2023 (End Date) under the authority of Title 38 United States Code (U.S.C.) 7406. During your period of appointment to our facility, you will be paid by VA using a disbursement agreement with _____ (Affiliate) and will be authorized to perform services as directed by **Simran Singh, MD, DEO**.

Acceptance of this letter, as signified by your signature below, and completion of the Standard Form (SF) 61 prior to the start of your training, serves as your appointment authorization for this training period. If you have prior federal service, you are requested to report to our Human Resources Management Office by _____ (date) for additional appointment information and processing. Please bring this letter with you, as well as any documents you may have relating to your prior federal service.

Sincerely yours,

Steve Savino, Senior Strategic Business Partner
(Appointment Authority)

Enclosure: SF 61

_____ _____
(Signature) (Date)

_____
(Printed or Typed Name)

_____
(Home Address)

Pick One
_____
(School or Program)

OMB Number: 2900-0205
Estimated Burden: 30 minutes

Department of Veterans Affairs

APPLICATION FOR HEALTH PROFESSIONS TRAINEES

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

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

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

1A. NAME	1B. OTHER NAMES USED

2. CURRENT& FULL STREET 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)
Cleveland, OH - Wade Park	☐ 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
(SELECT) *(If YES, complete 8c)*	(SELECT) *(If YES, complete 8c)*	(SELECT)

III - CITIZENSHIP

9A. CITIZENSHIP	9B. COUNTRY OF CITIZENSHIP
(SELECT)	

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? (SELECT)
DATE	ISSUE DATE	EXPIRATION DATE	ISSUE DATE	EXPIRATION DATE	DATE OF LAST VALIDATION (MM/DD/YYYY)

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

11A. The trainee has met all of the criteria of the Trainee Qualifications & Credentials Verification Letter (TQCVL).	YES
11B. Incomplete items on the TQCVL have been addressed and resolved.	YES
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
11F. Comments:	

12A. SIGNATURE OF FACILITY DESIGNATED EDUCATION OFFICER OR DESIGNEE	12B. TITLE: DEO	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) (ENTER "TBD" IF NPI IS CURRENTLY NOT AVAILABLE)

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? (SELECT)

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? (SELECT)

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
				(SELECT)	
				(SELECT)	

VIII - GRADUATES OF AN INTERNATIONAL MEDICAL SCHOOL

19A. ARE YOU A GRADUATE OF AN INTERNATIONAL MEDICAL SCHOOL?	19B. EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG) CERTIFICATE NUMBER	19C. ECFMG CERTIFICATE DATE
(SELECT)		

IX- INTERNSHIP, RESIDENCY AND FELLOWSHIP TRAINING (RESIDENTS & FELLOWS MUST LIST ALL PAST, CURRENT AND FUTURE ROTATION INFORMATION)

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

RESIDENTS & FELLOWS MUST LIST ALL PAST, CURRENT AND FUTURE ROTATION INFORMATION.
NOTE: SCHEDULE INFO IS NOT NEEDED TO COMPLETE SECTIONS 20A - 20F.

LAST NAME	FIRST NAME	MIDDLE NAME	SOCIAL SECURITY NUMBER

X - ADDITIONAL QUESTIONS

ITEM	SELECT "YES" OR "NO" FOR ITEMS 21-23. IF YES, EXPLAIN DETAILS IN PART XI	
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?	(SELECT)
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.	(SELECT)
23	Do you need accommodations to perform the procedures and essential functions of the training position for which you have applied?	(SELECT)

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	24B. DATE (mm/dd/yyyy)

LAST NAME	FIRST NAME	MIDDLE NAME	SOCIAL SECURITY NUMBER

AUTHORIZATION FOR RELEASE OF INFORMATION

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

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

SIGNATURE OF APPLICANT	DATE

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE

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

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

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

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

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

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

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

Declaration for Federal Employment*

Form Approved:
OMB No. 3206-0182

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

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?** (SELECT)

3c. **COUNTRY OF CITIZENSHIP**

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

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

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

Mobile

Alt

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? (SELECT)

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

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

Military Service

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

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.* (SELECT)

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.* (SELECT)

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.* (SELECT)

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.* (SELECT)

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.* (SELECT)

Declaration for Federal Employment*

Form Approved:
OMB No. 3206-0182

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

Additional Questions

14. Do any of your relatives work for the agency or government organization to which you are submitting this form? (Include: father, mother, husband, wife, son, daughter, brother, sister, uncle, aunt, first cousin, nephew, niece, father-in-law,mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepfather, stepmother, stepson, stepdaughter, stepbrother, stepsister, half brother, and half sister.) *If "YES," use item 16 to provide the relative's name,relationship, and the department, agency, or branch of the Armed Forces for which your relative works.* (SELECT)

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? (SELECT)

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

*17b. Appointee's Signature: Date

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

EVERYONE MUST SIGN AND DATE BOTH 17A & 17B

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:

18b. When you worked for the Federal Government the last time, did you waive Basic Life Insurance or any type of optional life insurance? (SELECT)

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. (SELECT)

U.S. Department of Veterans Affairs
Veterans Health Administration
VA Northeast Ohio Healthcare System

APPOINTMENT AFFIDAVITS

Resident / Fellow
(Position to which Appointed)

July 1, 2022
(Date Appointed)

Veterans Affairs
(Department or Agency)

VHA
(Bureau or Division)

Cleveland - Wade Park
(Place of Employment)

I, _____ do solemnly swear (or affirm) that--
(enter full name)

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 1 day of July 2022

at Cleveland (City) Ohio (State)

N/A
Seal

N/A
Commission Expires

(If by a Notary Public, the date of his/her Commission should be shown)

(Signature of Officer)

Human Resource Officer
(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.

U.S. Office of Personnel Management
The Guide to Processing Personnel Actions

Standard Form 61 - Revised August 2002 - NSN 7540-00-634-4015 - Previous editions not usable

THIS FORM IS NOT REQUIRED TO BE SIGNED IN THE PRESENCE OF A NOTARY OR VA OFFICIAL
ALL RESIDENTS & FELLOWS ARE REQUIRED TO SIGN IN THE SIGNATURE OF APPOINTEE FIELD

U.S. Department of Veterans Affairs
Veterans Health Administration
VA Northeast Ohio Healthcare System

Personal Health - Data Sheet

Name: LAST | FIRST | MIDDLE

Social Security Number:

Full Street Address & ZIP Code:

Mobile Number: Alternate / Home Number:

5l·ǘŜ ƻŦ .ƛǊǘƘ: Place ƻŦ .ƛǊǘƘ:

Fathers Full Name:

Mothers Full Name:

Mothers Full Maiden Name:

Occupation:

(SELECT) Employment Status

(SELECT) Marital Status

Emergency Contact Info

Name:

Relationship:

Phone:

Full Address:

U.S. Department of Veterans Affairs
Veterans Health Administration
VA Northeast Ohio Healthcare System

PIV FORM

Required information for VA Trainees

This information will be used by an official to create your access & sponsor you for your **PIV card**.

Please complete all fields except SOI#, SON# and OPAC#.

SOI #	SON #	OPAC#
VAP6	1638	3600-1200

Name:	First: Middle: Last:	NPI #
Social Security #:		
Date of Birth:		
Sex:		
Race / Ethnicity:	(SELECT)	
Eye Color:	(SELECT)	
Hair Color:	(SELECT)	
Height & Weight:	Feet: Inches: Weight: (Lbs)	
Contact Numbers:	Primary: Pager:	
Place of Birth:		
Current Address:		
Email:		
Citizenship / Visa:	**Are you a foreign national?** (SELECT)	
Job Title:	(SELECT) **Specify Dept:**	
Have a PIV/ID badge:	(SELECT) **Date of completed fingerprinting:**	
Have you been fingerprinted within the last 120 days at this VA facility? (SELECT)		
Name of facility where you previously had a PIV / ID badge: (enter N/A if needed)		

U.S. Department of Veterans Affairs

Veterans Health Administration
VA Northeast Ohio Healthcare System

Steps to getting a PIV card

Please read carefully so this process is easy and you are prepared to get your card upon visiting.

STEP 1: Get fingerprinted at least a month before needing a card (or when directed by HR / mgmt) Everyone must complete fingerprinting before getting a new card or replacement card. These are valid for 120 days. It takes 3 days to process fingerprints.

STEP 2: Request PIV card

For new employees, volunteers, and those with expiring, lost, or broken cards, contact your department's PIV Manager or Sponsor to complete the online application form. PIV Sponsor is usually supervisor, manager, AdPac, or HR dept. This is not done by the PIV office.

STEP 3: Visit the PIV office

Bring two forms of ID to the PIV office to have your photo taken (See I-9 form for a list of acceptable IDs). Documents must be original (not copies) and not expired. Your name on at least one of these documents must be your current legal name and match the name entered into the PIV system.

STEP 4: Picking up PIV card

Please allow at least 48 hours for the PIV office to have your card available. You will be required to set a personal identification number (PIN) that is 6 digits and then your card will be officially released to you.

CONTACT PIV OFFICE

216-791-3800 Ext# 64609

U.S. Department of Veterans Affairs

Veterans Health Administration

VA Northeast Ohio Healthcare System

Service:

CPRS, iMed Consent, Encounters Self-Certification/Acknowledgement

I, _____ (enter full name)

do hereby acknowledge completing the online CPRS Basic Training 2022 - 2023 - I was afforded the opportunity to ask questions related to the use of CPRS and iMed Consent. All of my questions concerning the use of CPRS and iMed Consent were adequately addressed by a CAC/Clinical Systems Specialist at this time. I understand that I need to call the CPRS Help Line at 66200 with any CPRS related questions during normal business hours and the National Help Desk at ext. 66685 during off hours.

I also acknowledge receiving the following: CPRS Pocket Guide for Clinicians trifold, iMed Consent Quick Start Guide and one Encounter Completion How-To Quick Reference Guide from the Informatics & Analytics Office at the Louis Stokes VA Medical Center, Cleveland, Ohio. I certify having a basic understanding in the use of the CPRS Electronic Medical Record clinical system to perform my job safely and effectively as a clinician at the Wade Park VAMC. I understand prior to all invasive procedures iMed Consent software will be used to obtain appropriate signatures when applicable including the practitioner obtaining consent, the patient or significant other and witness.

Clinician's Full Printed Name	CAC/Health Informatics Specialist Printed Name
Clinician's Signature	CAC/Health Informatics Specialist Signature
Date/Time Signed	Date/Time Signed

V.3.0

U.S. Department of Veterans Affairs

Veterans Health Administration

VA Northeast Ohio Healthcare System

Request for Scrubs

Name: _____ **Date:** _____

Rotation Start Date: _____ **Rotation End Date:** _____

Service: _____ **Title:** _____

Pants and shirts must be the same size (sizes go up to 3x)

Shirt Size: _____ **Pants Size:** _____

You will be issued a ScrubEX card to access the vendor managed machine to get your scrubs. This card must be returned to your Service POC / Residency Coordinator once your current rotation is completed.

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 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. OAA sponsored health professions trainees (HPTs) appointed under 38 U.S.C. 7405 or 7406 authority are employed in VA and are subjected to provisions of this policy.

2. This is to notify you that as an HPT, the Secretary of VA may deem your position as a sensitive position to protection of life or safety of patients and therefore 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. There are no pre-employment drug testing requirements for HPTs.

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 HPT subject to random drug testing you should be aware of the following:

   - Counseling and rehabilitation assistance are available to all HPTs through existing Employee Assistance Programs (EAP) at VA facilities (information on EAP can be obtained from your local Human Resources office). EAP plays a valuable role by helping employees, their families and their communities.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 may, at the direction of the facility's leadership, initiate disciplinary actions up to dismissal from VA rotation against any HPT who:
     - refuses to be tested,
     - refuses to obtain counseling or rehabilitation after a verified positive drug test, or
     - does not refrain from illegal drug use after a verified positive drug test.
   - VA will not initiate any disciplinary action against an employee who voluntarily identifies themselves as a user of illegal drugs prior to being notified of a scheduled drug test, obtains counseling or rehabilitation and thereafter refrains from using illegal drugs.

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 Use Disorder. https://www.opm.gov/policy-data-oversight/worklife/employee-assistance-programs/

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

Training Program and Affiliate

Print Name and Date Signed Signature

U.S. Department of Veterans Affairs

Veterans Health Administration

VA Northeast Ohio Healthcare System

FINAL ACKNOWLEDGEMENT OF COMPLETION PAGE
IN REGARD TO THE VA APPLICATION PACKET
PLEASE READ CAREFULLY!

Before signing this document for the final time, please make sure it is complete. After signing this page that it is complete, you will **NOT** be able to make changes.

PLEASE MAKE SURE THAT ALL APPROPIATE DROPDOWN BOXES ARE NOT LEFT ON "SELECT"

Areas that can be left blank include, but are not limited to:

a. Areas to be completed by VA staff or Education Officer
b. Areas outlined in dash marks looking like "---------"
c. Page 8, sections 18-18C

After signing this page, the document will be locked and no changes can be made unless the Adobe Digital signature is removed. If needed, the signature can be removed on this page to allow changes and then re-signed.

PLEASE SIGN ABOVE AND THEN EMAIL THIS DOCUMENT INCLUDING THE MTT CERTIFICATE OF COMPLETION TO: VHACleEduApps@va.gov WITH THE SUBJECT "LAST NAME, FIRST NAME".

SIGNING MUST BE DONE WITH AN ADOBE DIGITAL SIGNATURE. PLEASE DO NOT USE ANY OTHER SIGNATURE TYPES FOR SIGNING.

YES---> *Mr. Example*

Digitally signed by your common name here
DN: your distinguished name here
Reason: your signing reason here
Location: your signing location here
Date: 2010.03.17 17:42:22 -07'00'

NO--->

NOTE: WE REQUIRE A FRONT AND BACK COPY OF YOUR BLS OR ACLS CARD. IT NEEDS TO BE SENT AS A SEPARATE EMAIL TO VhaCleEduApps@va.gov