

Health Professions Trainees Form Guide

These next pages are intended to help Program Coordinators, Instructors, and Students understand how each form is to be completed, how to set up accounts in TMS, and how to schedule appointments, and what forms need to go with to those appointments.

If you still have any questions, please do not hesitate to contact the Sioux Falls VA Health Care System Education Department.

E-mail: vhasuxStudentRequest@va.gov

Onboarding Specialist: 605-336-3230 X6441

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This form is to be completed by a representative from the University/School.
This must be completed to request training.
Training requests will not be considered until this is completed and sent to the Sioux Falls VA.
Student onboarding will not begin until this is received.
ALL fields outlined in red must be completed.

VA



**U.S. Department
of Veterans Affairs**

Educational Sponsor – University/Program

Sponsoring Institution or VA facility: **University/School requesting training**

Training Program: **Degree program of student**

VA Facility: **Sioux Falls VA Healthcare System**

Date: **Enter today's Date**

Dear Medical Center Director:

I certify that all appropriate information for the health professions trainees listed on the attached TCQVL List of Trainees has been verified. At the time of verification, all trainees listed are fully qualified and have the necessary credentials to complete their scheduled clinical training at a Department of Veterans Affairs (VA) healthcare facility.

ALL trainees:

- Are enrolled in the designated training program and have met criteria for their specified level of training;
- Meet the physical requirements of the training program;
- Have had tuberculosis screening as required by the Center for Disease Control (CDC) or VA standards;
- Have had hepatitis B vaccination or have signed declination waivers;
- Have been vaccinated for influenza per VHA policy; currently by November 30th each year or, if declining vaccination, trainees are aware of the requirement to wear a face mask throughout the influenza season while at the VA healthcare facility;
- Have been screened against the Health and Human Services' List of Excluded Individuals and Entities (LEIE). <https://exclusions.oig.hhs.gov/> (all paid and WOC trainees)

As applicable:

- International medical school graduates have had primary source verification of the Educational Council for Foreign Medical Graduates (ECFMG) certificates.
- Licensed trainees have been screened against the National Practitioner Data Bank (NPDB) <https://www.npdb.hrsa.gov/>
- Trainees born male, both U.S. citizens and immigrants, who are between 18 and 25 years old, have registered with the Selective Service or provided a Status Information Letter.
- If required by the admission criteria of the training program, all trainees have had primary source verification of education and other credentials.

NOTE: List may not be all inclusive. Please mark which items below are required and have been verified.

- Reference letters
- Primary source verification of current and past license(s) or registration(s) in any field
- Certification(s) through the state licensing board(s) and/or national and state certification bodies
- Drug Enforcement Administration (DEA) registrations
- National Provider Identifier (NPI) registration
- Other:

As applicable, for non-U.S. citizen trainees:

- Documented proof of current immigrant, non-immigrant or exchange visitor status has been reviewed and **a copy attached** to include:
 - o Appropriate visa (J-1, J-2, H-1B, H-4, E-3); or
 - o Permanent Resident Card (formerly "Green Card"); or
 - o Deferred Action for Childhood Arrivals (DACA) trainee, Employment Authorization Document (Form I-766).
 - o Other visas require discussion with the VA Designated Education Officer (DEO) and may need decision of VA General Council.
- Appointment of non-US citizens must be approved by the VA Medical Center Director.

I will notify the VA DEO, as soon as possible but no later than 72 hours, of changes in the academic status of individual trainees, adverse actions that affect the trainee appointment, or changes in health status that pose a risk to the safety of trainees, other employees, or patients.

I certify that all documents pertaining to the listed trainees are maintained on file and available for review by VA officials by contacting the following Office:

Signature and Printed Name

Date

Title of Educational Official

[Titles include: Program Director, Designated Institutional Official (DIO), or Educational Dean, Dean for Academic Affairs, Dean]

VAMC Chief of Staff

Accept Do Not Accept (Select one)

Signature _____
Date _____

Printed Name: _____

VAMC Director

Accept Do Not Accept (Select one)

Signature _____
Date _____

Printed Name: _____

Enclosures: **TQCVL List of Trainee(s)**
cc: **VA Facility, Designated Educational Officer**

Health Professions Trainees Checklist

Student Name: _____

School: _____

Program of Study: _____

IMPORTANT: Ensure you read **before** completing the Checklist

- All paperwork, training, and fingerprinting must be completed and turned into the Sioux Falls VA at least **7 weeks(49 days)** prior to training start date.
 - Incomplete or incorrectly completed forms will be returned, and can cause a delay in training.
 - All forms must be typed, hand written forms will not be accepted, nor will pictures of forms be accepted.
 - For instructions on how to complete each form, please review the [HPT form guide](#) found on the Sioux Falls VA Health Professions Trainees site.
- *VA Employees do not need to complete the OF 306, the Fingerprint Form, the fingerprinting appointment, nor the TMS Training.

-All paperwork and training are to be completed prior to your fingerprinting appointment. All paperwork will be printed and brought with on the day of your appointment. Bring all forms to the Education Department Room 017 either prior or after your fingerprinting appointment.

Application for Health Professions Trainees

<https://www.va.gov/vaforms/medical/pdf/vha-10-2850d-fill.pdf>

Ensure pages 3 and 4 are signed

WOC Appointment Letter

<https://www.siouxfalls.va.gov/documents/WOC-Appointment-Letter.pdf>

Instructions to complete this form are on page 17 of the HPT Form Guide

OF 306 Declaration for Federal Employment *

http://www.opm.gov/forms/pdf_fill/of0306.pdf

Sign 17a ONLY. Do not sign 17b.

TMS Training*

<https://www.siouxfalls.va.gov/documents/HPT-Form-Guide.pdf> (Instructions on Page 18)

The training must be completed; there is no need to print the certificates unless specifically asked to do so.

Fingerprint Form*

<https://www.siouxfalls.va.gov/documents/HR-Fingerprint-Form.pdf>

Bring 2 copies. 1 for your fingerprinting appointment and 1 for the Education Department

Fingerprinting Appointment*

Create an account and schedule at <https://www.va-piv.com/>

<https://www.siouxfalls.va.gov/documents/HPT-Form-Guide.pdf> (Instructions on page 10)

DO NOT schedule more than 120 days (about 4 months) before start date!

You will need this account again at a later date.

Ensure you bring two forms of ID with you to any appointment with the PIV office.

-When scheduling the Fingerprinting Appointment, ensure you are allotting enough time in your schedule to turn in all of your paperwork for review and acceptance with the Sioux Falls VA Education Department.

Fingerprinting Appointment Date & time*

E-mail this date & time to vhasuxStudentRequest@va.gov

This is the checklist of paperwork, training, and appointments that students(Health Professions Trainees) must complete in order to onboard at the Sioux Falls VA.

This checklist contains links to all of the necessary paperwork, training, and appointments, and links to instructions on how to complete everything.

Education Department Office hours: 7:30am-4:00pm, with lunch sometime between 11:00am-12:00pm.

| | | | | | |
|--|-------------------|---|---|------------------------------------|--|
|  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) FULL LEGAL NAME, MUST REFLECT GOVERNMENT/ STATE ISSUED IDs | | | 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) <input type="checkbox"/> UNKNOWN | | 7C. VA TRAINING END DATE (mm/yyyy) <input type="checkbox"/> UNKNOWN | | | |
| II - U.S. MILITARY DUTY STATUS | | | | | |
| 8A. ARE YOU NOW IN U.S. MILITARY? <input type="checkbox"/> YES (If YES, complete 8c) <input type="checkbox"/> NO | | 8B. ARE YOU IN THE RESERVES OR NATIONAL GUARD? <input type="checkbox"/> YES (If YES, complete 8c) <input type="checkbox"/> NO | | 8C. BRANCH OF SERVICE | |
| III - CITIZENSHIP | | | | | |
| 9A. 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) | | | | 9B. COUNTRY OF CITIZENSHIP | |
| 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? <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. | | | | | |
| <u>11A through 12C to be completed by a Sioux Falls VA representative</u> | | | | | |
| 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? 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 |
|---------------------|--|-------------------------|---|---|---------------------------|
| | | | | | |
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| | | | | | |
| | | | | | |

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 |
|--------------------------------------|---|----------------|-------------------------|---|---------------------------------|
| | | | | | |
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| | | | | | |

| | |
|------------------------------------|------------------------|
| 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 <u>Student signs and dates</u> | 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.



DEPARTMENT OF VETERANS AFFAIRS
 Sioux Falls VA Health Care System
 2501 West 22nd Street
 Sioux Falls, SD 57105-9875

(Date)

Student Name

Dear :

Training Start Date and End Date must include Month, Day, and Year.

Welcome to the Department of Veterans Affairs. You will be assigned to our facility as a Student from to under authority 38 U.S.C. 7405(a).

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

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,

BETSY GEIVER
 Chief, HRMS

Enclosure

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

Select your Veteran Status.

VETERAN STATUS:

- 1) Vietnam Veteran (*) 2) Other Veteran 3) Non-Veteran

(*) For this purpose, a Vietnam Veteran's service is 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.

Signature
 FL 10-294

Date

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)

◆ **FULL LEGAL NAME-MUST REFLECT STATE/GOVERNMENT ISSUED IDs**

2. **SOCIAL SECURITY NUMBER**

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

3b. **ARE YOU A U.S. CITIZEN?**

YES NO (If "NO", provide country of citizenship) ◆

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

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

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

Day ◆

Night ◆

Selective Service Registration

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

7a. 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?

YES NO

(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.

10. Have you been convicted by a military court-martial in the past 7 years? (If no military service, answer "NO.") If

YES NO

"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.

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

Students signs and dates

DO NOT SIGN 17B. DO NOT COMPLETE ANYTHING BELOW

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

Make sure to read all instructions. Creating an account, what information to select and enter and printing certificates is all covered in these instructions. If you do not select the correct options you will not receive the correct training, you will have to contact the TMS helpdesk at 1 (855) 673-4357.

1.1 Already Have a TMS Account? Contact your VA POC or the ESD at 1 (855) 673-4357

1.2 Step-by-Step Instructions for Managed Self Enrollment (New Users)

1. From a computer, launch a web browser and navigate to <https://www.tms.va.gov/SecureAuth35/>
2. Click the [**Create New User**] button
3. Select the radio button for **ⒶVeterans Health Administration (VHA)** Click the [**Next**] button
4. Select the radio button for **ⒷHealth Professions Trainee (NOT WOC)** Click the [**Next**] button
5. **Complete all required fields, indicated by asterisk*** and any non-required fields if possible. **Note:** The email address you enter here will be your Username to log into the system.

My Account Information:

- Create Password*
- Re-enter Password*
- Social Security Number*
- Re-enter Social Security Number*
- Date of Birth*
- Legal First Name*
- Legal Last Name*
- Middle Name is optional, but extremely helpful
- Your e-mail Address* *(Enter a personal email address. Do not use a School email address. This address will become your UserID. Also, one-time-passcodes and training notifications will be sent here.)*
- Re-enter your e-mail address*
- Phone Number *(Enter your phone number. You will have the option to receive one-time-passcode information at this phone number.)*
- Time Zone ID*

My Job Information:

- VA Location Code* *(Filter and search for SUX, Select SUX)*
- Trainee Type*
- Specialty/Discipline*
- VA Point of Contact First Name* *(Eunmi)*
- VA Point of Contact Last Name* *(Simmons)*
- VA Point of Contact Email* *(eunmi.simmons@va.gov)*
- Point of Contact Phone Number* *(605-336-3230)*
- School/University*
- School/University Start Date*
- Estimated School/University Completion Date*

Click the [**SUBMIT**] button when all required fields are completed.

6. You should now see the Congratulations! Screen. Note your Username/Email Address.

WAIT 20 MINUTES

Make sure to read all instructions. Creating an account, what information to select and enter and printing certificates is all covered in these instructions. If you do not select the correct options you will not receive the correct training.

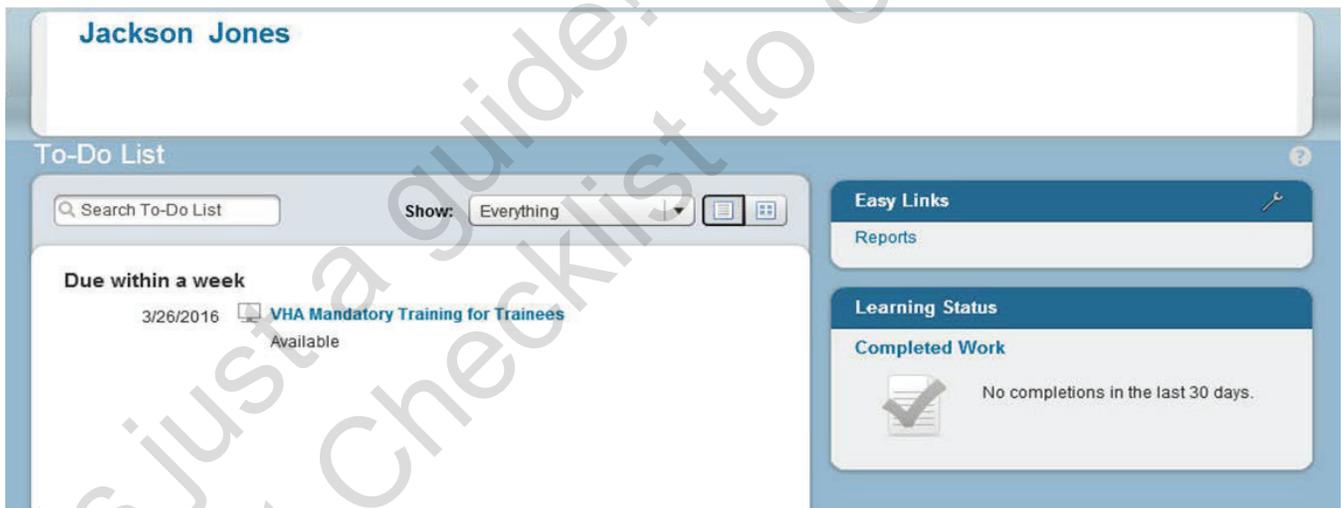
7. **After 20 minutes**, please return to <https://www.tms.va.gov/SecureAuth35/>
8. On the TMS 2.0 Login Screen enter your Username/Email Address and click the **[SUBMIT]** button
9. An email will be sent to your Username/Email Address containing a one-time-passcode enter it using your keyboard or the on-screen number pad and click the **[SUBMIT]** button
10. During this first time log in you will be asked to select and answer two security questions. These will be used to reset your TMS password.
11. Select questions, enter response, confirm response.
12. Select questions, enter response, confirm response.
13. Click the **[Save]** button.
14. You have now completed your TMS User Profile.

1.3 Launching and Completing the Content

1. Click on the the title of the *VHA Mandatory Training for Trainees* training item. **If you do not see this course, you selected the incorrect options, contact TMS Helpdesk, I cannot help you.**

Pop-Up blockers MUST BE TURNED OFF

2. Complete all of the item content following the on-screen instructions.
3. Exit the item as instructed to accurately record your effort.



4. To print a Certification of Completion, click on Completed Work

** Your SSN is used only as a unique identifier in the system to ensure users do not create multiple profiles. The SSN is stored in a Private Data Table that cannot be accessed anywhere via the VA TMS interface. It is securely transferred to a VA database table inside the VA firewall where it can be confirmed, if necessary, by appropriately vested system administrators and/or Help Desk staff.*

FINGERPRINT REQUEST FORM

Bring with you two (2) original IDs (Identity Source Documents) from the list below
<https://www.oit.va.gov/programs/piv/media/docs/IDMatrix.pdf>

Complete all fields outlined in red to the best of your ability

Applicant Category: Check One

| | | |
|------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> EMPLOYEE | <input type="checkbox"/> CONTRACTOR | <input checked="" type="checkbox"/> HEALTH PROFESSIONS TRAINEE (VHA intern, resident, fellow, student) |
| <input type="checkbox"/> AFFILIATE | <input type="checkbox"/> VOLUNTEER | <input type="checkbox"/> OTHER: |

ENTER YOUR NAME EXACTLY AS IT APPEARS ON IDs

| | | |
|--|--|---|
| Name: (Last, First, Middle) | | Other Last Names Used |
| | | |
| SSN (use of pseudo number is not permitted) | Position Title | Telephone # |
| | | |
| Date of Birth: (mm/dd/yyyy) | City/State and Country of Birth | |
| | | |
| E-Mail Address | Country of Citizenship | Dual Citizen? |
| | | |
| VA Work Location | Organization (VHA, VBA, NCA, VACO, etc.) | Start Date |
| Sioux Falls, SD | VHA | |
| Current Address | | |
| | | |
| Health Professions Trainees Only: School Name | | Training Program |
| Enter School you attend | | Enter what Degree/Program you attend at your school |

| | | | | | | |
|----------------------|-----------------|-------------------------------|--|-----------|----------------|--|
| FINGERPRINT LOCATION | | FINGERPRINT DATE (mm/dd/yyyy) | SCAR, MARK OR TATTOO (Provide one identifying feature) | | | |
| | | | Provide at least 1 identifying feature. | | | |
| GENDER (M/F) | HEIGHT (inches) | WEIGHT (US pounds) | HAIR COLOR | EYE COLOR | RACE/ETHNICITY | |
| | | | | | | |

Courtesy Prints for another Facility: If fingerprints are completed at another facility, the Sioux Falls VA Education Department still needs a copy of this form along with all others.
 Facility: Sioux Falls VA Health Care System

SOI# VA86
 SON# 1179
 Printed By: _____
 Transmitted to OP _____

Courtesy Prints for another Facility: If there is a VA closer to the student they can complete this appointment there. The SOI and SOI #s must be brought with or the Sioux Falls VA will not receive the results of the fingerprints, and will delay the onboarding process.

Fingerprint Results Cleared: YES NO (Circle One)

Date/Initials of Clearance: _____

Fingerprints are only good for 120 days. If an appointment is made too early, the fingerprints will have to be resubmitted, and will take additional time for the results to come back.

The Onboarding Specialist is unable to help with Fingerprinting Appointments or PIV Badge Photo Appointments. This is the responsibility of the Student to ensure they are making their appointment and showing up on time. Each appointment is allotted 15 minutes. Appointments fill up fast. If a student is late for their appointment, they may be sent away and have to reschedule.

This site will also be used to schedule PIV Badge Photo appointments. Students cannot make this appointments until the SFVAHCS informs the Affiliates Program Coordinator that the Students badge has been sponsored.

The VA Personal Information Verification (PIV Card)

STUDENTS: 2 FORMS OF ID MUST BE BROUGHT WITH TO BOTH APPOINTMENTS

- **YOU WILL NEED TO BRING YOUR DRIVER'S LICENSE AND SOCIAL SECURITY CARD, VALID PASSPORT OR A CERTIFIED COPY OF YOUR BIRTH CERTIFICATE WITH YOU.**
- PLEASE go to the following website to schedule your appointments:
- <https://VA-PIV.Com>
- **Accept terms**



- **DO NOT SIGN IN**
- **Go to top of the page and create an account**

- **ORGANIZATION IS VHA**
- **SELECT IF EMPLOYEE CONTRACTOR OR AFFILIATE (STUDENT)**

- **Make Appointment**

VA Appointment Scheduling for PIV Cards :: Applicant Account - Home

Welcome to the **PIV Appointment Scheduling tool**. This is where you will **MAKE, MODIFY** and **CANCEL** appointments for nearby VA facilities in support of PIV Card credential issuance activities.

The scheduling process is intuitive and easy to use. **HELP** is available in case you have any questions.

Please add "**do.not.reply@va-piv.com**" to your **contacts list**. This will ensure that you receive notification e-mails that might otherwise be filtered into Spam and Trash folders.

[Make Appointment](#)

The Facility Location service using the Zip Code is currently not working properly, please use the drop down box to find your facility. We apologize for the inconvenience, and we are working to fix this issue.

- **Select Location:**

VA Appointment Scheduling for PIV Cards :: Applicant Account - Make an Appointment

Please enter a zip code to view nearby locations or select a known site.

Zip Code:

[Continue](#)

Location:

[Continue](#)

- **Select Fingerprint**

VA Appointment Scheduling for PIV Cards :: Applicant Account - Choose an Appointment Activity

Please choose an activity for your appointment at **Sioux Falls VA Health Care System** below.

Activity:

[Continue](#) [Back to Locations](#)

(* Please Read *)

The PIV office will be re-located to Rm 029 in Bldg 1, (across from the Fitness Center) starting on April 15, 2015.

Reminder: When you are coming to do fingerprints, take your photo, or pickup your card you will need to have 2 valid forms of ID (i.e. Drivers License, SSN card, a certified birth certificate or Passport) with you at the appointment.

****Please be advised, you can only make one appointment at one time. If you attempt to make more than one appointment your earliest appointment will be cancelled.****

- Select Date/Select time slot

VA Appointment Scheduling for PIV Cards :: Applicant Account - Choose an Appointment Time Slot

Please choose a date and time for your **Fingerprint appointment at Sioux Falls VA Health Care System.**

September 2017

| Sun | Mon | Tue | Wed | Thu | Fri | Sat |
|-----|-----|-----|-----|-----|-----|-----|
| | 2 | 3 | 4 | 5 | 6 | 7 |
| 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| 15 | 16 | 17 | 18 | 19 | 20 | 21 |
| 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| 29 | 30 | | | | | |

AM/PM AM PM

| | | | |
|---------|---------|---------|---------|
| 7:30am | 7:45am | | |
| 8:00am | 8:15am | 8:30am | 8:45am |
| 9:15am | 9:30am | | |
| 10:00am | 10:15am | 10:30am | 10:45am |
| 11:00am | 11:15am | | |
| | | | |
| 12:30pm | 12:45pm | | |
| 1:00pm | 1:15pm | 1:45pm | |
| 2:15pm | 2:30pm | | |

SUMMARY OF SELECTIONS:
Appointment Date: 9/27/2017
Appointment Time: 10:15 AM

- Confirm Appointment

VA Appointment Scheduling for PIV Cards :: Applicant Account - Appointment Review

Please Review The **New** Appointment Details Displayed Below.
 You may **Cancel** this Appointment or **Confirm** this Appointment.

New Appointment Details to Review

Location: Sioux Falls VA Health Care System
 2501 West 22nd Street
 Sioux Falls, SD 57105

Activity: Fingerprint

Date: Tuesday, September 26th, 2017

Time: 1:15 PM

Held: GDY7S0JK

If there is a VA closer to where the student or school is located, a fingerprinting appointment can be scheduled there. This is called a Courtesy Fingerprint for the Sioux Falls VAHCS. Students will need to bring the following information with them.

SOI VA86
 SON 1179

Please check with that VA to ensure all requirements are the same.

The PIV Badge Photo Appointment will have to be made with the Sioux Falls VA PIV Office regardless if they are actually training here or at one of the CBOC sites. This cannot be completed at another VA.