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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) <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
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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
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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.		
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 <i>Sandra Stephens</i>	12B. TITLE ACOS/Education	12C. DATE

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER
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V- LICENSE, CERTIFICATION, OR REGISTRATION IN CURRENT CLINICAL PROFESSION

13A. LIST ALL LICENSES, CERTIFICATIONS, AND REGISTRATIONS, INCLUDING THE DRUG ENFORCEMENT AGENCY (DEA), THAT YOU HAVE NOW OR HAVE HAD AS A HEALTH PROFESSIONAL, I.E. MEDICAL, NURSING, PHARMACY, ETC.	13B. STATE ISSUING LICENSE	13C. LICENSE, CERTIFICATION OR REGISTRATION NUMBER	13D. EXPIRATION DATE (MM/DD/YYYY)

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

14A. LIST ALL LICENSES, CERTIFICATIONS, AND REGISTRATIONS, INCLUDING DEA, THAT YOU HAVE EVER HAD AS A HEALTH PROFESSIONAL, I.E. MEDICAL, NURSING, PHARMACY, ETC.	14B. STATE ISSUING LICENSE	14C. LICENSE, CERTIFICATION OR REGISTRATION NUMBER	14D. EXPIRATION DATE (MM/DD/YYYY)

15. ENTER YOUR NATIONAL PROVIDER IDENTIFIER (NPI)

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

16. DO YOU HAVE PENDING, OR HAVE YOU EVER HAD ANY LICENSE, CERTIFICATION, OR REGISTRATION TO PRACTICE (INCLUDING DEA CERTIFICATE) REVOKED, SUSPENDED, DENIED, RESTRICTED, OR PLACED ON A PROBATIONARY STATUS, OR HAVE YOU EVER VOLUNTARILY RELINQUISHED A LICENSE, CERTIFICATION, OR REGISTRATION IN LIEU OF FORMAL ACTION? YES - EXPLAIN IN PART XI NO

17. DO YOU HAVE PENDING, OR HAVE YOU EVER HAD CLINICAL PRIVILEGES AT ANY HEALTH CARE INSTITUTION OR AGENCY REVOKED, SUSPENDED, DENIED, RESTRICTED, LIMITED, OR PLACED ON A PROBATIONARY STATUS, OR HAVE YOU EVER VOLUNTARILY RELINQUISHED CLINICAL PRIVILEGES IN LIEU OF FORMAL ACTION? YES - EXPLAIN IN PART XI NO

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

18A. NAME OF SCHOOL	18B. ADDRESS (City, State, and Zip Code)	18C. START DATE (MM/YY)	18D. (EXPECTED) COMPLETION DATE (MM/YY)	18E. DIPLOMA, DEGREE OR CERTIFICATE AWARDED OR IN PROGRESS	18F. MAJOR FIELD OF STUDY

VIII - GRADUATES OF AN INTERNATIONAL MEDICAL SCHOOL

19A. ARE YOU A GRADUATE OF AN INTERNATIONAL MEDICAL SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO	19B. EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG) CERTIFICATE NUMBER	19C. ECFMG CERTIFICATE DATE
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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
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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 TIME STAMP DIGITAL	DATE
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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.

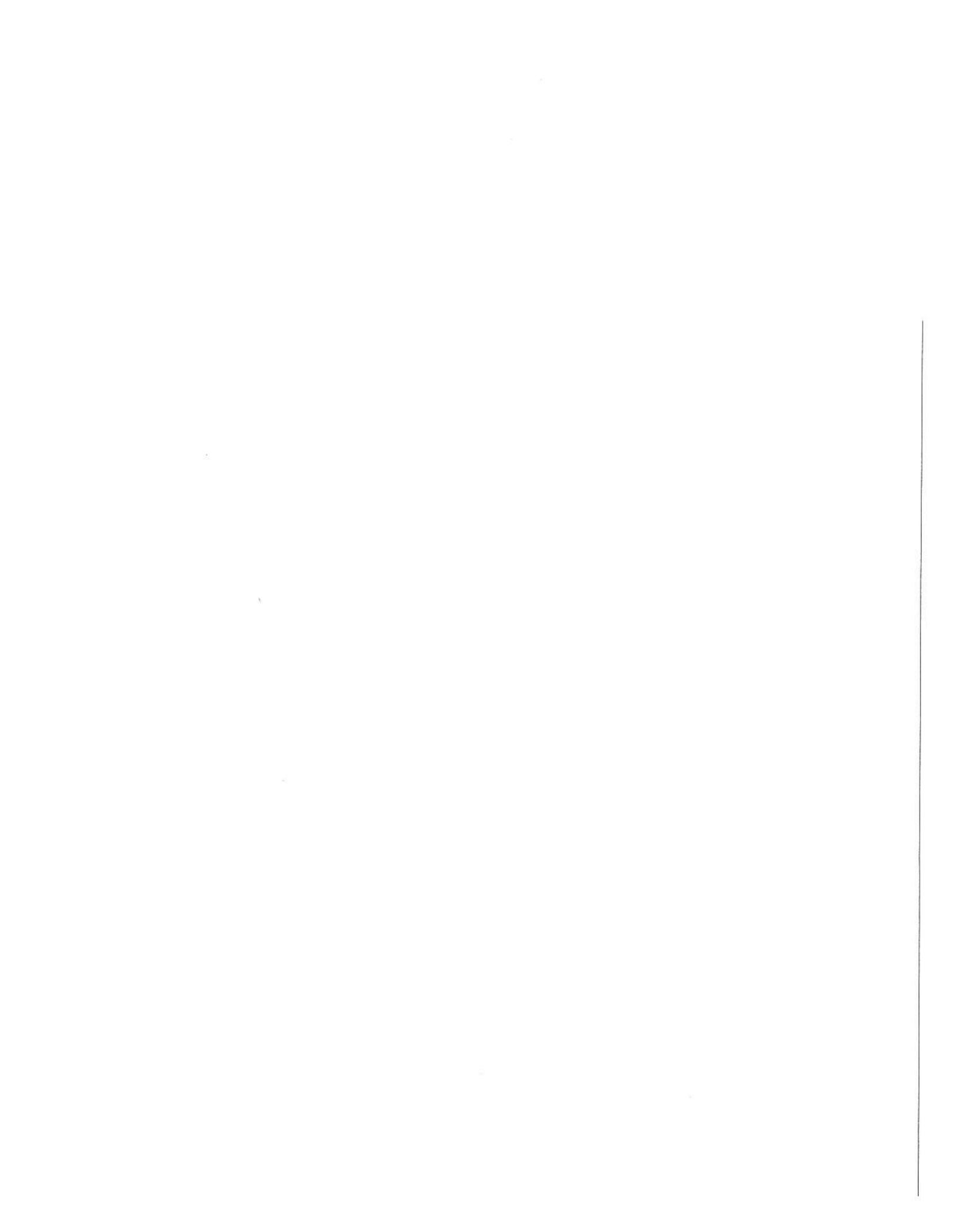
PURPOSES AND USES: The information requested on the application is collected to determine your qualifications and suitability for appointment to a VA clinical training program. If you are appointed by VA, the information will be used to make pay and benefit determinations and in personnel administration 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
Bay Pines VA Healthcare System
Post Office Box 5005
Bay Pines, Florida 33744



Date:

In Reply Refer To: 516/11B

Name:

Address:

City/State/Zip:

Welcome to the Bay Pines VA Healthcare System. You will be assigned to _____ Service as a _____, on a without compensation (WOC) basis. You will be under the guidance of _____ Service from _____ through _____ under authority 38 U.S.C. 7405(a)(1). During your period of affiliation with our facility, you are authorized to perform services as directed by _____

In accepting the WOC assignment, you will not receive any 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.

It is important that you receive appropriate orientation to our facility prior to providing care, treatment, and services. Please contact your preceptor and make arrangements for this to be scheduled.

If you agree to these conditions, please sign the statement below and return one copy to Education Service. Either party may terminate this agreement at any time by written notice of such intent.

Thank you in advance for your service to enhance our efforts to provide quality patient care.

Respectfully,

A handwritten signature in cursive script that reads "Sandra Stephens".

Sandra Stephens, MSHA, MBA
Acting Chief of Education Service

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

Signature of Employee

Date

**Department of
Veterans Affairs**

Memorandum

From: VHA Office of Academic Affiliations (OAA)

Subj: Random Drug Testing Notification and Acknowledgement

To: Health Professions Trainee (HPT) in a Testing Designated Positions (TDP)

1. On September 15, 1986, President Reagan signed Executive Order 12564, Drug-Free Federal Workplace, establishing a policy against the use of illegal drugs by Federal employees, whether on or off duty. In accordance with the Executive Order, VA has established a Drug-Free Workplace Program to include random testing for the use of illegal drugs by employees (to include trainees) in sensitive positions.
2. This is to notify you that as an HPT in a sensitive position you may be subject to random drug testing. The testing procedures, including the collection of a urine specimen, will be conducted in accordance with Department of Health and Human Services (HHS) Guidelines for Drug Testing Programs.
 - a. The only VHA Training Programs exempt from Random Drug Testing per policy are:
Clinical Pastoral Education (Chaplain), Social Work, Dietetics, Occupational Therapy, Optometry, Audiology, Speech Pathology, Non-Clinical and Administrative
3. You can be assured that the quality of testing procedures is tightly controlled, that the test used to confirm use of illegal drugs is highly reliable and that the test results will be handled with maximum respect for individual confidentiality, consistent with safety and security.
4. As a trainee subject to random drug testing you should be aware of the following:
 - Counseling and rehabilitation assistance are available to all trainees through existing Employee Assistance Programs (EAP) at VA facilities (information on EAP can be obtained from your local Human Resources office).
 - You will be given the opportunity to submit supplemental medical documentation of lawful use of an otherwise illegal drug to a Medical Review Officer (MRO).
 - VA will initiate termination of VA appointment and/or dismissal from VA rotation proceedings against any trainee who is found to use illegal drugs on the basis of a verified positive drug test.
 - Termination and/or dismissal from VA rotation proceedings will be initiated against any trainee who refuses to be tested.
5. Random testing will begin no sooner than 30 days from the date you sign this acknowledgement.
6. Visit the US Office of Personnel Management (OPM) Work-Life webpage for information on Services Available for You, Guidance & Legislation as well as Substance User Disorder.
<https://www.opm.gov/policy-data-oversight/worklife/employee-assistance-programs/>

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

Training Program and Affiliate

Print Name and Date Signed

Signature

APPOINTMENT AFFIDAVITS

(Position to which Appointed)

(Date Appointed)

Department of Veterans Affairs Bay Pines VA Healthcare System

(Department or Agency)

(Bureau or Division)

(Place of Employment)

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

A. OATH OF OFFICE

I will support and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties of the office on which I am about to enter. So help me God.

B. AFFIDAVIT AS TO STRIKING AGAINST THE FEDERAL GOVERNMENT

I am not participating in any strike against the Government of the United States or any agency thereof, and I will not so participate while an employee of the Government of the United States or any agency thereof.

C. AFFIDAVIT AS TO THE PURCHASE AND SALE OF OFFICE

I have not, nor has anyone acting in my behalf, given, transferred, promised or paid any consideration for or in expectation or hope of receiving assistance in securing this appointment.

(Signature of Appointee)

Subscribed and sworn (or affirmed) before me this ____ day of _____ 2 ____

at _____
(City) (State)

(SEAL)

Commission expires _____

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

Jeffrey Heinrichs, Human Resources
Officer Bay Pines VA Healthcare System

(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.

PIV Credential Identity Verification Matrix

All identity source documents shall be bound to the applicant and shall be neither expired or cancelled. **PIV and Non-PIV credentials require two forms of identification, one primary and one secondary. The secondary identity source document may be from the primary or secondary list, but if from the primary list it cannot be of the same type as the primary identity source document example.**

Flash Badges may be issued following review of a single primary or secondary identity document including applicant photograph. [FIPS 201-2](#)

Primary Identity Source Document	Secondary Identity Source Document
<ul style="list-style-type: none"> • A U.S. Passport or U.S. Passport Card • A Permanent Resident Card or Alien Registration Receipt Card (Form I-551) • A foreign passport • An Employment Authorization Document that contains a photograph (Form I-766) • A Driver's license or ID card issued by a State or possession of the United States provided it contains a photograph • A U.S. Military card • A U.S. Military dependent's ID card • A PIV Card 	<ul style="list-style-type: none"> • A U.S. Social Security Card issued by the Social Security Administration • An original or certified copy of a birth certificate issued by a state, county, municipality authority, possession or outlying possession of the U.S. bearing an official seal • An ID card issued by a federal, state, or local government agency or entity, provided it contains a photograph • A voter's registration card • A U.S. Coast Guard Merchant Mariner Card • A Certificate of U.S. Citizenship (Form N-560 or N-561) • A Certificate of Naturalization (Form N-550 or N-570) • A U.S. Citizen ID Card (Form I-197) • An Identification Card for Use of Resident Citizen in the United States (Form I-179) • A Certification of Birth Abroad or Certification of Report of Birth issued by the Department of State (Form FS-545 or Form DS-1350) • A Temporary Resident Card (Form I-688) • An Employment Authorization Card (Form I-688A) • A Reentry Permit (Form I-327) • A Refugee Travel Document (Form I-571) • An Employment authorization document issued by Department of Homeland Security (DHS) • An Employment Authorization Document issued by DHS with photograph (Form I-688B) • A driver's license issued by a Canadian government entity • A Native American tribal document

Updated 3/28/16

Bay Pines VA Healthcare System PERSONAL IDENTITY VERIFICATION (PIV) CARD

Instructions For Use

Card Applicant: Complete Section 1.

PIV Managers/Sponsors: Use Section 2 as needed.

(NOTE: This is a temporary document, for administrative use only, and **must be destroyed** once the information is entered in the PIV Enrollment Portal.)

SECTION 1: APPLICANT INFORMATION

PLEASE PRINT THE INFORMATION NEATLY

FULL LEGAL NAME: <u>Last</u> <u>First</u> <u>Middle</u>			NICKNAME (Optional):		
DATE OF BIRTH: mm/dd/yyyy:		U.S. SSN (ONLY):		PLACE OF BIRTH (U.S. City & State/Other Country):	
HOME TELEPHONE # (Optional):		HOME EMAIL (Optional):		COUNTRY OF CITIZENSHIP:	
GENDER:	RACE (SELECT ONE):	HEIGHT (Feet & Inches):	WEIGHT (Pounds):	EYE COLOR:	HAIR COLOR:
<input type="radio"/> MALE <input type="radio"/> FEMALE	<input type="radio"/> American Indian or Alaskan Native <input type="radio"/> Asian or Pacific Islander <input type="radio"/> Black-non-Hispanic Hispanic <input type="radio"/> White-non-Hispanic				
APPLICANT'S SIGNATURE & DATE:					

SECTION 2: MANAGERS & SPONSORS (As Needed)

Reminders for PIV Managers & Sponsors:

- If the Applicant is not a U.S. Citizen, be sure to check YES for Foreign National in the PIV Enrollment Portal.
- Check PHYSICAL ACCESS if the applicant is an Employee.
- We recommend that CRITICAL EMPLOYEE be checked for all Employees. The following statement will be on the back of the card: "To all law enforcement agencies: This Person is a critical employee of the VA and in times of civil emergency or disaster will be required to be on duty, please allow to work." (EMERGENCY RESPONDER is not used for most Employees.)

SELECT APPROPRIATE BLOCK FOR THIS CARD

Foreign National: YES <input type="checkbox"/> NO <input type="checkbox"/>		PIV Card <input type="checkbox"/>	NON-PIV Card <input type="checkbox"/>	Flash Badge <input type="checkbox"/>	Logical Access <input type="checkbox"/>	Physical Access <input type="checkbox"/>
WORK ADDRESS:			SPONSORING DEPARTMENT:		JOB TITLE:	
WORK PHONE:		WORK eMAIL:		COST CENTER:		MAIL ROUTING SYMBOL:

Please either fax the form to 727-398-9556 or email it to VHABAYAcademicAffiliations@va.gov

Last Name: As printed on Driver's License	
First Name: As printed on Driver's License	
Middle Name: As printed on driver's License. If no middle name type nml	
Social Security #: In this format 000-00-0000	
Date of Birth (MM/DD/YYYY):	
Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Race:	
Height (Feet/Inches):	
Weight:	
Eye Color:	
Hair Color:	
Place of Birth (City/State/Country):	
Full Current Address Street Address: City/State/Zip Code:	
Citizenship Country:	
Program of Study:	
School Name:	
Rotation dates(from-to dates) (MM/DD/YYYY)	From: To:
Mandatory Training Completion date (TMS)	



Student/Resident Orientation Handbook Bay Pines VA Healthcare System (BPVAHCS) Office of Academic Affiliation (OAA)

Bay Pines OAA location: Building 20, Room 200

Bay Pines OAA contacts: Main Line: 727- 398-9533,
727-398-6661, ext. 15033 or 727-398-6661, ext. 14038

Lee County OAA location: 2nd Floor, Room 2B-108

Lee County OAA contact: 239-652-1800, ext. 20633

Email: VHABAYAcademicAffiliations@va.gov

1. Bay Pines VAHCS is the fourth largest VA Healthcare System in the nation. Our Mission Statement is to fulfill President Lincoln's promise: "To care for him who shall have borne the battle, and for his widow, and his orphan" by serving and honoring America's Veterans.
2. A VA Identification badge along with school/residency photo ID is required to be worn above the waist while you are here doing your rotation. Please introduce your role and who your supervising/attending preceptor is to the Veterans that you are caring for. Patient Survey satisfaction data shows that this is important to our Veterans.
3. Bay Pines: Parking for students is in Lot 16, which is located next to the Credit Union. Residents must park in either Physician or Employee designated parking lots. You must obtain a decal (Students: tan color; Residents: red color) from the Police Service.

Lee County: Parking for students is located to the right hand side of the front parking lot (as you enter the main entrance). The signage states Volunteers and Employees but includes parking for Students/Residents as well. Please do not park in the immediate front of the building which is strictly reserved for our patients. Students/Residents will obtain a parking decal or temporary parking permit from the Police Service during orientation.

4. Bay Pines: If you have an emergency, call the Bay Pines main campus emergency number 711 and identify yourself, your location, and what the emergency is, such as a medical emergency, fire, police, or violent patient or visitor.

Lee County: If you have an emergency, call the Lee County emergency number 21111 and identify yourself, your location, and what the emergency is, such as a medical emergency, fire, police, or violent patient or visitor. If you are assigned to a Community Based Outpatient Clinic (CBOC) such as Naples, Port Charlotte, or Sebring, you must dial 911 for local emergency assistance.

5. Emergency Codes Designations:
 - Doctor Red = Fire
 - Code Blue = Medical Emergency
 - Code Purple = Computer System Failure
 - Code Orange = Missing Patient
 - Code White = Armed Aggressor
 - Code Adam = Missing Child

6. RACE = Rescue – Alarm – Contain - Extinguish (or Evacuate).
Make sure you review with your preceptor where the fire alarms, extinguishers, and fire exits are in the clinical or administrative area you are assigned to.
7. Veterans are twice as likely to die from suicide as Non-Veterans. The National VA Suicide Hotline is 800-273-8255. You have a duty to help prevent suicidal behaviors. Make sure that the environmental risk factors are reduced by eliminating structures that could support a hanging object, reduce strangulation devices and access to sharp objects. Many hospital suicides occur during shifts during hand-off points between clinical staff.
8. Hand hygiene is the single most important measure to reduce the risks of transmitting germs from one person to another or from one site to another. Make sure that you wash your hands at least 15 seconds, including the areas between the fingers, above the knuckles and wrists, and under fingernails. Alcohol gels are also available but should not replace hand washing if your hands are soiled, if you are leaving an isolation room, or if you are dealing with *Clostridium difficile*.
9. Bay Pines: Our Employee Health Program is available to you if you are injured at Bay Pines VAHCS. If you are hurt, tell your preceptor and go to Employee Health, which is in Bldg. 22, Room 116. For follow-up care you will need to consult your own Primary Care provider. Seasonal flu shots are available by calling extension 14225 for an appointment.

Lee County: Our Employee Health Program is available to you if you are injured at Lee County Healthcare Center. If you are hurt, tell your preceptor and go to Ambulatory Care Clinic which is located on the first floor, Section 1A-137. For follow-up care you will need to consult your own Primary Care provider. Seasonal flu shots can be obtained by calling extension 20143 for an appointment.

10. It is your responsibility to keep the computer access codes that you are given secure. Protect your computer codes by not sharing them with anyone. Log off whenever you walk away from the computer, even for a moment. Inactivity on the computer for more than thirty days will lock out your account.
11. Copy and pasting documents or cloned documentation is risky. Review the copy and paste information on the laminated card labeled Copy and Paste Buddy we gave you.
12. You may not use thumb drives or any other personally owned USB device on VA computers.
13. It is important that you always protect patient sensitive confidential information. Do not print out patient information and leave it at the printer for others to read.
14. Veteran Personal Identifiable Information and Patient Health information may not be stored or shared using Google Docs or any other similar site. VA network access to Google docs site has been blocked by the VA. As a trainee at the VA you cannot access Google Docs or similar sites from your home, your affiliate institution, and/or your mobile computing device to put Veteran information since it would be a violation of our Veterans' privacy.
15. Student documentation must be co-signed by a licensed provider within 24 hours. Make sure your documentation is timely and accurate.
16. A licensed independent practitioner (attending or supervising practitioner) must be in charge of Resident Supervision. The laminated card you were provided during orientation will inform you of the current policy. By signing this form, you agree that you have reviewed and will adhere to these requirements.

17. Whenever you are doing a rotation (whether monthly or longer) at Bay Pines, you must check in and check out with the Academic Affiliation Section in Education Service.
18. Please make sure on your last day of your rotation that you check out with your service first. If you are not returning for another rotation within 30 days, you are required to complete the clearance form and return the completed form to Academic Affiliations.
19. On the last rotation of your academic year, please go to the OAA website to complete the learner's perception survey. <http://www.va.gov/oaa/surveys>
20. If you have not already done so it is imperative that you log in to TMS and update your email to your VA.GOV email address. If you fail to do this your network account/computer access may be terminated during your rotation.
21. For trainees in a program sponsored by VA, whether paid by VA or without compensation (WOC) any disciplinary action on the part of VA will conform to VA's Human Resources policy. For a trainee in a program sponsored by an affiliate, further investigation and appropriate action, including possible remediation, disciplinary action, or dismissal from the training program, will be at the discretion of the affiliate and BPVAHCS. Please follow up with your program director for specific details.

Please keep the first three pages of this document for your information and turn in the fourth page signed to the Office of Academic Affiliations Office (OAA).

I acknowledge that I have reviewed and fully understand the information provided in this Resident/Student Orientation Information.

I have completed the Mandatory Training for Trainees online in TMS for this academic year and fully understand the material presented.

I have been given the opportunity to ask questions about the Bay Pines VAHCS Resident/Student Orientation program. If I have questions about the program in the future, I may contact the names listed on the first page of this document.

Print Name

Signature

Date

Clinical Trainee Registration Form

Department of Veterans Affairs

CLINICAL TRAINEE REGISTRATION FORM

Response is mandatory. This information will be kept confidential. It will be used for reporting purposes, conducting surveys, and improving the quality of VHA's clinical training programs. This information will be entered in the "New Person" file in Veterans Health Information Systems and Technology Architecture (Vista). **This form may also be printed from the OAA website: <http://vaww.va.gov/oaa/policies.asp>**

Disclosure of your Social Security Number (SSN) is mandatory to identify individuals with identical names. Failure to provide this information may delay or make impossible the proper application of Civil Service rules and regulations and VA personnel policies and thus may prevent you from obtaining clinical training at VA. Solicitation of the SSN is authorized under the provisions of Executive Order 9397, dated November 22, 1943.

The information gathered through the use of this number will be used as necessary for statistical studies and personnel administration in accordance with established regulations and published notices of systems of record.

First Name	MI	Last Name
Social Security Number		Date of Birth (MM/DD/YYYY)
Telephone Number		
Email Address		
Street Address		
City	State	Zip

Current Degree Level: (mark only one) [This refers to the degree you are currently working toward in school]

<input type="checkbox"/> Certificate/Diploma	<input type="checkbox"/> Post-master's fellowship
<input type="checkbox"/> Associate	<input type="checkbox"/> Doctoral
<input type="checkbox"/> Baccalaureate	<input type="checkbox"/> Postdoctoral (<i>other than residents</i>)
<input type="checkbox"/> Master's	<input type="checkbox"/> Residency/Fellowship

Program of Study: (mark only one)

(Discipline that best describes the current program of study)

- | | |
|---|---|
| <input type="checkbox"/> Audiology | <input type="checkbox"/> Medical/Surgical Support (Respiratory Tech, Biomedical Tech, etc.) |
| <input type="checkbox"/> Chaplaincy | <input type="checkbox"/> Nurse Anesthetist |
| <input type="checkbox"/> Dentistry | <input type="checkbox"/> Nursing |
| <input type="checkbox"/> Dietetics | <input type="checkbox"/> Optometry |
| <input type="checkbox"/> Health Information | <input type="checkbox"/> Other (such as Dental Hygienist) |
| <input type="checkbox"/> Health Services Research & Development | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Imaging (Radiologic/Ultrasound Tech, etc.) | <input type="checkbox"/> Physician Assistant |
| <input type="checkbox"/> Laboratory | <input type="checkbox"/> Podiatry |
| <input type="checkbox"/> Medical Student | <input type="checkbox"/> Psychology |
| <input type="checkbox"/> Medical Resident/Fellow | <input type="checkbox"/> Rehabilitation (OT, PT, KT, etc.) |
| <input type="checkbox"/> Medical Post-residency Physician in a VA Special Fellowship (Ambulatory Care, National Quality Scholars, Women's Health, etc.) | <input type="checkbox"/> Social Work |
| | <input type="checkbox"/> Speech-Language Pathology |

What is the <u>LAST YEAR</u> that you anticipate being in a training program at this VA facility?	Year:
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Declaration for Federal Employment*

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

Form Approved
OMB No. 3208-0182

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. 3208-C-82

(*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?**

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 *nob contendere* (no contest), but omit (1) traffic fines of \$300 or less, (2) any violation of law committed before your 16th birthday, (3) any violation of law committed before your 18th birthday if finally decided in juvenile court or under a Youth Offender law, (4) any conviction set aside under the Federal Youth Corrections Act or similar state law, and (5) any conviction for which the record was expunged under Federal or state law.

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

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

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

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

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

U.S. Office of Personnel Management

5 U.S.C. 1302, 3301, 3304, 3328 & 8716

Optional Form 306
Revised October 2011
Previous editions obsolete and unusable

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)

Appointing Officer:

Enter Date of Appointment or Conversion
MM / DD / YYYY

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

PLEASE SIGN 17a AND 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?

MM / DD / YYYY

DATE:

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

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

HEALTH CARE PERSONNEL INFLUENZA VACCINATION FORM

I am a VA: ___ Employee ___ Volunteer ___ Trainee (residents, interns and students)

I received the seasonal influenza vaccine this flu season (required documentation is attached.)

I decline to receive seasonal influenza vaccine at this time for the following reason:

Select the single answer that best fits your reason:

- I do not like needles.
- I have a philosophical or religious reason for not receiving the vaccine.
- I have an allergy to the vaccine or one of its components.
- I am concerned about the side effects/safety of the vaccine.
- I have never had the flu and don't think I will this season.
- I have another reason. (Please explain)

I acknowledge that VHA policy requires health care personnel to receive the influenza vaccine every year. I understand that if I decline to receive the vaccine and/or to provide proof of vaccination by November 30 or within two weeks of beginning employment if after November 30, I must wear a face mask according to requirements and guidelines within the Directive 1192, Seasonal Influenza Prevention Program. I understand that violation of the directive may result in disciplinary action.

I have read and fully understand the information on this form and have been given the opportunity to have my questions answered.

Signature: _____ Date: _____

Name (print): _____ Last 4 SS# _____

Dept./Serv: _____ Supervisor: _____

Employees and volunteers provide this form to the facility Employee Occupational Health Office. Trainees provide this form to the Designated Education Officer.