

REQUIRED DOCUMENTATION FOR COMPLETION OF SELECTION PACKAGE

The documents listed below must be completed by the selecting official and the tentatively selected, new or current employee before the selection will be approved by the Human Resources Office. Any missing or incorrect documents will delay the process until the missing or corrected documents are received.

Selecting officials may contact the individual that has been TENTATIVELY selected ONLY to obtain the needed information in completing the selection documentation. Selecting officials **WILL NOT** discuss an effective date or make any commitment of employment until notified by the Human Resources Office. At that time, the selecting official may contact the selected individual and discuss an effective date. The Human Resources Office will officially notify all applicants in writing of their selection or non-selection.

IF TENTATIVELY SELECTED INDIVIDUAL IS A CURRENT PERMANENT OR INDEFINITE TECHNICIAN, COMPLETE THE FOLLOWING:

[Technician/Military Assignment Data Form \(MOTP Form 296-1\)](#) - (Instructions are on the bottom of document). The **selecting official must** complete Section A. Section B is completed by the military unit of the selected individual.

IF TENTATIVELY SELECTED INDIVIDUAL IS A CURRENT TEMPORARY TECHNICIAN, COMPLETE THE FOLLOWING:

[Declaration for Federal Employment \(OF-306\)](#) - The selected individual **must complete this form and sign as an appointee in item 17b** (Appointee's signature).

[Technician/Military Assignment Data Form \(MOTP Form 296-1\)](#) - (Instructions are on the bottom of document) - The selecting official must complete Section A. Section B is completed by the military unit of the selected individual.

IF TENTATIVELY SELECTED INDIVIDUAL IS A NEW EMPLOYEE, COMPLETE THE FOLLOWING:

[Declaration for Federal Employment \(OF-306\)](#) - The selected individual must complete this form and **sign as an appointee in item 17b** (Appointee's signature).

[Technician/Military Assignment Data Form \(MOTP Form 296-1\)](#) - (Instructions are on the bottom of document) - The selecting official must complete Section A. Section B is completed by the military unit of the selected individual.

[Selective Service Registration Statement \(MOTP Form 296-3\)](#) - If the selected individual is a male born after 31 December 1959, he **must** complete this form.

[Ethnicity and Race Identification \(SF 181\)](#) - The selected individual must print name, social security number and birth date (month and year). Place an "X" in any of the boxes that apply that identifies his/her racial and national origin category.

[Self-Identification of Handicap \(SF 256\)](#) - Read instructions and Privacy Act information on back of form. On front of form, the **selected individual must** print name, birth date (month and year), social security number and enter the appropriate code in the upper right hand corner.

[Welfare to Work Program \(OPM 1635\)](#) - **THIS FORM IS OPTIONAL** - If selected individual chooses to complete this form, please print name and social security number and put an "X" in A or B.

DD Form 214s - Title 10 active duty time can be credited towards Service Computation Date for leave and retirement purposes. The selected individual must submit copies of their DD Form 214s to receive this credit.

IF THE POSITION HAS BEEN ADVERTISED AS INDEFINITE, COMPLETE THE FOLLOWING:

[Statement of Understanding for Indefinite Appointments \(MOTP Form 296-4\)](#) - The **selected individual must** read and understand his/her rights as an **Indefinite employee**. The selected individual and selecting official must sign in the appropriate blocks on this form.

IF THE POSITION HAS BEEN ADVERTISED AS TEMPORARY, COMPLETE THE FOLLOWING:

[Statement of Understanding for Temporary Appointments \(MOTP Form 296-5\)](#) - The **selected individual must** read and understand his/her rights as a **temporary employee**. The selected individual and selecting official must sign in the appropriate blocks on this form.

IF THE POSITION HAS BEEN ADVERTISED AS TEMPORARY PROMOTION, COMPLETE THE FOLLOWING:

[Statement of Understanding for Temporary Promotions \(MOTP Form 296-6\)](#) -The **selected individual must** read and understand his/her rights while serving on a **temporary promotion**. The selected individual and selecting official must sign in the appropriate blocks on this form.

Point of contact is the Human Resources Specialist (Recruitment and Placement) DSN 555-9500 ext. 39644 or commercial (573) 638-9500 ext. 39644.

BASELINE PHYSICALS / OCCUPATIONAL HEALTH DOCUMENTS

Personnel hired in an **ARMY FWS** (Federal Wage System) position in one of the series listed below are required to complete a baseline physical prior to their effective start date.

Supervisors are required to have the tentivaly selected individual complete the "Excepted Technician OccHealth Exam Required Demographic Information Template", as well as, an "Occupational Health Form" found in the links below.

2602 2604 2608 2614 2892 3105 3306 3401 3414

3703 3806 3806 4102 4255 4604 4606 4818 5378

5413 5801 5803 5823 6605 6610 6907 6912 8807

8852

[Occupational Health Form](#)

[Excepted Technician Occ Health Exam Required Demographic Information Template](#)

Point of contact for baseline physicals is Occupational Health Nurse, NGMO-HRD-HN (573) 638-9500 ext. 39743.

NEW EMPLOYEE ORIENTATION

New employees must report for orientation on the first Tuesday of the effective pay period. Once the Human Resources Office contacts the selecting official with an approved effective date, he/she is responsible to schedule **new employee orientation** with the representative within his or her region. For additional information and contacts, go to <http://www.moguard.com/Assets/Pages/82/Staff.aspx?ID=82> and click on “New Employee Orientation” and “Employee Orientation Sites”.

- 1) To complete the I-9 Form, new employees must report to orientation with:
 - a) A state issued driver's license or I.D. card with photograph, or a government ID card issued by a government agency or entity with a photograph, **and**
 - b) **Original** social security card;
or, a birth certificate issued by State, county, or municipal authority bearing a seal or other certification;

or, unexpired Department of Immigration and Naturalization employment authorization.

- 2) New employees also need to bring bank information (account number, routing number, and physical address of bank) to complete the direct deposit form.

Point of contact is the Human Resources Specialist (Recruitment and Placement)
DSN 555-9500 ext. 39644 or commercial (573) 638-9500 ext. 39644.

Declaration for Federal Employment*

Form Approved:
OMB No. 3206-0182

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

Instructions

The information collected on this form is used to determine your acceptability for Federal and Federal contract employment and your enrollment status in the Government's Life Insurance program. You may be asked to complete this form at any time during the hiring process. Follow instructions that the agency provides. If you are selected, before you are appointed you will be asked to update your responses on this form and on other materials submitted during the application process and then to recertify that your answers are true.

All your answers must be truthful and complete. **A false statement on any part of this declaration or attached forms or sheets may be grounds for not hiring you, or for firing you after you begin work. Also, you may be punished by a fine or imprisonment (U.S. Code, title 18, section 1001).**

Either type your responses on this form or print clearly in dark ink. If you need additional space, attach letter-size sheets (8.5" X 11"). Include your name, Social Security Number, and item number on each sheet. We recommend that you keep a photocopy of your completed form for your records.

Privacy Act Statement

The Office of Personnel Management is authorized to request this information under sections 1302, 3301, 3304, 3328, and 8716 of title 5, U. S. Code. Section 1104 of title 5 allows the Office of Personnel Management to delegate personnel management functions to other Federal agencies. If necessary, and usually in conjunction with another form or forms, this form may be used in conducting an investigation to determine your suitability or your ability to hold a security clearance, and it may be disclosed to authorized officials making similar, subsequent determinations.

Your Social Security Number (SSN) is needed to keep our records accurate, because other people may have the same name and birth date. Public Law 104-134 (April 26, 1996) asks Federal agencies to use this number to help identify individuals in agency records. Giving us your SSN or any other information is voluntary. However, if you do not give us your SSN or any other information requested, we cannot process your application. Incomplete addresses and ZIP Codes may also slow processing.

ROUTINE USES: Any disclosure of this record or information in this record is in accordance with routine uses found in System Notice OPM/GOVT-1, General Personnel Records. This system allows disclosure of information to: training facilities; organizations deciding claims for retirement, insurance, unemployment, or health benefits; officials in litigation or administrative proceedings where the Government is a party; law enforcement agencies concerning a violation of law or regulation; Federal agencies for statistical reports and studies; officials of labor organizations recognized by law in connection with representation of employees; Federal agencies or other sources requesting information for Federal agencies in connection with hiring or retaining, security clearance, security or suitability investigations, classifying jobs, contracting, or issuing licenses, grants, or other benefits; public and private organizations, including news media, which grant or publicize employee recognitions and awards; the Merit Systems Protection Board, the Office of Special Counsel, the Equal Employment Opportunity Commission, the Federal Labor Relations Authority, the National Archives and Records Administration, and Congressional offices in connection with their official functions; prospective non-Federal employers concerning tenure of employment, civil service status, length of service, and the date and nature of action for separation as shown on the SF 50 (or authorized exception) of a specifically identified individual; requesting organizations or individuals concerning the home address and other relevant information on those who might have contracted an illness or been exposed to a health hazard; authorized Federal and non-Federal agencies for use in computer matching; spouses or dependent children asking whether the employee has changed from a self-and-family to a self-only health benefits enrollment; individuals working on a contract, service, grant, cooperative agreement, or job for the Federal government; non-agency members of an agency's performance or other panel; and agency-appointed representatives of employees concerning information issued to the employees about fitness-for-duty or agency-filed disability retirement procedures.

Public Burden Statement

Public burden reporting for this collection of information is estimated to vary from 5 to 30 minutes with an average of 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of the collection of information, including suggestions for reducing this burden, to the U.S. Office of Personnel Management, Reports and Forms Manager (3206-0182), Washington, DC 20415-7900. The OMB number, 3206-0182, is valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

Declaration for Federal Employment*

Form Approved:
OMB No. 3206-0182

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

GENERAL INFORMATION

1. **FULL NAME** (Provide your full name. If you have only initials in your name, provide them and indicate "Initial only". If you do not have a middle name, indicate "No Middle Name". If you are a "Jr.," "Sr.," etc. enter this under Suffix. (Last, Suffix, First and Middle)



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? (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

Declaration for Federal Employment*

Form Approved:
OMB No. 3206-0182

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

Additional Questions

14. Do any of your relatives work for the agency or government organization to which you are submitting this form? (Include: father, mother, husband, wife, son, daughter, brother, sister, uncle, aunt, first cousin, nephew, niece, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepfather, stepmother, stepson, stepdaughter, stepbrother, stepsister, half brother, and half sister.) If "YES," use item 16 to provide the relative's name, relationship, and the department, agency, or branch of the Armed Forces for which your relative works. YES NO
15. Do you receive, or have you ever applied for, retirement pay, pension, or other retired pay based on military, Federal civilian, or District of Columbia Government service? YES NO

Continuation Space / Agency Optional Questions

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

Certifications / Additional Questions

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

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

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

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

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

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

- 18a. When did you leave your last Federal job? _____
DATE: MM / DD / YYYY
- 18b. When you worked for the Federal Government the last time, did you waive Basic Life Insurance or any type of optional life insurance? YES NO DO NOT KNOW
- 18c. If you answered "YES" to item 18b, did you later cancel the waiver(s)? If your answer to item 18c is "NO," use item 16 to identify the type(s) of insurance for which waivers were not canceled. YES NO DO NOT KNOW

TECHNICIAN/MILITARY ASSIGNMENT DATA FORM

INDIVIDUAL'S NAME:

SSN (Last Four Only):

SECTION A

TECHNICIAN INFORMATION

UNIT/ACTIVITY OF EMPLOYMENT:

TECHNICIAN POSITION TITLE:

TECHNICIAN POSITION DESCRIPTION NUMBER:

TECHNICIAN GRADE:

AUTHORIZED TECHNICIAN GRADE:

EFFECTIVE DATE OF THIS TECHNICIAN ASSIGNMENT:

d-mmm-yyyy

TECHNICIAN SUPERVISOR'S SIGNATURE AND DATE:

SECTION B

MILITARY INFORMATION

MILITARY UNIT OF ASSIGNMENT:

MILITARY GRADE:

ARMY

UIC:

AIR

PAS:

FAC:

POSITION NUMBER:

DUTY MOS/SSI/AFSC:

TITLE:

EFFECTIVE DATE OF MILITARY ASSIGNMENT:

d-mmm-yyyy

* SOURCE DOCUMENT:

TYPE OF LATEST SECURITY INVESTIGATION:

DATE SECURITY INVESTIGATION COMPLETED:

d-mmm-yyyy

MILITARY COMMANDER'S SIGNATURE AND DATE:

(or designated official, i.e., SSS, CBPO, etc.)

INSTRUCTIONS

TECHNICIAN SUPERVISOR: Fill in NAME, SSN and ALL blocks in Section A of this form. Forward to Commander of technician's Military Unit of Assignment for completion of Section B and return to you for your review. Forward completed form with selection package or SF-52, Request for Personnel Action.

MILITARY COMMANDER: Complete ALL blocks in Section B and return promptly to the technician supervisor.

*If the individual was assigned by orders, cite the order number, issuing headquarters and date.

PERSONNEL ACTIONS WILL BE PROCESSED ONLY AFTER TECHNICIAN AND MILITARY COMPATIBILITY REQUIREMENTS ARE IN ACCORDANCE WITH LAW AND REGULATIONS OF THE NATIONAL GUARD BUREAU.

APPLICANT'S STATEMENT OF SELECTIVE SERVICE REGISTRATION STATUS

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 be registered with the Selective Service System, unless you meet certain exemptions under Selective Service law. If you are required to register but knowingly and willfully fail to do so, you are ineligible for appointment by executive agencies of the Federal Government.

NON-REGISTRANTS UNDER AGE 26

If you are under age 26 and have not registered as required, you should register promptly at a United States Post Office, or consular office if you are outside the United States.

NON-REGISTRANTS AGE 26 OR OVER

If you were born in 1960 or later, are 26 years of age or older, and were required to register but did not do so, you can no longer register under Selective Service law. Accordingly, you are not eligible for appointment to an executive agency unless you can prove to the Office of Personnel Management (OPM) that your failure to register was neither knowing nor willful. You may request an OPM decision through the agency that was considering you for employment by returning this statement with your written request for an OPM determination together with any explanation and documentation you wish to furnish to prove that your failure to register was neither knowing nor willful.

PRIVACY ACT STATEMENT

Because information on your registration status is essential for determining whether you are in compliance with 5 U.S.C. 3328, failure to provide the information requested by this statement will prevent any further consideration of your application for appointment. This information is subject to verification with the Selective Service System and may be furnished to other Federal agencies for law enforcement or other authorized use in implementing this law.

FALSE STATEMENT NOTIFICATION

A false statement may be grounds for not hiring you, or for firing if you have already begun work. Also, you may be punished by fine or imprisonment (Section 1001 of Title 18, United States Code.)

CERTIFICATION OF REGISTRATION STATUS

Check one:

- I certify I am registered with the Selective Service System.
- I certify I have been determined by the Selective Service System to be exempt from the registration provisions of Selective Service law.
- I certify I have not registered with the Selective Service System.
- I certify I have not reached my 18th birthday and understand I am required by law to register at that time.

Legal signature of individual

Date signed

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| U.S. Office of Personnel Management Guide to Personnel Data Standards | ETHNICITY AND RACE IDENTIFICATION (Please read the Privacy Act Statement and instructions before completing form.) | | |
| Name (Last, First, Middle Initial) | Social Security Number | Birthdate (Month and Year) | |
| Agency Use Only | | | |
| <p>Privacy Act Statement</p> <p>Ethnicity and race information is requested under the authority of 42 U.S.C. Section 2000e-16 and in compliance with the Office of Management and Budget's 1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. Providing this information is voluntary and has no impact on your employment status, but in the instance of missing information, your employing agency will attempt to identify your race and ethnicity by visual observation.</p> <p>This information is used as necessary to plan for equal employment opportunity throughout the Federal government. It is also used by the U. S. Office of Personnel Management or employing agency maintaining the records to locate individuals for personnel research or survey response and in the production of summary descriptive statistics and analytical studies in support of the function for which the records are collected and maintained, or for related workforce studies.</p> <p>Social Security Number (SSN) is requested under the authority of Executive Order 9397, which requires SSN be used for the purpose of uniform, orderly administration of personnel records. Providing this information is voluntary and failure to do so will have no effect on your employment status. If SSN is not provided, however, other agency sources may be used to obtain it.</p> | | | |
| <p>Specific Instructions: The two questions below are designed to identify your ethnicity and race. Regardless of your answer to question 1, go to question 2.</p> | | | |
| <p>Question 1. Are You Hispanic or Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | | | |
| <p>Question 2. Please select the racial category or categories with which you most closely identify by placing an "X" in the appropriate box. Check as many as apply.</p> | | | |
| RACIAL CATEGORY (Check as many as apply) | | DEFINITION OF CATEGORY | |
| <input type="checkbox"/> American Indian or Alaska Native | | A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. | |
| <input type="checkbox"/> Asian | | A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. | |
| <input type="checkbox"/> Black or African American | | A person having origins in any of the black racial groups of Africa. | |
| <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | | A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. | |
| <input type="checkbox"/> White | | A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. | |

Standard Form 181
Revised August 2005
Previous editions not usable

42 U.S.C. Section 2000e-16

NSN 7540-01-099-3446

SELF-IDENTIFICATION OF DISABILITY

(see instructions and Privacy Act information on reverse)

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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| Last Name, First Name, and MI | Date of Birth (mm/yy) | Social Security Number | ENTER CODE HERE _____ > <input type="text"/> |
| <p>Definition: An Individual with a disability: A person who (1) has a physical impairment or mental impairment (psychiatric disability) that substantially limits one or more of such person's major life activities; (2) has a record of such impairment; or (3) is regarded as having such an impairment. This definition is provided by the Rehabilitation Act of 1973, as amended (29 U.S.C. 701 et. seq.).</p> | | <p>Purpose: Self-identification of disability status is essential for effective data collection and analysis. The information you provide will be used for statistical purposes only and will not in any way affect you individually. While self-identification is voluntary, your cooperation in providing accurate information is critical.</p> | |
| <p>Part I. Targeted/Severe Disabilities</p> <p>Hearing 18 - Total deafness in both ears (with or without understandable speech)</p> <p>Vision 21 - Blind (inability to read ordinary size print, not correctable by glasses, or no usable vision, beyond light perception)</p> <p>Missing Extremities 30 - Missing extremities (missing one arm or leg, both hands or arms, both feet or legs, one hand or arm and one foot or leg, one hand or arm and both feet or legs, both hands or arms and one foot or leg, or both hands or arms and both feet or legs)</p> <p>Partial Paralysis 69 - Partial paralysis (because of a brain, nerve or muscle impairment, including palsy and cerebral palsy, there is some loss of ability to move or use a part of the body, including both hands; any part of both arms or legs; one side of the body, including one arm and one leg; and/or three or more major body parts)</p> <p>Complete Paralysis 79 - Because of a brain, nerve or muscle impairment, including palsy and cerebral palsy, there is a complete loss of ability to move or use a part of the body, including both hands; one or both arms or legs; the lower half of the body; one side of the body, including one arm and one leg; and/or three or more major body parts</p> <p>Other Impairments 82 - Epilepsy 90 - Severe intellectual disability 91 - Psychiatric disability 92 - Dwarfism</p> | | <p>Part II. Other Disabilities</p> <p>Hearing Conditions 15 - Hearing impairment/hard of hearing</p> <p>Vision Conditions 22 - Visual impairments (e.g., tunnel or monocular vision or blind in one eye)</p> <p>Physical Conditions 26 - Missing extremities (one hand or one foot) 40 - Mobility impairment (e.g., cerebral palsy, multiple sclerosis, muscular dystrophy, congenital hip defects, etc.) 41 - Spinal abnormalities (e.g., spina bifida, scoliosis) 44 - Non-paralytic orthopedic impairments: chronic pain, stiffness, weakness in bones or joints, some loss of ability to use part or parts of the body 51 - HIV Positive/AIDS 52 - Morbid obesity 61 - Partial paralysis of one hand, arm, foot, leg, or any part thereof 70 - Complete paralysis of one hand 80 - Cardiovascular/heart disease with or without restriction or limitation on activity; a history of heart problems w/complete recovery 83 - Blood diseases (e.g., sickle cell anemia, hemophilia) 84 - Diabetes 86 - Pulmonary or respiratory conditions (e.g., tuberculosis, asthma, emphysema, etc.) 87 - Kidney dysfunction (e.g., required dialysis) 88 - Cancer (present or past history) 93 - Disfigurement of face, hands, or feet (such as those caused by burns or gunshot wounds) and noticeable gross facial birthmarks 95 - Gastrointestinal disorders (e.g., Crohn's Disease, irritable bowel syndrome, colitis, celiac disease, dysphexia, etc.) 98 - History of alcoholism</p> <p>Speech/Language/Learning Conditions 13 - Speech impairment - includes impairments of articulation (unclear language sounds), fluency (stuttering), voice (with normal hearing), dysphasia, or history of laryngectomy 94 - Learning disability - a disorder in one or more of the processes involved in understanding, perceiving, or using language or concepts (spoken or written) (e.g., dyslexia, ADD/ADHD)</p> <p>Other Options 01 - I do not wish to identify my disability status. (Please read the notes on the next page.) (Note: Your personnel officer may use this code if, in his or her judgment, you used an incorrect code.) 05 - I do not have a disability. 06 - I have a disability, but it is not listed on this form.</p> | |

The Rehabilitation Act of 1973

The Rehabilitation Act, as amended (29 U.S.C. 701, et seq.), requires each agency in the executive branch of the Federal Government to establish programs that will facilitate the hiring, placement, and advancement of individuals with disabilities. The best means of determining agency progress in this respect is through the production of reports at certain intervals showing such things as the number of employees with disabilities who are hired, promoted, trained, or reassigned over a given time period; the percentage of employees with disabilities in the workforce and in various grades and occupations; etc. Such reports bring to the attention of agency top management, the U.S. Office of Personnel Management (OPM), and the Congress deficiencies within specific agencies or the Federal Government as a whole in the hiring, placement, and advancement of individuals with disabilities and, therefore, are the essential first step in improving these conditions and consequently meeting the requirements of the Rehabilitation Act.

The disability data collected on employees will be used only in the production of reports such as those previously mentioned and not for any purpose that will affect them individually. The only exception to this rule is that the records may be used for selective placement purposes and selecting special populations for mailing of voluntary personnel research surveys. In addition, every precaution will be taken to ensure that the information provided by each employee is kept to the strictest confidence and is known only to those individuals in the agency Personnel Office who obtain and record the information for entry into the agency's and OPM's personnel systems. You should also be aware that participation in the disability reporting system is entirely voluntary, **with the exception of employees appointed under Schedule A, SECTION 213.3102(u) (Severe physical or mental disabilities)**. These employees will be requested to identify their disability status and if they decline to do so, their correct disability code will be obtained from medical documentation used to support their appointment.

Employees will be given every opportunity to ensure that the disability code carried in their agency's and OPM's personnel systems is accurate and is kept current. They may exercise this opportunity by asking their Personnel Officer to see a printout of the code and definition from their records. The code carried on employees in the agency's system will be identical to that carried in OPM's system.

Your cooperation and assistance in establishing and maintaining an accurate and up-to-date disability report system is sincerely appreciated.

Privacy Act Statement

Collection of the requested information is authorized by the Rehabilitation Act, as amended (29 U.S.C. 701, et seq.). Solicitation of your Social Security Number (SSN) is authorized by Executive Order 9397, which permits agencies to use the SSN as the means for identifying persons with disabilities in personnel information systems. Your SSN will only be used to ensure that your correct disability code is recorded along with other employee information that your agency and OPM maintain on you. Furnishing your SSN or any other data requested for this collection effort is voluntary and failure to do so will have no effect on you. It should be noted, however, that where individuals decline to furnish their SSN, the SSN will be obtained from other records in order to ensure accurate and complete data. Employees appointed under Schedule A, Section 213.3102 (u) (Severe physical or mental disabilities) are requested to furnish an accurate disability code, but failure to do so will not affect them. Where employees hired under one of these appointing authorities fail to disclose their disability(ies), however, the appropriate code will be determined from the employee's existing records or medical documentation physically submitted upon appointment.

STATEMENT OF UNDERSTANDING FOR INDEFINITE APPOINTMENTS

This agency is required by the Office of Personnel Management to certify that all indefinite employees are informed of the following:

a. will immediately be terminated from any Federal Bonus Program and/or Student Loan Repayment Program, point of contact for the MOARNG is the Director of Personnel, Incentives Branch, and for the MOANG is the Base Retention Office Manager;

b. do not acquire permanent status;

c. permanent status Title 32 Excepted Technicians will forfeit their status and any inherent rights as a permanent employee;

d. must meet all military membership and compatibility requirements;

e. do not serve a trial period;

f. may be separated when their services are no longer needed, all separations must be preceded by a 30 day advance notice;

g. are in Tenure Group III for reduction-in-force purposes; and

h. may be promoted, changed to lower grade, or reassigned to other positions with indefinite status.

Your signature and date below, certifies that you understand these requirements.

Selected Candidate's Signature

Date

Selected Candidate's Name (Please Print)

Selecting Official's Signature Block and Signature

Date

STATEMENT OF UNDERSTANDING FOR TEMPORARY APPOINTMENTS

This agency is required by the Office of Personnel Management to certify that all temporary employees are informed of the following:

a. will be terminated from any bonus or loan repayment program if appointment is for longer than 179 consecutive days. Effective date of termination will be the first day of temporary Technician employment. Any payment made after the effective date of termination will be subject to recoupment. Point of contact for the MOARNG is the Director of Personnel, Incentives Branch, and for the MOANG is the Base Retention Office Manager;

b. a temporary employee serves under an appointment limited to 1 (one) year;

c. a temporary employee is subject to termination at any time;

d. a temporary employee does not confer eligibility to be promoted or reassigned to other positions, or the ability to be noncompetitively converted to a Career-Conditional appointment; and

e. permanent status Title 32 Excepted Technicians will forfeit their status and any inherent rights as a permanent employee.

Your signature and date below, certifies that you understand these requirements.

Selected Candidate's Signature

Date

Selected Candidate's Name (Please Print)

Selecting Official's Signature Block and Signature

Date

STATEMENT OF UNDERSTANDING FOR TEMPORARY PROMOTIONS

This agency is required by the Office of Personnel Management to certify that all employees on temporary promotion are informed of the following:

- a. the employee will be subject to having the promotion terminated, and be returned to their permanent position at any time prior to the not-to-exceed date of this promotion without the use of Adverse Action or Reduction-In-Force procedures;
- b. should a Reduction-In-Force situation arise, the employee's permanent position will be the position he/she will be considered to occupy, and not the position to which temporarily promoted to;
- c. the grade and salary of the position to which temporarily promoted to can not be used as Highest Previous Rate; and
- d. a temporary promotion may not exceed 5 years.

Your signature and date below, certifies that you understand these requirements.

Selected Candidate's Signature

Date

Selected Candidate's Name (Please Print)

Selecting Official's Signature Block and Signature

Date

MISSOURI ARMY NATIONAL GUARD OCCUPATIONAL HEALTH FORM

Return to:

Occupational Health Nurse
2302 Militia Drive
Jefferson City, MO 65101-1203

| FAMILY HISTORY: Mark an "X" in either the "Yes" or "No" box next to any of the following conditions or diseases anyone in your family (mother, father, brother, sister, grandparent, aunt, uncle, children) has ever had. | YES | NO |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| ANEMIA, BLOOD DISEASE OR BLEEDING TENDENCY | | |
| ASTHMA, HAYFEVER, OR ALLERGIES | | |
| BIRTH DEFECT | | |
| CANCER OR TUMOR | | |
| DIABETES (sugar disease) | | |
| EYE TROUBLE | | |
| EPILEPSY, FITS OR CONVULSIONS | | |
| HEARING TROUBLE, HIGH BLOOD PRESSURE, OR STROKE | | |
| KIDNEY TROUBLE | | |
| LUNG TROUBLE | | |
| SOME OTHER DISEASE OR CONDITION WHICH RUNS IN YOUR FAMILY (List) | | |
| PERSONAL HISTORY. Answer each of the following questions by making an "X" in either the "Yes" or "No" box to the right of each question. | YES | NO |
| ARE YOU ALLERGIC OR HAD A BAD REACTION TO ANY DRUG, MEDICATION, CHEMICAL OR OTHER SUBSTANCE (for example: Blood, Bee Sting, Dusts, or Penicillin?) | | |
| HAVE YOU EVER RECEIVED A BLOOD TRANSFUSION? | | |
| HAVE YOU EVER BEEN HOSPITALIZED FOR ANY ILLNESS, INJURY, OR OPERATION? | | |
| HAVE YOU EVER HAD HEPATITIS, LIVER DISEASE, OR YELLOW JAUNDICE? | | |
| HAVE YOU EVER HAD ANY SERIOUS ILLNESS, INJURY OR OTHER MEDICAL PROBLEM? | | |
| ARE YOU NOW TAKING ANY DRUGS OR MEDICATIONS (Including those you buy without prescription)? | | |
| HAVE YOU EVER BEEN TOLD BY A MEDICAL PERSON THAT YOU HAD SOMETHING WRONG WITH YOUR: | | |
| X-RAY? | | |
| BREATHING TEST? | | |
| HEARING TEST? | | |
| BLOOD TEST? | | |
| OTHER _____? | | |
| HAVE YOU EVER BEEN ADVISED BY A MEDICAL PERSON TO TAKE MEDICINE FOR: | | |
| DIABETES? | | |
| HIGH BLOOD PRESSURE? | | |
| EPILEPSY? | | |
| TUBERCULOSIS? | | |
| HEART TROUBLE? | | |
| DO YOU SMOKE CIGARETTES? | | |
| IF YES, HOW MANY PACKS A DAY? _____ | | |
| HOW MANY YEARS HAVE YOU SMOKED CIGARETTES? _____ | | |
| IF NO, DID YOU EVER SMOKE CIGARETTES? | | |
| HOW MANY PACKS A DAY? _____ | | |
| HOW MANY YEARS DID YOU SMOKED CIGARETTES? _____ WHAT YEAR DID YOU STOP? _____ | | |
| DO YOU SMOKE CIGARS OR A PIPE? | | |
| IF YES, HOW MANY CIGARS OR POUCHES PER WEEK? _____ | | |
| HOW MANY YEARS HAVE YOU SMOKED CIGARS OR A PIPE? _____ | | |
| IF NO, DID YOU EVER SMOKE CIGARS OR A PIPE? | | |
| HOW MANY CIGARS OR POUCHES PER WEEK? _____ | | |
| HOW MANY YEARS DID YOU SMOKED CIGARS OR A PIPE? _____ WHAT YEAR DID YOU STOP? _____ | | |
| HOW MUCH ALCOHOL DO YOU USUALLY DRINK? LIQUOR _____ OUNCES PER WEEK | | |
| BEER _____ BOTTLES PER WEEK | | |
| WINE _____ GLASSES PER WEEK | | |
| HAVE YOU/HAS YOUR SPOUSE EVER TRIED TO HAVE CHILDREN BUT HAVE BEEN UNABLE TO? | | |
| HAVE YOU/HAS YOUR SPOUSE EVER BEEN PREGNANT? | | |
| IF YES, HOW MANY PREGNANCIES? _____ | | |
| DID ANY PREGNANCY RESULT IN AN ABORTION OR MISCARRIAGE? HOW MANY? _____ | | |
| STILLBIRTH? HOW MANY? _____ | | |
| PREMATURE BIRTH? HOW MANY? _____ | | |
| ABNORMAL BIRTH? HOW MANY? _____ | | |
| IS YOUR SPOUSE/ARE YOU NOW PREGNANT? | | |

INTERIM HISTORY. Mark an "X" in either the "Yes" or "No" box.

In the past year, have you:

FOR MEN ONLY:

- | | |
|---------------------------------------------------------------|-----------------------|
| 1. NOTICED A DISCHARGE FROM YOUR PENIS? | 1. _____ YES _____ NO |
| 2. NOTICED ANY LUMPS OR CHANGE IN THE SIZE OF YOUR TESTICLES? | 2. _____ YES _____ NO |
| 3. HAD PAIN IN YOUR TESTICLES OR PENIS? | 3. _____ YES _____ NO |

FOR WOMEN ONLY:

- | | |
|---------------------------------------------------------------------------|-----------------------|
| 4. NOTICED A CHANGE IN YOUR MENSTRUAL PERIODS? | 4. _____ YES _____ NO |
| 5. BEEN TROUBLED WITH MORE PAIN DURING YOUR MENSTRUAL PERIODS THAN USUAL? | 5. _____ YES _____ NO |
| 6. HAD HEAVIER MENSTRUAL BLEEDING THAN USUAL? | 6. _____ YES _____ NO |
| 7. HAD ANY VAGINAL BLEEDING BETWEEN YOUR MENSTRUAL PERIODS? | 7. _____ YES _____ NO |
| 8. BEEN TROUBLED WITH A VAGINAL DISCHARGE? | 8. _____ YES _____ NO |
| 9. BEEN TROUBLED WITH PAIN DURING SEXUAL INTERCOURSE? | 9. _____ YES _____ NO |

FOR ALL EXAMINEES

- | | |
|---------------------------------------------------------------------------------------------|------------------------|
| 10. BEEN TROUBLED WITH DIZZINESS OR LIGHTHEADEDNESS? | 10. _____ YES _____ NO |
| 11. HAD A FAINTING OR BLACKOUT SPELL? | 11. _____ YES _____ NO |
| 12. HAD A CONVULSION, FIT, OR SEIZURE? | 12. _____ YES _____ NO |
| 13. NOTICED WEAKNESS OR PARALYSIS OF ANY PART OF YOUR BODY? | 13. _____ YES _____ NO |
| 14. HAD TROUBLE KEEPING YOUR BALANCE? | 14. _____ YES _____ NO |
| 15. NOTICED SHAKING OF ANY PART OF YOUR BODY? | 15. _____ YES _____ NO |
| 16. NOTICED TINGLING OR NUMBNESS OF ANY PART OF YOUR BODY? | 16. _____ YES _____ NO |
| 17. NOTICED A DECREASE IN YOUR COORDINATION? | 17. _____ YES _____ NO |
| 18. HAD A LOSS OF CONSCIOUSNESS? | 18. _____ YES _____ NO |
| 19. HAD SLURRED SPEECH OR LOSS OF SPEECH? | 19. _____ YES _____ NO |
| 20. HAD MORE TROUBLE CONCENTRATING ON YOUR WORK THAN USUAL? | 20. _____ YES _____ NO |
| 21. BEEN MORE WORRIED OR ANXIOUS THAN USUAL? | 21. _____ YES _____ NO |
| 22. BEEN MORE DEPRESSED OR UNHAPPY THAN USUAL? | 22. _____ YES _____ NO |
| 23. NOTICED ANY CHANGE IN YOUR PERSONALITY? | 23. _____ YES _____ NO |
| 24. HAD TROUBLE MAKING DECISIONS? | 24. _____ YES _____ NO |
| 25. BEEN TROUBLED WITH PERIODS OF MENTAL CONFUSION OR DISORIENTATION? | 25. _____ YES _____ NO |
| 26. HAD ANY SEXUAL DIFFICULTIES? | 26. _____ YES _____ NO |
| 27. BEEN TROUBLED WITH PAIN IN YOUR JOINTS? | 27. _____ YES _____ NO |
| 28. NOTICED STIFFNESS OF ANY OF YOUR JOINTS? | 28. _____ YES _____ NO |
| 29. NOTICED SWELLING OR REDNESS OF ANY OF YOUR JOINTS? | 29. _____ YES _____ NO |
| 30. BEEN TROUBLED WITH BACK PAIN? | 30. _____ YES _____ NO |
| 31. HAD DIFFICULTY WALKING? | 31. _____ YES _____ NO |
| 32. NOTICED A CHANGE IN THE COLOR OF YOUR SKIN? | 32. _____ YES _____ NO |
| 33. BEEN TROUBLED WITH ITCHING SKIN, ACNE, OR SKIN RASHES? | 33. _____ YES _____ NO |
| 34. DEVELOPED ANY GROWTHS OR SORES ON YOUR SKIN? | 34. _____ YES _____ NO |
| 35. NOTICED A CHANGE IN ANY GROWTH OR SORES? | 35. _____ YES _____ NO |
| 36. NOTICED A CHANGE IN OR HAD BLEEDING OF A MOLE? | 36. _____ YES _____ NO |
| 37. NOTICED YOU BRUISE MORE EASILY OR HAVE TROUBLE STOPPING EVEN A SMALL CUT FROM BLEEDING? | 37. _____ YES _____ NO |
| 38. HAD EYE IRRITATION OR PAIN? | 38. _____ YES _____ NO |
| 39. NOTICED A DECREASE IN YOUR ABILITY TO SEE? | 39. _____ YES _____ NO |
| 40. HAD DOUBLE VISION OR SLURRED VISION? | 40. _____ YES _____ NO |
| 41. HAD UNEXPLAINED FLASHES OF LIGHT, HALOS OR FLOATING OBJECTS IN FRONT OF YOUR EYES? | 41. _____ YES _____ NO |
| 42. HAD A TEMPORARY LOSS OF VISION? | 42. _____ YES _____ NO |

INTERIM HISTORY (Continued)

In the past year, have you:

- | | |
|--------------------------------------------------------------------------------------|------------------------|
| 43. HAD MORE THAN THREE COLDS? | 43. _____ YES _____ NO |
| 44. HAD WHEEZING? | 44. _____ YES _____ NO |
| 45. BEEN TROUBLED WITH COUGHING? | 45. _____ YES _____ NO |
| 46. COUGHED UP THICK MUCOUS OR PHLEGM (THICK SPIT) | 46. _____ YES _____ NO |
| 47. COUGHED UP BLOOD? | 47. _____ YES _____ NO |
| 48. HAD TIGHTNESS, PRESSURE, OR PAIN IN YOUR CHEST | 48. _____ YES _____ NO |
| 49. HAD RACING OR THUMPING OF YOUR HEART? | 49. _____ YES _____ NO |
| 50. SHORTNESS OF BREATH? | 50. _____ YES _____ NO |
| 51. HAD TROUBLE BREATHING WHEN YOU EXERT YOURSELF? | 51. _____ YES _____ NO |
| 52. HAD TROUBLE BREATHING WHEN YOU LIE DOWN? | 52. _____ YES _____ NO |
| 53. NEEDED TO USE MORE THAN ONE PILLOW OR RAISE THE HEAD OF YOUR BED TO GO TO SLEEP? | 53. _____ YES _____ NO |
| 54. AWAKENED AND HAD TROUBLE CATCHING YOUR BREATH? | 54. _____ YES _____ NO |
| 55. NOTICED SWELLING IN YOUR FEET OR ANKLES? | 55. _____ YES _____ NO |
| 56. HAD PAIN OR CRAMPS IN YOUR LEGS WHEN YOU WALK? | 56. _____ YES _____ NO |
| 57. NOTICED YOUR HANDS, FEET OR LIPS TURN BLUE OR BLEACH WHITE? | 57. _____ YES _____ NO |
| 58. HAD DIFFICULTY SWALLOWING? | 68. _____ YES _____ NO |
| 59. BEEN TROUBLED WITH BELCHING, BLOATING, OR HEARTBURN? | 59. _____ YES _____ NO |
| 60. BEEN TROUBLED WITH STOMACH OR ABDOMINAL PAIN? | 60. _____ YES _____ NO |
| 61. BEEN TROUBLED WITH NAUSEA, VOMITING, OR BELCHING UP FOOD? | 61. _____ YES _____ NO |
| 62. VOMITED BLOOD? | 62. _____ YES _____ NO |
| 63. BEEN TROUBLED WITH DIARRHEA OR LOOSE STOOLS? | 63. _____ YES _____ NO |
| 64. BEEN TROUBLED WITH CONSTIPATION? | 64. _____ YES _____ NO |
| 65. NOTICED A CHANGE IN YOUR BOWEL HABITS? | 65. _____ YES _____ NO |
| 66. NOTICED A CHANGE IN THE COLOR OR CONSISTENCY OF YOUR STOOL? | 66. _____ YES _____ NO |
| 67. HAD ANY BLOODY OR BLACK, TARRY LOOKING STOOLS? | 67. _____ YES _____ NO |
| 68. BEEN TROUBLED WITH RECTAL OR ANAL PAIN? | 68. _____ YES _____ NO |
| 69. NOTICED ANY RECTAL OR ANAL BLEEDING? | 69. _____ YES _____ NO |
| 70. HAD ANY BURNING OR PAIN WHEN YOU URINATE? | 70. _____ YES _____ NO |
| 71. NOTICED ANY BLOOD IN YOUR URINE? | 71. _____ YES _____ NO |
| 72. NOTICED A CHANGE IN THE COLOR OF YOUR URINE? | 72. _____ YES _____ NO |
| 73. HAD TO URINATE MORE OFTEN THAN USUAL? | 73. _____ YES _____ NO |
| 74. HAD TO WAKE UP AT NIGHT TO URINATE? | 74. _____ YES _____ NO |
| 75. HAD DIFFICULTY CONTROLLING YOUR URINE? | 75. _____ YES _____ NO |
| 76. HAD DIFFICULTY IN STARTING YOUR URINE FLOW? | 76. _____ YES _____ NO |

INTERIM HISTORY (CONTINUED)

IN THE PAST YEAR, HAVE YOU:

77. HAD A WEIGHT CHANGE OF MORE THAN 10 POUNDS? 77. _____ YES _____ NO
78. MADE A CHANGE IN APPETITE 78. _____ YES _____ NO
79. BEEN MORE THIRSTY THAN USUAL? 79. _____ YES _____ NO
80. HAD MORE FATIGUE THAN USUAL? 80. _____ YES _____ NO
81. HAD MORE WEAKNESS THAN USUAL? 81. _____ YES _____ NO
82. HAD FEVER OR CHILLS? 82. _____ YES _____ NO
83. HAD TROUBLE TOLERATING HEAT OR COLD? 83. _____ YES _____ NO
84. HAD NIGHT SWEATS? 84. _____ YES _____ NO
85. HAD MORE TROUBLE SLEEPING THAN USUAL? 85. _____ YES _____ NO
86. NOTICED A DISCHARGE FROM EITHER BREAST? 86. _____ YES _____ NO
87. NOTICED A LUMP IN EITHER BREAST? 87. _____ YES _____ NO
88. BEEN TROUBLED WITH PAIN IN YOUR BREASTS? 88. _____ YES _____ NO
89. NOTICED A GROWTH OR LUMP ON ANY PART OF YOUR BODY? 89. _____ YES _____ NO
90. HAD ANY PROBLEM WITH YOUR HAIR OR NAILS? 90. _____ YES _____ NO
91. BEEN TROUBLED WITH PAIN IN YOUR ARMS, LEGS, FEET OR HANDS? 91. _____ YES _____ NO
92. NOTICED A DECREASE IN YOUR ABILITY TO PERFORM CERTAIN PHYSICAL ACTIVITIES? 92. _____ YES _____ NO
-
93. HAD PAIN OR STIFFNESS OF YOUR NECK? 93. _____ YES _____ NO
94. NOTICED ANY LUMPS OR SWELLING IN YOUR NECK? 94. _____ YES _____ NO
95. BEEN TROUBLED WITH HEADACHES? 95. _____ YES _____ NO
-
96. NOTICED A DECREASE IN YOUR ABILITY TO SMELL? 96. _____ YES _____ NO
97. BEEN TROUBLED WITH A DISCHARGE FROM YOUR NOSE? 97. _____ YES _____ NO
98. HAD NOSEBLEEDS? 98. _____ YES _____ NO
99. NOTICED SORES IN YOUR NOSE? 99. _____ YES _____ NO
100. HAD TROUBLE BREATHING THROUGH YOUR NOSE? 100. _____ YES _____ NO
101. BEEN TROUBLED WITH IRRITATION OF YOUR NOSE? 101. _____ YES _____ NO
102. HAD NOSE HOARSENESS OR TROUBLE TALKING? 102. _____ YES _____ NO
-
103. NOTICED BLEEDING OR IRRITATION OF YOUR GUMS OR TONGUE? 103. _____ YES _____ NO
104. NOTICED ANY SORES IN YOUR MOUTH? 104. _____ YES _____ NO
103. NOTICED A CHANGES IN THE TASTE OF FOOD OR DRINK? 105. _____ YES _____ NO
106. NOTICED A DECREASE IN YOUR ABILITY TO HEAR? 106. _____ YES _____ NO
107. HAD RINGING OR OTHER UNUSUAL SOUNDS IN YOUR EARS? 107. _____ YES _____ NO
108. HAD PAIN IN YOUR EARS? 108. _____ YES _____ NO
-
109. DO YOU HAVE ANY CONCERNS YOU WISH TO DISCUSS WITH THE PHYSICIAN? 109. _____ YES _____ NO

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN)

Sections 133, 1071-87, 3012, 5031 and 8012, title 10, United States Code and Executive Order 9397.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) of member or sponsor is required to identify and retrieve health care records.

3. ROUTINE USES

The primary use of this information is to provide, plan and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: Aid in preventive health and communicable disease control programs and report medical conditions required by law to federal, state and local agencies; compile statistical data; conduct research; teach; determine suitability of persons for service or assignments; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state, or local government upon request in the pursuit of their official duties.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

In the case of military personnel, the requested information is mandatory because of the need to document all active duty medical incidents in view of future rights and benefits. In the case of all other personnel/beneficiaries, the requested information is voluntary. If the requested information is not furnished, comprehensive health care may not be possible, but CARE WILL NOT BE DENIED.

This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

SIGNATURE OF PATIENT OR SPONSOR

SSN OF MEMBER OR SPONSOR

DATE

Excepted Technician OccHealth Exam Required
Demographic Information Template

Personal Information

Today's Date:
(e.g. dd/mm/yyyy)

SSN:

First Name:

Last Name:

DOB:
(e.g. dd/mm/yyyy)

Gender:
(e.g. M or F)

Home Address:

City:

State:
(e.g. VA)

Zip:
(5 digit)

Home Phone:
(only numeric)

Alternate/Cell Phone:
(only numeric)

Email:
(.mil / .gov only)

Personal Email:

Is the above information correct contact information for scheduling services, if not, please enter appropriate scheduling contact information below?

Contact Information

Home Address:

City:

State:
(e.g. VA)

Zip:
(5 digit)

Contact Phone:
(only numeric)

Alternate/Cell Phone:
(only numeric)

Contact Email:
(.mil / .gov only)

Current Fulltime Military/Gov Employment Status

Pay Plan:
(e.g. Wage Grade)

Occ Code:
(e.g. 0007/ Correctional Officer)

Duty Title Description:
(e.g. Correctional Officer)

Current Fulltime Military/Gov Address

UIC:
(6 Characters, starts with 'W')

Agency Address:

City:

State:
(e.g. VA)

Zip:
(5 digit)

Supervisor Name:

Supervisor Work Phone:
(No DSN)

Supervisor Email:
(.mil / .gov only)

Current Military/Unit Employment Status

Please fill in one: **Title 10** **Title 32**

Rank:
(e.g. Private)

MOS:
(e.g. 13F)

Actual Title:

Current Military/Unit Agency Address

UIC:
(6 Characters, starts with 'W')

Agency Address:

City:

State:
(e.g. VA)

Zip:
(5 digit)

Work Phone:
(only numeric)

Preferred Exam Location

City:

State:
(e.g. VA)

Zip:
(5 digit)