Released 5/11/00.

DCP USE ONLY: Date Avail: _____ **Cat:** _____ **TrnCode:** _____ **Appt Type:** _____ **Age:** _____ **Grad Date:** _____

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service

OMB No. 0937-0025
Expiration: 7/31/2000

PHS-50
Rev. 7/97

APPLICATION FOR APPOINTMENT AS A COMMISSIONED OFFICER IN THE U.S. PUBLIC HEALTH SERVICE COMMISSIONED CORPS

BEFORE COMPLETING THE APPLICATION, READ ATTACHED INSTRUCTIONS CAREFULLY. GIVE COMPLETE ANSWERS TO ALL ITEMS.

TYPE OR PRINT IN INK. If additional space is needed, attach an 8 1/2 x 11 inch sheet of paper. Include your name, address, social security number, and the pertinent item numbers on each sheet so used. All material submitted becomes the property of the Federal Government and will not be returned. Part of the information will be used for a suitability/background investigation. **YOU MUST SIGN THIS APPLICATION ON PAGE 4 OR YOUR APPLICATION WILL NOT BE PROCESSED.**

Submit signed original and a clearly readable copy (photocopy acceptable) with **original signature** to: Division of Commissioned Personnel, PSC, HRS, 5600 Fishers Lane, Room 4-20, Rockville, MD 20857-0001.

1a. FULL NAME *(Last, First, Middle)* (Maiden, if Any)

1b. OTHER NAMES USED From: *(MM/YYYY)* Through: *(MM/YYYY)*
(Continue in Item # 27 if needed)

2. SOCIAL SECURITY NUMBER ___ - ___ - ___

3. DAE OF BIRTH *(MM/DD/YY)* ___ / ___ / ___

4. TYPE OF DUTY(IES) FOR WHICH YOU ARE APPLYING: *(Indicate all that are applicable and appropariate, Dates MM/YYYY)*

☐ General Duty (extended Active Duty) Available for Active Duty: ___ / ___

☐ Junior COSTEP From: ___ / ___ To: ___ / ___

☐ Senior COSTEP From: ___ / ___ To: ___ / ___

5. CURRENT INFORMATION FOR CONTACTING YOU:
(YOU MUST NOTIFY DCP IMMEDIATELY OF ANY CHANGES)

Mail: Street: _____
Street: _____
City: _____
State: ___ ZIP: _____ + _____
Telephone (Include Area Code):
Current: (___) ___ - ___
Business: (___) ___ - ___ Ext. ___
FAX: (___) ___ - ___
E-Mail: _____

6. "PERMANENT" INFORMATION FOR CONTACTING YOU:

Mail: Contact Name: _____
Street: _____
Street: _____
City: _____
State: ___ ZIP: _____ + _____
Telephone (Include Area Code):
Home: (___) ___ - ___
Business: (___) ___ - ___ Ext. ___
FAX: (___) ___ - ___
Any additional information should be listed in Item # 27.

7. CITIZENSHIP INFORMATION
☐ Native ☐ Naturalized
Place of Birth: _____
If Naturalized: Date Naturalized: *(MM/DD/YYYY)* ___ / ___ / ___ Name on Certificate: _____

8. BASIC EDUCATION AND PROFESSIONAL TRAINING (Include below, all degrees you have earned or training you will have completed by the time you are available for appointment. Official transcripts to include final or latest grading period for all college, graduate, and professional training MUST BE SUBMITTED BEFORE SELECTION CAN BE MADE.)

COLLEGE, UNIVERSITY, OR OTHER INSTITUTION (Include City, State, and ZIP	DATES ATTENDED FROM (MM/DD/YYYY)	DATES ATTENDED TO (MM/DD/YYYY)	TOTAL HOURS CREDIT *(Specify)* Qtr. or Sem.	MAJOR	DEGREE	OFFICIAL NUMBER YEARS IN PROGRAM	DEGREE REQUIREMENTS FULFILLED (MM/YYYY)	DEGREE CONFERRED OR TO BE CONFERRED

INTERNSHIP OR RESIDENCY COMPLETED (MUST PROVIDE CERTIFICATE), CURRENTLY SERVING, OR SCHEDULED TO COMMENCE

HOSPITAL OR INSTITUTION (Include City, State, and ZIP	FROM (MM/DD/YYYY)	TO (MM/DD/YYYY)	SPECIFY TYPE AND SPECIALT Y(if applicable) (e.g. Rotating, Mixed, or Straight, Categorical, Surgery, Family Practice)

9. UNIFORMED SERVICE: List below in chronological order all service you have had in the ARMY, NAVY, AIR FORCE, MARINE CORPS, COAST GUARD, and the COMMISSIONED CORPS OF THE NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION or the PUBLIC HEALTH SERVICE. Include any present military affiliations: PHS, Reserve Unit, ROTC commitment, etc. Except for PHS affiliation, you must initiate a release from such Service contingent upon your appointment to the Commissioned Corps of the PHS or provide proof of discharge.

SERVICE COMPONENT	REGULAR OR RESERVE	HIGHEST RANK HELD	DUTY FROM *(MM/DD/YYYY)*	DUTY TO *(MM/DD/YYYY)*	ACTIVE OR INACTIVE DUTY

10. Were you ever rejected for duty in any branch of a Univormed service?
☐ Yes ☐ No (If "Yes", state when and where rejected and cause)

11. DEPENDENTS INFORMATION (Full name of spouse and full name(s) and date(s) of birth of child(ren) and/or other dependent(s))

(Name)	*(Relationship)*	*(Date of Birth: MM/DD/YYYY)*
	SPOUSE	___ / ___ / ___
		___ / ___ / ___
		___ / ___ / ___

(Continued)

Indicate Answers by Placing an "X" in the Appropriate Column.

		YES	NO
12.	Have you ever been convicted, forfeited collateral, or are you now under charges for any felony or for any firearms or explosives violations? (A felony is defined as any offense punishable by imprisonment for a term exceeding one year but does not include any offense classified as a misdemeanor under the laws of a State and punishable by a term of imprisonment of two years or less.		
13.	During the past seven years, have you been convicted, imprisoned, on probation or parole or forfeited collateral, or are you now under charges for any offense against the law not included in item 12 above? (When answering items 12 and 13, you may omit: (a) traffic fines for which you paid a fine of $150.00 or less, (b) any offense committed before your 18th birthday which was finally adjudicated in a juvenile court or under a youth offender law, (c) any conviction the record of which has been expunged under Federal or State law, and (d) any conviction set aside under the Federal Youth Corrections Act or similar State authority.)		
14.	Are you delinquent on the repayment of any Federal debt(s)? If your answer is "Yes," please provide an explanation in item 27. (Examples of Federal debt include delinquent taxes, audit disallowances, guaranteed or direct student loans, FHA loans, and other miscellaneous administrative debts. The definition of delinquency for the purposes of direct and guaranteed loans are any loan(s) more than 31 days past due on a scheduled payment. Deferred loans are not considered delinquent.)		
15.	Are you a conscientioius objector to military service? (If "No" go to question 17)		
16.	If you are a conscientious objector, are you willing to serve in a noncombatant position? (**NOTE**: By Executive Order, the PHS Commissioned Corps may be militarized during times of national emergency and does have officers serving in support roles at all times. If in item 15 you stated an objection, you would be precluded from appointment in the Commissioned Corps of the Public Health Service.)		
17.	If in the military service, were you ever convicted by a general court martial?		
18.	Have you ever been charged with, or are currently facing charges, of a violation of any State law pertaining to habit-forming drugs, narcotics, or intoxicating liquor? (**NOTE**: If your answer to items 12, 13, 14, 17, or 18 is "Yes," give details in item 27. Show for each offense: (a) date, (b) charge, (c) place, (d) court, and (e) action taken.)		

19. REFERENCES List the names of four individuals, including your most recent employer, with whom you have had professional affiliation or training at some time during the past seven years. Include, where applicable, Dean of College; Dean of Graduate or Professional school; Director of Intern Training Program; Director of Graduate, Post-Graduate, Residency, or Specialty training; chairpersons of departments in which graduate or professional work was taken; or employment supervisors.

	FULL NAME	PROFESSIONAL RELATIONSHIP TO APPLICANT	BUSINESS ADDRESS *(Organization and Street, City, State, ZIP, Telephone)*
1)			( ) -
2)			( ) -
3)			( ) -
4)			( ) -

20. LIST STATES GRANTING FULL/UNRESTRICTED PROFESSIONAL LICENSES/CERTIFICATES *(Include license or registry number and expiration date and provide a copy of the license/registration)*

21. DRUG ENFORCEMENT ADMINISTRATION (DEA) CONTROLLED SUBSTANCE REGISTRATION INFORMATION

(If you were never registered, so state)

A. List all jurisdictions (past and present) where you are or were registered under Title 21, U.S. Controlled Substances Act, and provide your DEA controlled substance registration number for each jurisdiction.

	YES	NO
B. Has your registration under this Act ever been denied, suspended, revoked, refused renewal, or voluntarily surrendered?		
C. Have you ever been charged with, or are currently facing charges of, a violation of this Act?		

22. STATUS IN PROFESSIONAL BOARDS (Indicate date and type of board, and whether Board Eligible, Board Certified, or Board Examination has been taken. submit copy of ECFMG Certificate and Board Certification, if any.)

23. EXPLAIN ALL "YES" ANSWERS IN ITEM 27.

	YES	NO
A. Have you ever been denied membership or renewal thereof, or been subject to disciplinary proceedings by any medical or professional organization?		
B. Have you ever lost or had your professional practice license revoked?		
C. Have liability claims been filed against you, or against a hospital, corporation, or government based on a case under your care?		
D. Have judgements or settlements been made against you, or against a hospital, corporation, or government based on a case directly under your care?		
E. Have you ever had, or are you about to have, your professional liability insurance declined, canceled, issued on special terms, or refused renewal?		
F. Have you ever been censured or reprimanded by a licensing board, hospital medical board/staff, or any other professional organization?		
G. Have you ever been sanctioned by the Medicare or Medicaid Programs or by any other Federal agency?		
H. Have any or all of your privileges at any health care facility ever been, or are about to be, limited, suspended, revoked, refused renewal, or voluntarily surrendered?		

24. Provide the names and addresses (past and present) of all of your professional liability insurers and your policy numbers.

(Continued)

25. EMPLOYMENT HISTORY

Begin with current or most recent work or volunteer experience and work back. Account for any periods of unemployment exceeding three months on the last line of the experience blocks in order of occurrence. Do not list any employment prior to commencing undergraduate school. For your PROFESSIONAL EXPERIENCE AND WORK RECORD, include professional training positions not reflected in item 27. Include assistantships, apprenticeships, and fellowships. Describe your duties, including: (a) professional skills involved; (b) degree of responsibility; (c) complexity of duties; (d) extent of supervision received and exercised; (e) extent of public contact; and (f) extent of influence on policy.

DATES EMPLOYED (MM/YYYY) From: ___/_____ To: ___/_____	EMPLOYER/ ERIFIER NAME/MILITARY DUTY LOCATION			YOUR POSITION TITLE/ MILITARY RANK
EMPLOYER'S/VERIFIER'S STREET ADDRESS	CITY (Country)	STATE	ZIP (+4) ______+____	TELEPHONE NUMBER (____) ____ - _____
STREET ADDRESS OF JOB LOCATION	CITY (Country)	STATE	ZIP (+4) ______+____	TELEPHONE NUMBER (____) ____ - _____
SUPERVISOR'S NAME & STREET ADDRESS (If different than job Location)	CITY (Country)	STATE	ZIP (+4) ______+____	TELEPHONE NUMBER (____) ____ - _____
AVERAGE NUMBER OF HOURS PER WEEK (If less than 40 hours state specific schedule)	KIND OF BUSINESS OR ORGANIZATION (e.g., education, health, social services, etc.)			
REASON FOR LEAVING OR WISHING TO LEAVE				
DESCRIPTION OF WORK (Describe your specific duties, responsibilities, and accomplishments in this job.)				

DATES EMPLOYED (MM/YYYY) From: ___/_____ To: ___/_____	EMPLOYER/ ERIFIER NAME/MILITARY DUTY LOCATION			YOUR POSITION TITLE/ MILITARY RANK
EMPLOYER'S/VERIFIER'S STREET ADDRESS	CITY (Country)	STATE	ZIP (+4) ______+____	TELEPHONE NUMBER (____) ____ - _____
STREET ADDRESS OF JOB LOCATION	CITY (Country)	STATE	ZIP (+4) ______+____	TELEPHONE NUMBER (____) ____ - _____
SUPERVISOR'S NAME & STREET ADDRESS (If different than job Location)	CITY (Country)	STATE	ZIP (+4) ______+____	TELEPHONE NUMBER (____) ____ - _____
AVERAGE NUMBER OF HOURS PER WEEK (If less than 40 hours state specific schedule)	KIND OF BUSINESS OR ORGANIZATION (e.g., education, health, social services, etc.)			
REASON FOR LEAVING OR WISHING TO LEAVE				
DESCRIPTION OF WORK (Describe your specific duties, responsibilities, and accomplishments in this job.)				

DATES EMPLOYED (MM/YYYY) From: ___/_____ To: ___/_____	EMPLOYER/ ERIFIER NAME/MILITARY DUTY LOCATION			YOUR POSITION TITLE/ MILITARY RANK
EMPLOYER'S/VERIFIER'S STREET ADDRESS	CITY (Country)	STATE	ZIP (+4) ______+____	TELEPHONE NUMBER (____) ____ - _____
STREET ADDRESS OF JOB LOCATION	CITY (Country)	STATE	ZIP (+4) ______+____	TELEPHONE NUMBER (____) ____ - _____
SUPERVISOR'S NAME & STREET ADDRESS (If different than job Location)	CITY (Country)	STATE	ZIP (+4) ______+____	TELEPHONE NUMBER (____) ____ - _____
AVERAGE NUMBER OF HOURS PER WEEK (If less than 40 hours state specific schedule)	KIND OF BUSINESS OR ORGANIZATION (e.g., education, health, social services, etc.)			
REASON FOR LEAVING OR WISHING TO LEAVE				
DESCRIPTION OF WORK (Describe your specific duties, responsibilities, and accomplishments in this job.)				

(Continued)

26. ADDITIONAL SKILLS AND QUALIFICATIONS

FOREIGN LANGUAGE: Do you have adequate competency to use any language(s) in performance of duty? ☐ YES ☐ NO, If "Yes", specify language and proficiency level. **1** = Elementary Proficiency, **2** = General Professional Proficiency, **3** = Functionally Native Proficiency

Language	Proficiency	Language	Proficiency

OTHER SKILLS (Acquired through formal training, former job, or hobbies: e.g., licensed amateur radio operator, pilot, scuba diver.)

TYPES OF ASSIGNMENTS IN WHICH YOU ARE INTERESTED

(Consideration will be given to stated preferences, however, the needs of the Public Health Service Commissioned Corps will have priority. Indicate also the names of any officials with whom you have discussed an assignment. Do not list casual conversations, but only program interviews relative to placement.)

GEOGRAPHIC AREAS IN WHICH YOU PREFER TO SERVE

27. SPACE FOR DETAILED ANSWERS

(Indicate item numbers to which the answers apply. If more space is required, attach an 8 1/2 x 11 inch sheet of paper. Write your name, present mailing address, and Social Secureity Number on each sheet.)

ATTENTION - THIS STATEMENT MUST BE SIGNED BY ALL APPLICANTS
Read the following paragraphs carefully before signing this Statement.

A false answer to any question in this Statement may be grounds for not appointing you, or for dismissing you after appointment, and may be punishable by fine or imprisonment (U.S. Code, Title 18, Section 1001). All the information you give will be considered in reviewing your application.

AUTHORITY FOR RELEASE OF INFORMATION

I have completed this Statement with the knowledge and understanding that any or all items contained herein may be subject to investigation prescribed by law or Presidential directive and I consent to the release of information concerning my capacity and fitness by employers, educational institutions, law enforcement agencies, and other individuals and agencies, to duly accredited investigators, Personnel Staffing Specialists, and other authorized employees of the Federal Government for that purpose. I hereby release from liability all representatives of the Federal Government for their acts performed in good faith and without malice in connection with evaluating my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to these representatives in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for appointment in the Commissioned Corps of the United States Public Health Service.

CERTIFICATION

I certify that all of the statements made by me are true, complete, and correct to the best of my knowledge and belief and are made in good faith. I am willing to serve in any area or climate or wherever the exigencies of the Public Health Service Commissioned Corps may require.

PRINT OR TYPE NAME AND SIGN IN INK	DATE