OCCO USE ONLY: Date Avail: ________ Cat: ________ Trn Code: ____________ Appt Type: ________ Age: _____ Grad Date: ________

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

OMB No. 0937-0025
Expiration: 9/30/2006

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 ½ 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 5 OR YOUR APPLICATION WILL NOT BE PROCESSED**. The U.S. Public Health Service Commissioned Corps is a Uniformed Service.

Submit signed original and a clearly readable copy (photocopy acceptable) with **original signature** to: Office of Commissioned Corps Operations, 1101 Wootton Parkway, Suite 100, Rockville, MD 20852. Facsimiles will not be accepted.

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

2. SOCIAL SECURITY NUMBER
__ __ __ – __ __ – __ __ __ __

3a. DATE OF BIRTH *(MM/DD/YYYY)*
__ __ / __ __ / __ __ __ __

1b. OTHER NAMES USED From: *(MM/YYYY)* Through: *(MM/YYYY)*
(Continue in Item 30 if needed)
________________________ __ __ / __ __ __ __ __ __ / __ __ __ __
________________________ __ __ / __ __ __ __ __ __ / __ __ __ __

3b. PLACE OF BIRTH *(City and State)*

4. PROFESSION OR INTENDED PROFESSION *(e.g., Chemist, Nurse, Physician)*

5. CITIZENSHIP *(Only United States citizens may be appointed to the Commissioned Corps of the Public Health Service)*

☐ NATIVE* ☐ If NATURALIZED *(Answer A, B, C, D)*

A. Entered: Month__________ Day__________ Year__________
B. Naturalized: Month__________ Day__________ Year__________
C. Naturalization Number: ______________________________
D. Person to whom number was issued: ______________________
Place Naturalized: ______________________________

** If U.S. citizen born abroad, provide Consulate Report of Birth or other proof of U.S. citizenship.*

6. TYPES OF DUTY(IES) FOR WHICH YOU ARE APPLYING:
(Indicate all that are applicable and appropriate, Dates MM/YYYY)

☐ General Duty (extended Active Duty–Full-time)
Available for Active Duty:
__ __ / __ __ __ __

☐ Junior COSTEP *(Applicant must be a full-time student)*
From: __ __ / __ __ __ __
To: __ __ / __ __ __ __

☐ Senior COSTEP *(Applicant must be a full-time student)*
From: __ __ / __ __ __ __
To: __ __ / __ __ __ __

7. CURRENT INFORMATION FOR CONTACTING YOU: *(YOU MUST NOTIFY THE OFFICE OF COMMISSIONED CORPS OPERATIONS (OCCO) IMMEDIATELY OF ANY CHANGES)* **Applicant MUST complete the following:**

Mail: Contact Name: ______________________________
Street: ______________________________
City: ______________________________
State: __ __ ZIP: __ __ __ __ __ + __ __ __ __
Telephone (Include Area Code):
Current: (__ __ __) __ __ __ – __ __ __ __
Business: (__ __ __) __ __ __ – __ __ __ __ Ext.__________
FAX: (__ __ __) __ __ __ – __ __ __ __
E-Mail: ______________________________

8. "PERMANENT" INFORMATION FOR CONTACTING YOU:

Mail: Contact Name: ______________________________
Street: ______________________________
City: ______________________________
State: __ __ ZIP: __ __ __ __ __ + __ __ __ __
Telephone (Include Area Code):
Current: (__ __ __) __ __ __ – __ __ __ __
Business: (__ __ __) __ __ __ – __ __ __ __ Ext.__________
FAX: (__ __ __) __ __ __ – __ __ __ __
Any additional information should be listed in Item 30.

9. 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. Foreign medical graduates must submit a copy of ECFMG with application. Official transcripts to include final or latest grading period for all college, graduate, and professional training* ***MUST BE SUBMITTED BEFORE YOU CAN BE APPOINTED****.)*

COLLEGE, UNIVERSITY, OR OTHER INSTITUTION ***List chronologically–latest first*** *(Include City, State, and ZIP)*	DATES ATTENDED FROM *(MM/DD/YYYY)*	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 WILL BE CONFERRED *(MM/YYYY)*

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

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

10. UNIFORMED SERVICE: List below in chronological order all service you have had in the ARMY, NAVY, AIR FORCE, MARINE CORPS, COAST GUARD, COMMISSIONED CORPS OF THE NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION, and COMMISSIONED CORPS OF THE U.S. PUBLIC HEALTH SERVICE (PHS). **NOTE**: If U.S. Public Health Service, include PHS Serial Number. Include any present Uniformed Services affiliations: PHS, Reserve Unit, ROTC commitment, etc. **Except for PHS affiliation, you will soon be asked to initiate a request for inter-service transfer, conditional release, or to provide proof of discharge, as may be applicable to your situation. No immediate action is required. Total active service time includes full-time active duty plus short tours. Do not add in reserve time when not on active reserve duty.**

BRANCH OF SERVICE Example: Army, Navy, etc.	REGULAR OR RESERVE COMPONENT	HIGHEST RANK HELD	DUTY FROM: *(MM/DD/YYYY)* TO: *(MM/DD/YYYY)*	ACTIVE OR INACTIVE DUTY	TOTAL *ACTIVE* NON-PUBLIC HEALTH SERVICE TIME *(In years and months)*

11. Were you ever rejected for duty in any branch of a Uniformed Service?
☐ Yes ☐ No If "Yes," state when and where rejected and cause: ______

12. DEPENDENTS INFORMATION (Full name of spouse and full name(s) and date(s) of birth of child(ren) and/or other dependent(s)): *(Continue in Item 30 if needed)*

(Name)	*(Relationship)*	*(Date of Birth: MM/DD/YYY)*
	SPOUSE	__ __ / __ __ / __ __ __ __
		__ __ / __ __ / __ __ __ __
		__ __ / __ __ / __ __ __ __

	Indicate Answers by Placing an "X" in the Appropriate Column.	YES	NO
13.	Have you ever received a Federal Government scholarship? If Yes, check appropriately: ☐ Indian Health Service ☐ National Health Service Corps ☐ Other *Describe:* ______ Length of Service obligation: _____ Years		
14.	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 1 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 2 years or less.)		
15.	During the past 7 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 14 above? (When answering Items 14 and 15, you may omit: (a) traffic fines for which you paid a fine of $150 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.)		
16.	Are you delinquent on the repayment of any Federal debt(s)? If your answer is "Yes," please provide an explanation in Item 30. (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.)		
17.	Are you a conscientious objector to military service? (If "No," go to Item 19.)		
18.	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 this Item (18) you state an objection, you will be precluded from appointment in the Commissioned Corps of the U.S. Public Health Service.)		
19.	If you served in the military service, were you ever convicted by a general court martial or have you ever received less than an honorable discharge?		
20.	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 14, 15, 16, 19, or 20 is "Yes," give details in Item 30. Show for each offense: (a) date, b) charge, (c) place, (d) court, and (e) action taken.)		

21. REFERENCES: List the names of four individuals, who have knowledge of your "knowledge, skills, and abilities," including your most recent employer, with whom you have had professional affiliation or training at some time during the past 7 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; chairperson of departments in which graduate or professional work was taken; or employment supervisors. Forward to these individuals form PHS-1813, "Reference Request for Applicants to the USPHS Commissioned Corps."

	FULL NAME	PROFESSIONAL RELATIONSHIP TO APPLICANT	BUSINESS ADDRESS *(Organization and Street, City, State, ZIP, Telephone)*
1)			 E-mail address: FAX No.: Phone: __ __ __ __ __ __ – __ __ __ __
2)			 E-mail address: FAX No.: Phone: __ __ __ __ __ __ – __ __ __ __
3)			 E-mail address: FAX No.: Phone: __ __ __ __ __ __ – __ __ __ __
4)			 E-mail address: FAX No.: Phone: __ __ __ __ __ __ – __ __ __ __

22. LIST STATES GRANTING FULL/UNRESTRICTED PROFESSIONAL LICENSES/CERTIFICATES/REGISTRATIONS *(Include license or registry number and expiration date and **provide a copy of the license/certificate/ registration**.) NOTE: Nurses must provide a photocopy of NCLEX certificate or other proof that this was the licensure examination taken.*

23. 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.

(Explain all "Yes" answers in Item 30)	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 the Controlled Substance Act?		

24. STATUS IN PROFESSIONAL U.S. 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.**)*

25. EXPLAIN ALL "YES" ANSWERS IN ITEM 30. (*Questions must be answered even if not in a field where licensure is required.)*	YES	NO
A. Have you ever been denied membership or renewal thereof, or been subject to disciplinary proceedings by any medical or professional organizaiton?		
B. Have you ever lost or had your professional practice license revoked or restricted or have you ever been placed on probation?		
C. Have liability claims been filed against you, or against a hospital, corporation, or government based on a case under your care?		
D. Have judgments 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?		

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

27. EMPLOYMENT HISTORY

Begin with current or most recent work or volunteer experience and work back. Account for any periods of unemployment 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 9. 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. Provide ***all*** work experience - use photocopies of page 4 to continue.

DATES EMPLOYED *(MM/YYYY)* From: __ __ / __ __ __ __ To: __ __ / __ __ __ __	EMPLOYER / VERIFIER 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 (*Indicate full or part-time*)	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.)*

27. EMPLOYMENT HISTORY (Continued)

DATES EMPLOYED *(MM/YYYY)* From: __ __ / __ __ __ __ To: __ __ / __ __ __ __	EMPLOYER / VERIFIER 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 (*Indicate full or part-time*)	KIND OF BUSINESS OR ORGANIZATION *(e.g., education, health, social services, etc.)*			

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DESCRIPTION OF WORK *(Describe your specific duties, responsibilities, and accomplishments in this job.)*

DATES EMPLOYED *(MM/YYYY)* From: __ __ / __ __ __ __ To: __ __ / __ __ __ __	EMPLOYER / VERIFIER 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 (*Indicate full or part-time*)	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.)*

28. 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

HONORS AND AWARDS (Acquired by academic or non-academic experience.)

NONDEGREE RELATED TRAINING (e.g., computer skills, public speaking, leadership recognition, American Council of Learned Societies (ACLS) fellowship program, Basic Life Support (BLS), Cardiopulmonary Resuscitation (CPR), Emergency Medical Services, etc.)

LIST CURRENT OR FORMER MEMBERSHIP IN PROFESSIONAL ASSOCIATIONS (Also indicate office(s) held and committee membership(s).)

29. TYPES OF ASSIGNMENTS IN WHICH YOU ARE INTERESTED

Officers are required to serve in any area or climate or wherever the needs of the Public Health Service Commissioned Corps may require.

Do you have a preference for assignment to a particular program? ☐ YES ☐ NO If "Yes," which program? (e.g., Indian Health Service, Federal Bureau of Prisons, etc.)

GEOGRAPHIC AREAS IN WHICH YOU PREFER TO SERVE *(i.e., Department of Health and Human Services Regional Areas are as follows: Region I: CT,MA,NH,RI,VT,ME; Region II: NY,NJ,PR,VI; Region III: DE,MD,PA,VA,WV,DC; Region IV: AL,FL,GA,KY,MS,NC,SC,TN; Region V: IL,IN,MI,MN,OH,WI; Region VI: AR,LA,NM,OK,TX; Region VII: IA,KS,MO,NE; Region VIII: CO,MT,ND,SD,WY,UT; Region IX: AZ,CA,HI,NV,GU,AP,AS; Region X: AK,ID,OR,WA.)*

30. SPACE FOR DETAILED ANSWERS

(Indicate item numbers to which the answers apply. If more space is required, attach an 8 ½ x 11 inch sheet of paper. **Write your name, present mailing address, and Social Security 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 needs of the Public Health Service Commissioned Corps may require.

PRINT OR TYPE NAME AND SIGN IN INK	DATE