



**SUBSTITUTE
TEACHER
AVID TUTOR
APPLICATION
PACKET**



DEPARTMENT OF DEFENSE EDUCATION ACTIVITY
PACIFIC DIRECTOR'S OFFICE
UNIT 35007
APO AP 96376-5007

DODEA PACIFIC SUBSTITUTE TEACHER/AVID TUTOR APPLICATION CHECKLIST

The application is approved _____
Administrator's Signature _____ Date _____

Hold application until further notice _____
Administrator's Signature _____ Date _____

****APPLICATIONS RECEIVED ON MAY 31 WILL NOT BE PROCESSED UNTIL THE START OF THE NEXT SCHOOL YEAR****

Attention: _____ No. of Pages (inc. header) _____
Human Resources Representative

SENDER REMARKS:

Sending the following documents for the subject new Substitute Teacher:

Name: _____ SSN: _____

- Geographic Availability Form
 - SF 61 (Appointment Affidavit) – Leave date appointed blank. This will be filled in on the date you are appointed.
 - Federal Resume (**OF 612 no longer accepted**) – **MUST INCLUDE THE FOLLOWING:**
 - Job Information** (Announcement number, title, series and grade of job for which applying) **Personal Information** (Full name, mailing address w/ zip code, day and evening phone numbers w/ area code, social security #, country of citizenship, veteran's preference, reinstatement eligibility, highest Federal civilian grade held) **Education** (High school: name, city, and state, date of diploma or GED, Colleges or universities: name, city and state, majors, type and year of any degrees received) **Work Experience** (Job title, duties and accomplishments, employer's name and address, supervisor's name and phone number, starting and ending dates, hours per week, salary, indicate whether we may contact your current supervisor)
 - Other Qualifications** (Job-related training courses, skills, certificates and licenses, honors, awards and special accomplishments; for example, publications, memberships in professional or honor societies, leadership activities, public speaking and performance awards)
 - OF 306 Declaration for Federal Employment – Please sign Blocks 17a and 17b
 - SF-144 Statement of Prior Federal Service
 - Address Change Form W-4 Tax Form SF-1199-A Direct Deposit Form State Tax Withholding Form
 - SF256 Self Identification of Handicap SF 181 Race and National Origin Identification Form
 - I-9 Form Emergency Notification Data Dual Compensation Form Pre-Employment Questionnaire
 - Military Reserve/Guard Status Form Retired Military Data Form
 - Pre-Appointment Certificate Statement for Selective Service Registration
 - Cleared Installation Records Check (IRC) – **FOR JAPAN, KOREA & OKINAWA APPLICANTS ONLY**
 - SF-1152 – Beneficiary Form must be signed and dated. Must be signed by two witnesses
 - Signed EQIP certification pages Signed Request for Personnel Action (SF-52)
 - SF-87 (Two finger print cards required) Please see the school's secretary for more information
- ADDITIONAL DOCUMENTS REQUIRED FOR GUAM APPLICANTS ONLY:**
- Local Police Clearance
 - Transcripts – 60 semester credits or College degree required
 - Certification of Tuberculosis Screening

GEOGRAPHIC AVAILABILITY FORM FOR

SUBSTITUTE/AVID TUTOR APPLICATIONS

PLEASE READ CAREFULLY BEFORE COMPLETING THIS FORM

Applicants **must** select schools within their local commuting area. Local commuting area means the geographic area that usually constitutes an area in which you live and can reasonably be expected to travel back and forth daily to your usual employment.

Applicants will not be considered for positions outside their local commuting area.

I'm applying for (check one or both) Substitute Teaching Position AVID Tutor Position

Check all locations where you would accept employment based on the definition of "Local Commuting Area".

JAPAN DISTRICT SCHOOLS

<input type="checkbox"/> Yokota HS	<input type="checkbox"/> Sollars ES	<input type="checkbox"/> Yokosuka MS	<input type="checkbox"/> Zama HS
<input type="checkbox"/> Yokota MS	<input type="checkbox"/> Perry HS	<input type="checkbox"/> Sullivans ES	<input type="checkbox"/> Zama MS
<input type="checkbox"/> Yokota West ES	<input type="checkbox"/> Perry ES	<input type="checkbox"/> Ikego ES	<input type="checkbox"/> Arnn ES
<input type="checkbox"/> Mendel ES	<input type="checkbox"/> Kinnick HS	<input type="checkbox"/> Byrd ES	<input type="checkbox"/> Lanham ES
<input type="checkbox"/> Edgren HS	<input type="checkbox"/> Darby ES	<input type="checkbox"/> Sasebo ES	
<input type="checkbox"/> Cummings ES	<input type="checkbox"/> EJ King HS		

Please Check:

I understand that I can only be considered for schools within my local commuting area. The schools that I selected within the **Japan District** meet the definition of "Local Commuting Area" as described above.

Signature

Date

Check all locations where you would accept employment based on the definition of "Local Commuting Area".

KOREA DISTRICT SCHOOLS

<input type="checkbox"/> Daegu ES/MS	<input type="checkbox"/> Seoul ES	<input type="checkbox"/> Osan ES	<input type="checkbox"/> Camp Casey ES
<input type="checkbox"/> Daegu HS	<input type="checkbox"/> Seoul MS	<input type="checkbox"/> Osan MS	<input type="checkbox"/> Camp Humphreys Central ES
<input type="checkbox"/> CT Joy	<input type="checkbox"/> Seoul HS	<input type="checkbox"/> Osan HS	<input type="checkbox"/> Camp Humphreys HS

Please Check:

I understand that I can only be considered for schools within my local commuting area. The schools that I selected within the **Korea District** meet the definition of "Local Commuting Area" as described above.

Signature

Date

Check all locations where you would accept employment based on the definition of "Local Commuting Area".

OKINAWA DISTRICT SCHOOLS

<input type="checkbox"/> Kadena ES	<input type="checkbox"/> Ryukyu MS	<input type="checkbox"/> Stearly Heights ES	<input type="checkbox"/> Zukaran ES
<input type="checkbox"/> Kadena MS	<input type="checkbox"/> Amelia Earhart IS	<input type="checkbox"/> Lester MS	<input type="checkbox"/> Killen ES
<input type="checkbox"/> Kadena HS	<input type="checkbox"/> Bob Hope ES	<input type="checkbox"/> Kubasaki HS	<input type="checkbox"/> Kinser ES
<input type="checkbox"/> Bechtel ES			

Please Check:

I understand that I can only be considered for schools within my local commuting area. The schools that I selected within the **Okinawa District** meet the definition of "Local Commuting Area" as described above.

Signature

Date

Check all locations where you would accept employment based on the definition of "Local Commuting Area".

GUAM DISTRICT SCHOOL

<input type="checkbox"/> Guam HS	<input type="checkbox"/> Anderson ES
<input type="checkbox"/> McCool ES	<input type="checkbox"/> Anderson MS

Please Check:

I understand that I can only be considered for schools within my local commuting area. The schools that I selected within the **Guam District** meet the definition of "Local Commuting Area" as described above.

Signature

Date

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. First, Middle, Last, Suffix)



2. SOCIAL SECURITY NUMBER	3a. PLACE OF BIRTH (Include city and state or country)
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3b. ARE YOU A U.S. CITIZEN? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "NO", provide country of citizenship) ◆	4. DATE OF BIRTH (MM / DD / YYYY) ◆
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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

STATEMENT OF PRIOR FEDERAL SERVICE
To be Completed by Employee

1. Name (Last, First, Middle Initial)	2. Social Security Number	3. Date of Birth (Month, Day, Year)
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4. Does the application or resume that you submitted, for the position to which you are being appointed, list all of your Federal government civilian and uniformed service, including beginning and ending dates, as well as the type of appointment and work schedule for civilian service?
 Yes — If "Yes", check this block and skip to Item 8. No — If "No", check this block and complete Items 5 - 9.

5. List below your prior civilian service. Include service with the DC Government on appointments made before October 1, 1987.

NAME AND LOCATION OF AGENCY	FROM			TO			TYPE OF APPOINTMENT AND WORK SCHEDULE (Full-Time, Part-Time, or Intermittent)
	Year	Month	Day	Year	Month	Day	

6. During periods of employment shown in Item 5, did you have a total of more than 6 months' absence without pay during any one calendar year?
 Yes — If "Yes", list the following information. No — If "No", go to Item 7.

TYPE OF ABSENCE, IF KNOWN (LWOP, Furlough, Suspension, AWOL, or Placement in Nonpay Status)	FROM			TO			TOTAL		
	Year	Month	Day	Year	Month	Day	YEARS	MONTHS	DAYS

7. List all uniformed service below. List active service in any branch of the Armed Forces of the United States, including active duty as a reservist, and active service in the commissioned corps of the Public Health Service or the National Oceanic and Atmospheric Administration.

BRANCH OF SERVICE	FROM			TO			DISCHARGE (Honorable or Dishonorable)
	Year	Month	Day	Year	Month	Day	

8. Do you claim any type of veterans' preference which has not been verified?

- No Yes — Check one of the statements, if it applies to you. I claim preference as the:
 Spouse of a disabled veteran Mother of a deceased or disabled veteran Unmarried widow/widower of a veteran

9. **CERTIFICATION:** The prior Federal civilian and uniformed service listed on my application/resume and listed above constitutes my entire record of Federal employment. I have no other Federal service for which I want to claim credit.

Signature	Date
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ADDRESS CHANGE FORM

PRIVACY ACT STATEMENT

Personal information is solicited on this form. As required by the Privacy Act of 1974, we advise:

1. **AUTHORITY:** 37 U.S.C. 101 et seq. 5 U.S.C., Chapter 55; 10 U.S. C., Chapters 67, 71, and 871; Title 39, U.S.C. 406 and Title 10, U.S.C. 8013; E.O. 9397, Nov 1943.
2. **PRINCIPAL PURPOSES:** To permit address changes for the Joint Uniform Military Pay system (JUMPS), the Retired Pay Systems, the Reserve component pay systems, and the civilian pay systems. To maintain a record of current address for pay related matters and bonds.
3. **ROUTINE USES:** Information may be disclosed to the General Accounting Office to provide financial information; Federal, State, and local courts for tax and welfare purposes; U.S. Treasury to provide information on bonds purchased; and the Department of Justice in some cases for criminal prosecution, civil litigation, or investigative purposes.
4. **Disclosure:** Voluntary; however, failure to provide the requested information as well as the SSN may result in a delay in receipt of funds, Leave and Earning Statement, Net Pay Advices, and miscellaneous pay related documents.

NAME	SSN	SCHOOL/DIVISION
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NEW MAILING ADDRESS

STREET ADDRESS/PSC BOX	
CITY, STATE, APO/FPO	ZIP
EMPLOYEE SIGNATURE	DATE

Form W-4 (2012)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2012 expires February 18, 2013. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends).

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity

income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2012. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Future developments. The IRS has created a page on www.irs.gov for information about Form W-4, at www.irs.gov/w4. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted on that page.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A	<u> </u>
B	Enter "1" if: { <ul style="list-style-type: none"> • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. 	B	<u> </u>
C	Enter "1" for your spouse . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	<u> </u>
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D	<u> </u>
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E	<u> </u>
F	Enter "1" if you have at least \$1,900 of child or dependent care expenses for which you plan to claim a credit (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F	<u> </u>
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three to seven eligible children or less "2" if you have eight or more eligible children. • If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child	G	<u> </u>
H	Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ▶	H	<u> </u>
	For accuracy, complete all worksheets that apply. { <ul style="list-style-type: none"> • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2. • If you are single and have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$10,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld. • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below. 		

----- Separate here and give Form W-4 to your employer. Keep the top part for your records. -----

Form W-4 Department of the Treasury Internal Revenue Service	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="margin: 0;">▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</p>	OMB No. 1545-0074 2012
1 Your first name and middle initial	Last name	2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)	5 <u> </u>	
6 Additional amount, if any, you want withheld from each paycheck	6 \$ <u> </u>	
7 I claim exemption from withholding for 2012, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶ 7 <u> </u>		
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.		
Employee's signature (This form is not valid unless you sign it.) ▶		Date ▶
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2012 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions	1	\$ _____
2	Enter: $\left\{ \begin{array}{l} \$11,900 \text{ if married filing jointly or qualifying widow(er)} \\ \$8,700 \text{ if head of household} \\ \$5,950 \text{ if single or married filing separately} \end{array} \right\}$	2	\$ _____
3	Subtract line 2 from line 1. If zero or less, enter “-0-”	3	\$ _____
4	Enter an estimate of your 2012 adjustments to income and any additional standard deduction (see Pub. 505)	4	\$ _____
5	Add lines 3 and 4 and enter the total. (Include any amount for credits from the <i>Converting Credits to Withholding Allowances for 2012 Form W-4</i> worksheet in Pub. 505.)	5	\$ _____
6	Enter an estimate of your 2012 nonwage income (such as dividends or interest)	6	\$ _____
7	Subtract line 6 from line 5. If zero or less, enter “-0-”	7	\$ _____
8	Divide the amount on line 7 by \$3,800 and enter the result here. Drop any fraction	8	_____
9	Enter the number from the Personal Allowances Worksheet , line H, page 1	9	_____
10	Add lines 8 and 9 and enter the total here. If you plan to use the Two-Earners/Multiple Jobs Worksheet , also enter this total on line 1 below. Otherwise, stop here and enter this total on Form W-4, line 5, page 1	10	_____

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the Deductions and Adjustments Worksheet)	1	_____
2	Find the number in Table 1 below that applies to the LOWEST paying job and enter it here. However , if you are married filing jointly and wages from the highest paying job are \$65,000 or less, do not enter more than “3”	2	_____
3	If line 1 is more than or equal to line 2, subtract line 2 from line 1. Enter the result here (if zero, enter “-0-”) and on Form W-4, line 5, page 1. Do not use the rest of this worksheet	3	_____
Note. If line 1 is less than line 2, enter “-0-” on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.			
4	Enter the number from line 2 of this worksheet	4	_____
5	Enter the number from line 1 of this worksheet	5	_____
6	Subtract line 5 from line 4	6	_____
7	Find the amount in Table 2 below that applies to the HIGHEST paying job and enter it here	7	\$ _____
8	Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	\$ _____
9	Divide line 8 by the number of pay periods remaining in 2012. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2011. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	\$ _____

Table 1

Table 2

Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$5,000	0	\$0 - \$8,000	0	\$0 - \$70,000	\$570	\$0 - \$35,000	\$570
5,001 - 12,000	1	8,001 - 15,000	1	70,001 - 125,000	950	35,001 - 90,000	950
12,001 - 22,000	2	15,001 - 25,000	2	125,001 - 190,000	1,060	90,001 - 170,000	1,060
22,001 - 25,000	3	25,001 - 30,000	3	190,001 - 340,000	1,250	170,001 - 375,000	1,250
25,001 - 30,000	4	30,001 - 40,000	4	340,001 and over	1,330	375,001 and over	1,330
30,001 - 40,000	5	40,001 - 50,000	5				
40,001 - 48,000	6	50,001 - 65,000	6				
48,001 - 55,000	7	65,001 - 80,000	7				
55,001 - 65,000	8	80,001 - 95,000	8				
65,001 - 72,000	9	95,001 - 120,000	9				
72,001 - 85,000	10	120,001 and over	10				
85,001 - 97,000	11						
97,001 - 110,000	12						
110,001 - 120,000	13						
120,001 - 135,000	14						
135,001 and over	15						

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

BURDEN ESTIMATE STATEMENT

The estimated average burden associated with this collection of information is 10 minutes per respondent or recordkeeper, depending on individual circumstances. Comments concerning the accuracy of this burden estimate and suggestions for reducing this burden should be directed to the Financial Management Service, Facilities Management Division, Property & Supply Section, Room B-101, 3700 East-West Highway, Hyattsville, MD 20782 or the Office of Management and Budget, Paperwork Reduction Project (1510-0007), Washington, D.C. 20503.


PLEASE READ THIS CAREFULLY

All information on this form, including the individual claim number, is required under 31 USC 3322, 31 CFR 209 and/or 210. The information is confidential and is needed to prove entitlement to payments. The information will be used to process payment data from the Federal agency to the financial institution and/or its agent. Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the Direct Deposit/Electronic Funds Transfer Program.

INFORMATION FOUND ON CHECKS

Most of the information needed to complete boxes A, C, and F in Section 1 is printed on your government check:

- (A)** Be sure that payee's name is written exactly as it appears on the check. Be sure current address is shown.
- (C)** Claim numbers and suffixes are printed here on checks beneath the date for the type of payment shown here. Check the Green Book for the location of prefixes and suffixes for other types of payments.
- (F)** Type of payment is printed to the left of the amount.

United States Treasury 15-51 000		Check No. 0000 415785						
	<table border="1" style="margin: auto;"> <tr> <td>Month</td> <td>Day</td> <td>Year</td> </tr> <tr> <td style="text-align: center;">08</td> <td style="text-align: center;">31</td> <td style="text-align: center;">84</td> </tr> </table>	Month	Day	Year	08	31	84	AUSTIN, TEXAS
Month	Day	Year						
08	31	84						
<table border="1" style="margin: auto;"> <tr> <td style="width: 100px; height: 20px;"></td> <td style="width: 20px; text-align: center;">00</td> <td style="width: 20px; text-align: center;">C</td> </tr> </table>			00	C	28 28			
	00	C						
Pay to the order of 		<table border="1" style="margin: auto;"> <tr> <td style="width: 50px;">DOLLARS</td> <td style="width: 50px;">CTS</td> </tr> <tr> <td style="text-align: center;">\$****100</td> <td style="text-align: center;">00</td> </tr> </table>	DOLLARS	CTS	\$****100	00		
DOLLARS	CTS							
\$****100	00							
 (A)		 (F)						
NOT NEGOTIABLE								
":00000518": 041571926"								

SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS

Joint account holders should immediately advise both the Government agency and the financial institution of the death of a beneficiary. Funds deposited after the date of death or ineligibility, except for salary payments, are to be returned to the Government agency. The Government agency will then make a determination regarding survivor rights, calculate survivor benefit payments, if any, and begin payments.

CANCELLATION

The agreement represented by this authorization remains in effect until cancelled by the recipient by notice to the Federal agency or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so.

The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately advise the Federal agency if the authorization is cancelled by the financial institution. The financial institution cannot cancel the authorization by advice to the Government agency.

CHANGING RECEIVING FINANCIAL INSTITUTIONS

The payee's Direct Deposit will continue to be received by the selected financial institution until the Government agency is notified by the payee that the payee wishes to change the financial institution receiving the Direct Deposit. To effect this change, the payee will complete a new SF 1199A at the newly selected financial institution. It is recommended that the payee maintain accounts at both financial institutions until the transition is complete, i.e. after the new financial institution receives the payee's Direct Deposit payment.

FALSE STATEMENTS OR FRAUDULENT CLAIMS

Federal law provides a fine of not more than \$10,000 or imprisonment for not more than five (5) years or both for presenting a false statement or making a fraudulent claim.



State Withholding Request Form

SOCIAL SECURITY NUMBER ____ - ____ - ____		MARITAL STATUS	
		<input type="radio"/> SINGLE	<input type="radio"/> MARRIED
FIRST NAME (PLEASE PRINT CLEARLY) _____	M.I. _____	LAST NAME (PLEASE PRINT CLEARLY) _____	
ADDRESS _____			
CITY _____	STATE _____	ZIP CODE _____	

STATE WITHHOLDING INFORMATION

1. LIST THE STATE THAT YOU WOULD LIKE STATE TAXES TO BE WITHHELD	_____
2. ADDITIONAL AMOUNT, IF ANY, YOU WANT WITHHELD FROM EACH PAY PERIOD (ENTER IN WHOLE DOLLARS)	_____ .00
3. TOTAL NUMBER OF EXEMPTIONS	_____
4. I CERTIFY THAT I AM EXEMPT FROM WITHHOLDING BECAUSE MY RESIDENT STATE DOES NOT IMPOSE SUCH TAXES	<input type="checkbox"/> CHECK HERE
_____ (ENTER STATE OF RESIDENCE)	

I CERTIFY, UNDER PENALTIES PROVIDED BY LAW, THAT I AM ENTITLED TO THE NUMBER OF WITHHOLDING ALLOWANCES CLAIMED ON LINE 3 ABOVE, OR IF CLAIMING EXEMPTION FROM WITHHOLDING, THAT I AM ENTITLED TO CLAIM THE EXEMPT STATUS ON LINE 4.

EMPLOYEE SIGNATURE _____	DATE _____
--------------------------	------------

SELF-IDENTIFICATION OF DISABILITY
 (see instructions and Privacy Act information on reverse)

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, dysphagia, 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.

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

Privacy Act Statement

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.

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.

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.

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.**

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.)
 Yes No

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.

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.

Instructions

Read all instructions carefully before completing this form.

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the United States) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents presented have a future expiration date may also constitute illegal discrimination. For more information, call the Office of Special Counsel for Immigration Related Unfair Employment Practices at 1-800-255-8155.

What Is the Purpose of This Form?

The purpose of this form is to document that each new employee (both citizen and noncitizen) hired after November 6, 1986, is authorized to work in the United States.

When Should Form I-9 Be Used?

All employees (citizens and noncitizens) hired after November 6, 1986, and working in the United States must complete Form I-9.

Filling Out Form I-9

Section 1, Employee

This part of the form must be completed no later than the time of hire, which is the actual beginning of employment. Providing the Social Security Number is voluntary, except for employees hired by employers participating in the USCIS Electronic Employment Eligibility Verification Program (E-Verify). **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Noncitizen nationals of the United States are persons born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.

Employers should note the work authorization expiration date (if any) shown in **Section 1**. For employees who indicate an employment authorization expiration date in **Section 1**, employers are required to reverify employment authorization for employment on or before the date shown. Note that some employees may leave the expiration date blank if they are aliens whose work authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia or the Republic of the Marshall Islands). For such employees, reverification does not apply unless they choose to present

in Section 2 evidence of employment authorization that contains an expiration date (e.g., Employment Authorization Document (Form I-766)).

Preparer/Translator Certification

The Preparer/Translator Certification must be completed if **Section 1** is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete **Section 1** on his or her own. However, the employee must still sign **Section 1** personally.

Section 2, Employer

For the purpose of completing this form, the term "employer" means all employers including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors. Employers must complete **Section 2** by examining evidence of identity and employment authorization within three business days of the date employment begins. However, if an employer hires an individual for less than three business days, **Section 2** must be completed at the time employment begins. Employers cannot specify which document(s) listed on the last page of Form I-9 employees present to establish identity and employment authorization. Employees may present any List A document **OR** a combination of a List B and a List C document.

If an employee is unable to present a required document (or documents), the employee must present an acceptable receipt in lieu of a document listed on the last page of this form. Receipts showing that a person has applied for an initial grant of employment authorization, or for renewal of employment authorization, are not acceptable. Employees must present receipts within three business days of the date employment begins and must present valid replacement documents within 90 days or other specified time.

Employers must record in Section 2:

1. Document title;
2. Issuing authority;
3. Document number;
4. Expiration date, if any; and
5. The date employment begins.

Employers must sign and date the certification in **Section 2**. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they must be made for all new hires. Photocopies may only be used for the verification process and must be retained with Form I-9. **Employers are still responsible for completing and retaining Form I-9.**

For more detailed information, you may refer to the *USCIS Handbook for Employers* (Form M-274). You may obtain the handbook using the contact information found under the header "USCIS Forms and Information."

Section 3, Updating and Reverification

Employers must complete **Section 3** when updating and/or reverifying Form I-9. Employers must reverify employment authorization of their employees on or before the work authorization expiration date recorded in **Section 1** (if any). Employers **CANNOT** specify which document(s) they will accept from an employee.

- A. If an employee's name has changed at the time this form is being updated/reverified, complete Block A.
- B. If an employee is rehired within three years of the date this form was originally completed and the employee is still authorized to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.
- C. If an employee is rehired within three years of the date this form was originally completed and the employee's work authorization has expired **or** if a current employee's work authorization is about to expire (reverification), complete Block B; and:
 - 1. Examine any document that reflects the employee is authorized to work in the United States (see List A **or** C);
 - 2. Record the document title, document number, and expiration date (if any) in Block C; and
 - 3. Complete the signature block.

Note that for reverification purposes, employers have the option of completing a new Form I-9 instead of completing **Section 3**.

What Is the Filing Fee?

There is no associated filing fee for completing Form I-9. This form is not filed with USCIS or any government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the Privacy Act Notice below.

USCIS Forms and Information

To order USCIS forms, you can download them from our website at www.uscis.gov/forms or call our toll-free number at 1-800-870-3676. You can obtain information about Form I-9 from our website at www.uscis.gov or by calling 1-888-464-4218.

Information about E-Verify, a free and voluntary program that allows participating employers to electronically verify the employment eligibility of their newly hired employees, can be obtained from our website at www.uscis.gov/e-verify or by calling 1-888-464-4218.

General information on immigration laws, regulations, and procedures can be obtained by telephoning our National Customer Service Center at 1-800-375-5283 or visiting our Internet website at www.uscis.gov.

Photocopying and Retaining Form I-9

A blank Form I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed Form I-9s for three years after the date of hire or one year after the date employment ends, whichever is later.

Form I-9 may be signed and retained electronically, as authorized in Department of Homeland Security regulations at 8 CFR 274a.2.

Privacy Act Notice

The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Office of Special Counsel for Immigration-Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 12 minutes per response, including the time for reviewing instructions and completing and submitting the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., 3rd Floor, Suite 3008, Washington, DC 20529-2210. OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**

Department of Homeland Security
U.S. Citizenship and Immigration Services

**Form I-9, Employment
Eligibility Verification**

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification (To be completed and signed by employee at the time employment begins.)

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- A citizen of the United States
- A noncitizen national of the United States (see instructions)
- A lawful permanent resident (Alien #) _____
- An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - month/day/year)

Employee's Signature	Date (month/day/year)
----------------------	-----------------------

Preparer and/or Translator Certification (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	
Date (month/day/year)	

Section 2. Employer Review and Verification (To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)

List A	OR	List B	AND	List C
Document title: _____	OR	_____	AND	_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____				

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) _____ and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name and Address (Street Name and Number, City, State, Zip Code)		Date (month/day/year)

Section 3. Updating and Reverification (To be completed and signed by employer.)

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)
-----------------------------	--

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: _____	Document #: _____	Expiration Date (if any): _____
-----------------------	-------------------	---------------------------------

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date (month/day/year)
--	-----------------------

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be unexpired

LIST A

**Documents that Establish Both
Identity and Employment
Authorization**

LIST B

**Documents that Establish
Identity**

LIST C

**Documents that Establish
Employment Authorization**

	OR	
<p>1. U.S. Passport or U.S. Passport Card</p>		<p>1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address</p>
<p>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</p>		<p>1. Social Security Account Number card other than one that specifies on the face that the issuance of the card does not authorize employment in the United States</p>
<p>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</p>	<p>2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address</p>	<p>2. Certification of Birth Abroad issued by the Department of State (Form FS-545)</p>
<p>4. Employment Authorization Document that contains a photograph (Form I-766)</p>	<p>3. School ID card with a photograph</p>	<p>3. Certification of Report of Birth issued by the Department of State (Form DS-1350)</p>
<p>5. In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form</p>	<p>4. Voter's registration card</p>	<p>4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal</p>
	<p>5. U.S. Military card or draft record</p>	<p>5. Native American tribal document</p>
	<p>6. Military dependent's ID card</p>	
	<p>7. U.S. Coast Guard Merchant Mariner Card</p>	<p>6. U.S. Citizen ID Card (Form I-197)</p>
	<p>8. Native American tribal document</p>	
	<p>9. Driver's license issued by a Canadian government authority</p>	<p>For persons under age 18 who are unable to present a document listed above:</p>
<p>6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI</p>	<p>10. School record or report card</p>	<p>8. Employment authorization document issued by the Department of Homeland Security</p>
	<p>11. Clinic, doctor, or hospital record</p>	
	<p>12. Day-care or nursery school record</p>	

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)

RECORD OF EMERGENCY DATA

PRIVACY ACT STATEMENT

AUTHORITY: 5 USC 552, 10 USC 655, 1475 to 1480 and 2771, 38 USC 1970, 44 USC 3101, and EO 9397 (SSN).

PRINCIPAL PURPOSES: This form is used by military personnel and Department of Defense civilian and contractor personnel, collectively referred to as civilians, when applicable. For military personnel, it is used to designate beneficiaries for certain benefits in the event of the Service member's death. It is also a guide for disposition of that member's pay and allowances if captured, missing or interned. It also shows names and addresses of the person(s) the Service member desires to be notified in case of emergency or death. For civilian personnel, it is used to expedite the notification process in the event of an emergency and/or the death of the member. The purpose of soliciting the SSN is to provide positive identification. All items may not be applicable.

ROUTINE USES: None.

DISCLOSURE: Voluntary; however, failure to provide accurate personal identifier information and other solicited information will delay notification and the processing of benefits to designated beneficiaries if applicable.

INSTRUCTIONS TO SERVICE MEMBER

This extremely important form is to be used by you to show the names and addresses of your spouse, children, parents, and any other person(s) you would like notified if you become a casualty (other family members or fiancée), and, to designate beneficiaries for certain benefits if you die. IT IS YOUR RESPONSIBILITY to keep your Record of Emergency Data up to date to show your desires as to beneficiaries to receive certain death payments, and to show changes in your family or other personnel listed, for example, as a result of marriage, civil court action, death, or address change.

INSTRUCTIONS TO CIVILIANS

This extremely important form is to be used by you to show the names and addresses of your spouse, children, parents, and any other person(s) you would like notified if you become a casualty. Not every item on this form is applicable to you. This form is used by the Department of Defense (DoD) to expedite notification in the case of emergencies or death. It does not have a legal impact on other forms you may have completed with the DoD or your employer.

IMPORTANT: This form is divided into two sections: Section 1 - Emergency Contact Information and Section 2 - Benefits Related Information. READ THE INSTRUCTIONS ON PAGES 3 AND 4 BEFORE COMPLETING THIS FORM.

SECTION 1 - EMERGENCY CONTACT INFORMATION

1. NAME (Last, First, Middle Initial)		2. SSN	
3a. SERVICE/CIVILIAN CATEGORY <input type="checkbox"/> ARMY <input type="checkbox"/> NAVY <input type="checkbox"/> MARINE CORPS <input type="checkbox"/> AIR FORCE <input type="checkbox"/> DoD <input type="checkbox"/> CIVILIAN <input type="checkbox"/> CONTRACTOR			b. REPORTING UNIT CODE/DUTY STATION
4a. SPOUSE NAME (If applicable) (Last, First, Middle Initial) <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		b. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER	
5. CHILDREN a. NAME (Last, First, Middle Initial)	b. RELATIONSHIP	c. DATE OF BIRTH (YYYYMMDD)	d. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER
6a. FATHER NAME (Last, First, Middle Initial)	b. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER		
7a. MOTHER NAME (Last, First, Middle Initial)	b. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER		
8a. DO NOT NOTIFY DUE TO ILL HEALTH	b. NOTIFY INSTEAD		
9a. DESIGNATED PERSON(S) (Military only)		b. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER	
10. CONTRACTING AGENCY AND TELEPHONE NUMBER (Contractors only)			

SECTION 2 - BENEFITS RELATED INFORMATION

11a. BENEFICIARY(IES) FOR DEATH GRATUITY <i>(Military only)</i>	b. RELATIONSHIP	c. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER	d. PERCENTAGE
12a. BENEFICIARY(IES) FOR UNPAID PAY/ALLOWANCES <i>(Military only) NAME AND RELATIONSHIP</i>		b. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER	c. PERCENTAGE
13a. PERSON AUTHORIZED TO DIRECT DISPOSITION (PADD) <i>(Military only) NAME AND RELATIONSHIP</i>		b. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER	
14. CONTINUATION/REMARKS			
15. SIGNATURE OF SERVICE MEMBER/CIVILIAN <i>(Include rank, rate, or grade if applicable)</i>	16. SIGNATURE OF WITNESS <i>(Include rank, rate, or grade as appropriate)</i>		17. DATE SIGNED <i>(YYYYMMDD)</i>

INSTRUCTIONS FOR PREPARING DD FORM 93

(See appropriate Service Directives for supplemental instructions for completion of this form at other than MEPS)

All entries explained below are for electronic or typewriter completion, except those specifically noted. If a computer or typewriter is not available, print in black or blue-black ink insuring a legible image on all copies. Include "Jr.," "Sr.," "III" or similar designation for each name, if applicable. When an address is entered, include the appropriate ZIP Code. If the member cannot provide a current address, indicate "unknown" in the appropriate item. Addresses shown as P.O. Box Numbers or RFD numbers should indicate in Item 14, "Continuations/Remarks", a street address or general guidance to reach the place of residence. In addition, the notation "See Item 14" should be included in the item pertaining to the particular next of kin or when the space for a particular item is insufficient. If the address for the person in the item has been shown in a preceding item, it is unnecessary to repeat the address; however, the name must be entered. Those items that are considered not applicable to civilians will be left blank.

ITEM 1. Enter full last name, first name, and middle initial.

ITEM 2. Enter social security number (SSN).

ITEM 3a. Service. **Military:** Mark X in appropriate block. **Civilian:** Mark two blocks as appropriate. Examples: an Army civilian would mark Army and either Civilian or Contractor; a DoD civilian, without affiliation to one of the Military Services, would mark DoD and then either Civilian or Contractor as appropriate.

ITEM 3b. Reporting Unit Code/Duty Station. See Service Directives.

ITEM 4a. Spouse Name. Enter last name (if different from Item 1), first name and middle initial on the line provided. If single, divorced, or widowed, mark appropriate block.

ITEM 4b. Address and Telephone Number. Enter the "actual" address and telephone number, not the mailing address. Include civilian title or military rank and service if applicable. If one of the blocks in 4a is marked, leave blank.

ITEM 5a-d. Children. Enter last name (only if different from Item 1) first name and middle initial, relationship, and date of birth of all children. If none, so state. Include illegitimate children if acknowledged by member or paternity/maternity has been judicially decreed. Relationship examples: son, daughter, stepson or daughter, adopted son or daughter or ward. Date of birth example: 19950704. For children not living with the member's current spouse, include address and name and relationship of person with whom residing in item 5d.

ITEM 6a. Father Name. Last name, first name and middle initial.

ITEM 6b. Address and Telephone Number of Father. If unknown or deceased, so state. Include civilian title or military rank and service if applicable. If other than natural father is listed, indicate relationship.

ITEM 7a. Mother Name. Last name, first name and middle initial.

ITEM 7b. Address and Telephone Number of Mother. If unknown or deceased, so state. Include civilian title or military rank and service if applicable. If other than natural mother is listed, indicate relationship.

ITEM 8. Persons Not to be Notified Due to Ill Health.

a. List relationship, e.g., "Mother," of person(s) listed in Items 4, 5, 6, or 7 who are not to be notified of a casualty due to ill health. If more than one child, specify, e.g., "daughter Susan." Otherwise, enter "None".

b. List relationship, e.g., "Father" or name and address of person(s) to be notified in lieu of person(s) listed in item 8a. If "None" is entered in Item 8a, leave blank.

ITEM 9a. This item will be used to record the name of the person or persons, if any, other than the member's primary next of kin or immediate family, to whom information on the whereabouts and status of the member shall be provided if the member is placed in a missing status. Reference 10 USC, Section 655. **NOT APPLICABLE to civilians.**

ITEM 9b. Address and telephone number of Designated Person(s). **NOT APPLICABLE to civilians.**

ITEM 10. Contracting Agency and Telephone Number (**Contractors only**). **NOT APPLICABLE to military personnel.** Civilian contractors will provide the name of their contracting agency and its telephone number. Example: XYZ Electric, (703) 555-5689. The telephone number should be to the company or corporation's personnel or human resources office.

ITEM 11a. Beneficiary(ies) for Death Gratuity (**Military only**). Enter first name(s), middle initial, and last name(s) of the person(s) to receive death gratuity pay. A member may designate one or more persons to receive all or a portion of the death gratuity pay. The designation of a person to receive a portion of the amount shall indicate the percentage of the amount, to be specified only in 10 percent increments, that the person may receive. If the member does not wish to designate a beneficiary for the payment of death gratuity, enter "None," or if the full amount is not designated, the payment or balance will be paid as follows:

- (1) To the surviving spouse of the person, if any;
- (2) To any surviving children of the person and the descendants of any deceased children by representation;
- (3) To the surviving parents or the survivor of them;
- (4) To the duly appointed executor or administrator of the estate of the person;
- (5) If there are none of the above, to other next of kin of the person entitled under the laws of domicile of the person at the time of the person's death.

The member should make specific designations, as it expedites payment.

INSTRUCTIONS FOR PREPARING DD FORM 93

(Continued)

ITEM 11a. (Continued) Seek legal advice if naming a minor child as a beneficiary. If a member has a spouse but designates a person other than the spouse to receive all or a portion of the death gratuity pay, the Service concerned is required to provide notice of the designation to the spouse. **NOT APPLICABLE to civilians.**

Item 11b. Relationship. **NOT APPLICABLE to civilians.**

ITEM 11c. Enter beneficiary(ies) full mailing address and telephone number to include the ZIP Code. **NOT APPLICABLE to civilians.**

ITEM 11d. Show the percentage to be paid to each person. Enter 10%, 20%, 30%, up to 100% as appropriate. The sum shares must equal 100 percent. If no percent is indicated and more than one person is named, the money is paid in equal shares to the persons named. **NOT APPLICABLE to civilians.**

ITEM 12a. Beneficiary(ies) for Unpaid Pay/Allowance (Military only). Enter first name(s), middle initial, last name(s) and relationship of person to receive unpaid pay and allowances at the time of death. The member may indicate anyone to receive this payment. If the member designated two or more beneficiaries, state the percentage to be paid each in item 10c. If the member does not wish to designate a beneficiary, enter "By Law." The member is urged to designate a beneficiary for unpaid pay and allowances as payment will be made to the person in order of precedence by law (10 USC 2771) in the absence of a designation. Seek legal advice if naming a minor child as beneficiary. **NOT APPLICABLE to civilians.**

ITEM 12b. Enter beneficiary(ies) full mailing address and telephone number to include the ZIP Code. **NOT APPLICABLE to civilians.**

ITEM 12c. If the member designated two or more beneficiaries, state the percentage to be paid each in this section. The sum shares must equal 100 percent. **NOT APPLICABLE to civilians.**

ITEM 13a. Enter the name and relationship of the Person Authorized to Direct Disposition (PADD) of your remains should you become a casualty. Only the following persons may be named as a PADD: surviving spouse, blood relative of legal age, or adoptive relatives of the decedent. If neither of these three can be found, a person standing in loco parentis may be named. **NOT APPLICABLE to civilians.**

ITEM 13b. Address and telephone number of PADD. **NOT APPLICABLE to civilians.**

ITEM 14. Continuations/Remarks. Use this item for remarks or continuation of other items, if necessary. Prefix entry with the number of the item being continued; for example, 5/John J./son/ 19851220/321 Pecan Drive, Schertz TX 78151. Also use this item to list name, address, and relationship of other persons the member desires to be notified. Other dependents may also be listed. This block offers the greatest amount of flexibility for the member to record other important information not otherwise requested but considered extremely useful in the casualty notification and assistance process. Besides continuing information from other blocks on this form, the member may desire to include additional information such as: NOK language barriers, location or existence of a Will, additional private insurance information, other family member contact numbers, etc. If additional space is required, attach a supplemental sheet of standard bond paper with the information.

ITEM 15. Signature of Service Member/Civilian. Check and verify all entries and sign all copies in ink as follows: First name, middle initial, last name. Include rank, rate, or grade if applicable. May be electronically signed (see DoD Instruction 1300.18 for guidelines).

ITEM 16. Signature of Witness. Have a witness (disinterested person) sign all copies in ink as follows: First name, middle initial, last name. Include rank, rate, or grade as appropriate. A witness signature is not required for electronic versions of the DD Form 93 (see DoD Instruction 1300.18).

ITEM 17. Date the member or civilian signs the form. This item is an ink entry and must be completed on all copies.

DUAL COMPENSATION ACT

The DUAL COMPENSATION ACT prohibits an individual from receiving pay from more than one position for more than an aggregate of forty (40) hours of work in one calendar week. This prohibition applies to employees paid from either appropriated or non-appropriated funds, or a combination thereof, and includes temporary, part-time and intermittent appointments.

This law is not applicable to enlisted off-duty military personnel in relation to their military duty; however, in the event an off-duty military member is appointed to more than one non-appropriated fund (NAF) position, the forty (40) hour aggregate is applicable to the hours worked in the NAF position.

CERTIFICATION

I have read and understand the provisions of the DUAL COMPENSATION ACT cited above and certify that:

- I am not currently employed in a position paid from either appropriated or non-appropriated funds.
- I am currently employed in the following position:

Position Title: _____

Grade: _____

Work Schedule Full-time/Part-time/Intermittent: _____

Number of work hours per week: _____

Organization: _____

Supervisor's Name: _____

Telephone Number: _____

I understand that violation of the DUAL COMPENSATION ACT will result in my being indebted to the United States Government and may require repayment of wages erroneously earned.

I certify that my statement above is true, complete and correct to the best of my knowledge.

Printed Name

Date

Signature

**PRE-EMPLOYMENT QUESTIONNAIRE
TO DETERMINE ELIGIBILITY FOR EMPLOYMENT**

INSTRUCTIONS: TO BE COMPLETED BY CANDIDATES WHO ARE LIVING IN THE OVERSEAS AREA. The purpose of this questionnaire is to obtain information in order to determine the eligibility of applicants for Department of Defense Dependents Schools (DoDDS) positions serviced by the DoDDS Personnel Center. This form is not intended to establish overseas entitlements. Please complete all questions and return the completed form with your application for employment. Enter "N/A" if a statement is not applicable.

1. Are you a citizen of the United States? Yes _____ No _____
Also, list additional countries you are a citizen of:

2. I have resided in _____ since _____
(country name) (date)
3. My reason for being in this country is: _____
4. _____ I arrived in this country to be with my military/DoD civilian sponsor, but my trip was not at Government expense (i.e., I am not command sponsored).
5. I am an employee or the family member of an employee of a private firm doing work in this country. The firm's name is: _____. The expiration of this assignment is: _____.
6. _____ I am on contract/I am a family member of a person hired on contract to support the U.S. Forces. The contract is with _____. The contract also provides me with an U.S. Forces I.D card (Yes or No) _____. (company name)
7. _____ I am retired/retiring from active military service. The date of retirement is/was: _____.
8. I have _____ I have not _____ been issued a work permit from the host country.
9. I have _____ I have not _____ been employed since being in this country.

Name of employer(s), dates, and location(s) of work:

10. I own _____ I do not own _____ a residence in the host country.
11. I have _____ I have not _____ paid income taxes to the host country.
12. Other: Please use the space below to explain.

I understand that a false statement on my part of this questionnaire may be grounds for not hiring me or grounds for removing me after I begin work. I understand it is my responsibility to notify the Personnel Center promptly of any changes in the information provided in this questionnaire.

(Signature) Date _____

Printed Name _____

MILITARY RESERVE OR GUARD STATUS CODE

NAME: _____

Please check the appropriate line to indicate your military reserve or guard status.

- 0. No military status.
- 1. Active Reservist – Consists of members that are assigned to a reserve unit. Both obligated and non-obligated members having a training and must participate in Annual Training, (AT). Personnel who are assigned to an authorized position mobilization TDA, and who require pre-mobilization experience and training. These personnel are considered available for mobilization or national emergency, and a minimum of 12 days of AT, exclusive of travel time, is required.
- 2. Individual Ready Reserve – Consists of members of the Individual Ready Reserve (IRR). These personnel are not assigned to a reserve unit. This category also includes IRR members who are mobilization designees (MOB-DES), i.e., assigned to authorized augmentation positions on mobilization TDA.
- 3. Standby Reserve – Consists of active members who are permitted to participate voluntarily in Inactive Duty Training (IDT), but without pay or travel allowance. Retirement points or promotion credit, or both, may be earned. These personnel are non-unit members.
- 4. Retired Reserve – Consists of former members of the reserve programs as an Officer, Warrant Officer, or Enlisted Person. THESE RESERVISTS ARE NOT RECEIVING RETIREMENT PAY. (Employees drawing retirement pay from the Reserve Program must be coded in the Retired Military data element).
- 5. Army Reserve Technician/Active Reservist (Dual Status) – Same as code 1 above, plus serving in the Army Reserve Technician Program. Meaning that his/her duties as a civilian employee are the same as reservists.
- 6. Army Reserve Technician/Ready Reserve (Dual Status) – Employees covered by code 2 above who are also serving in the Army Reserve Technician Program.
- 7. Army Reserve Technician/Standby Reserve (Dual Status) – Same as code 3 above, plus serving in the Army Reserve Technician Program.
- 8. Army Reserve Technician (Non-Dual Status) – An individual who is a civilian employee working under the Army Reserve Technician Program, but not serving in the Reserve Program.
- 9. All Other Uniformed Services – Consists of all other members that are assigned to an Uniformed Services Unit (i.e., Air National Guard, Army National Guard, or Coast Guard).

I will notify the Pacific Personnel Center when there is a change in my reserve/guard status.

Signature

Appointment Date: _____

RETIRED MILITARY DATA

NAME: _____

1. Please check the appropriate line which identifies your recall status as retired military.

- _____ a. Officer-Regular Component-has pre-assignment recall orders.
- _____ b. Officer-Regular Component-No pre-assignment recall orders.
- _____ c. Warrant Officer- Regular Component-has pre-assignment recall orders.
- _____ d. Warrant Officer- Regular Component- No pre-assignment recall orders.
- _____ e. Officer- Non-regular Component- Has pre-assignment recall orders.
- _____ f. Officer- Non-regular Component- No pre-assignment recall orders.
- _____ g. Warrant Officer- Non-regular Component- Has pre-assignment recall orders.
- _____ h. Warrant Officer- Non-regular Component- No pre-assignment recall orders.
- _____ i. Enlisted Personnel- Regular Component- Has pre-assignment recall orders.
- _____ j. Enlisted Personnel- Regular Component- No pre-assignment recall orders.
- _____ k. Enlisted Personnel- Non-regular Component- Has pre-assignment recall orders.
- _____ l. Enlisted Personnel- Non-regular Component- No pre-assignment recall orders.
- _____ m. None of the above.

2. Please answer by marking the appropriate box, as it could affect your retention standing:

- a. Was your retirement based on disability which resulted from an injury or disease received in the line of duty as a direct result of armed conflict?
_____ No _____ Yes (Verification from service department will be obtained)
- b. Was your retirement based on a disability which was caused by an instrumentality of war and occurred in the line of duty during a period of war?
_____ No _____ Yes (Verification from service department will be obtained)

PRE-APPOINTMENT CERTIFICATION STATEMENT FOR
SELECTIVE SERVICE REGISTRATION

IMPORTANT NOTICE: **If you are a male born after December 31, 1959**, and you want to be employed by the Federal Government, you must (subject to certain exceptions) be registered with the Selective Service System.

PRIVACY ACT STATEMENT: We need information on your registration with the Selective Service System to see whether you are affected by the laws we must follow in deciding who may be employed by the Federal Government.

CRIMINAL PENALTY STATEMENT: A false statement by you may be grounds for not hiring you, or for firing you after you begin work. Also, you may be punished by fine or imprisonment (U.S. code, Title 18, Section 1001).

REVIEW: If your employing agency has informed you that you cannot be appointed to a position in an **executive agency because of your failure to register, and you wish to establish that your non-compliance** with the law was neither knowing nor willful, you may write to:

U.S. Office of Personnel Management
NACI Center
IOD-SAB
Boyers, PA 16018

CERTIFICATION OF REGISTRATION STATUS

- I certify that **I am registered** with the Selective Service System.
- I certify that **I am not required** to be registered with the Selective Service System.

(Legal Signature)

(Date)

**CRIMINAL HISTORY BACKGROUND CHECK FOR INDIVIDUALS IN
TEACHING/CHILDCARE SERVICES POSITIONS**

RELEASE/CONSENT STATEMENT

AUTHORITY: 42USC 1341 AND 10USC 3013

PRINCIPAL PURPOSE: To comply with public law 101-647, Section 231, Crime Control Act of 1990, and DODI 1402.5, Criminal History Background Checks on Individuals in Child Care Services Positions 19 Jan 93.

DISCLOSURE: Mandatory. Failure to disclose this information precludes consideration of an applicant for employment in the Department of Defense Dependents Schools.

EMPLOYEE STATEMENT:

I understand that the employee is obligated to require a records check as a condition of employment in accordance with PL 101.647, that I have a right to obtain a copy of the report provided to the employer and a right to challenge the accuracy and completeness of any information in the report. I have been advised that my being hired/retained will be based upon successful completion of the background checks. I understand that Installation Records Checks (IRC) will be performed in addition to the National Agency Check with Inquiries (NACI).

The following is a list of state(s) in which I have resided in for the past 5 years (if you resided in that state under the name other than shown on your application, please give the name(s) used while a resident/employee in that state).

STATE	FROM/TO (DATES)	OTHER NAMES USED
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The following is a list of DoD installations where I have resided or worked within the last two years.

DoD Installation	From/TO (DATES)	OTHER NAMES USED
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby authorize the DoDDS Pacific Personnel Center to forward the information attached for the purpose of conducting the required checks.

Print Name

Date

Signature

Date



DEPARTMENT OF DEFENSE EDUCATION ACTIVITY PACIFIC
DIRECTOR'S OFFICE
UNIT 35007
APO AP 96376-5007

MEMORANDUM FOR

SUBJECT: Installation Records Check (IRC)

Reference: DODI 1402, Criminal History Background Checks on Individuals in Child Care Services

We request a records review on the person named below who has applied for a Teaching or Educational Support position with the Department of Defense Dependent Schools. A statement from the applicant authorizing release of this information is attached.

- a. Applicant's Name: _____
- b. Other Names Used: _____
- c. SSN: _____
- d. Date of Birth: _____
- e. Place of Birth/Home of Record: _____

If the records review reveals any derogatory information, please fax it directly to our offices at 098-957-4517. For questions pertaining to this records check, please contact us at DSN 644-5866.

A handwritten signature in blue ink that reads "Amina Ridge".

Amina Ridge
Deputy Chief, Human Resources Division
DoDEA Pacific Director's Office

Attachment: As Stated

FROM: PMO ADMIN SECTION

TO: DoDDS Pacific Director's Office, Attn: Human Resources Division

- a. Background check is clear.
- b. Background check reveals questionable information.

Printed name of Certifying Official: _____

Signature of Certifying Official: _____

Date: _____

Designation of Beneficiary

Unpaid Compensation of Deceased Civilian Employee

Important:
Read all instructions before
filling in this form

A. Identification

Name <i>(last, first, middle)</i>		Date of birth <i>(mm, dd, yyyy)</i>	Social Security Number
Department or agency in which presently employed <i>(or former department or agency)</i> :			
Department or agency	Bureau	Division	Location <i>(City, state and ZIP code)</i>

I, the employee named above, canceling any and all previous Designations of Beneficiary heretofore made by me, do now designate the beneficiary or beneficiaries named below to receive any **unpaid compensation** due and payable after my death. I understand that this Designation of Beneficiary relates solely to money due as defined in 5 U.S.C. 5581, 5582, 5583, and in no way will affect the disposition of any benefit which may become payable under the Retirement or Group Life Insurance Acts applicable to my Government service. I further understand that this Designation of Beneficiary will remain in full force and effect until (1) I expressly change or revoke it in writing, (2) I transfer to another agency, or (3) I am reemployed by the same or another department or agency of the Government.

B. Information Concerning The Beneficiaries (See Examples of Designations):

First name, middle initial, and last name of each beneficiary	Address (Including ZIP code) of each beneficiary	Relationship	Share to be paid to each beneficiary
Date of designation <i>(mm, dd, yyyy)</i>	Your signature		Total = %

C. Witnesses (A witness is not eligible to receive payment as a beneficiary):

We, the undersigned, certify that this statement was signed in our presence.

Signature of witness	Number and street	City, state and ZIP code
Signature of witness	Number and street	City, state and ZIP code

Receiving agency certification

I have reviewed this designation and certify that the designated shares total 100% and that no witnesses are designated as beneficiaries.

Date received	Signature	Date
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Type or print your return address to insure return

Important - The filing of this form will completely cancel any Designation of Beneficiary you may have previously filed. Be sure to name in this form all persons you wish to designate as beneficiaries of any unpaid compensation payable at your death.

Examples of Designations

1. HOW TO DESIGNATE ONE BENEFICIARY

Do not write names as M.E. Brown or as Mrs. John H. Brown. If you want to designate your estate as beneficiary, enter "My estate" in the beneficiary column.

First name, middle initial, and last name of each beneficiary	Address (Including ZIP code) of each beneficiary	Relationship	Share to be paid to each beneficiary
Mary E. Brown	214 Central Avenue Muncie, IN 47303	Domestic Partner	100%

2. HOW TO DESIGNATE MORE THAN ONE

Be sure that the shares to be paid to the several beneficiaries add up to 100 percent.

First name, middle initial, and last name of each beneficiary	Address (Including ZIP code) of each beneficiary	Relationship	Share to be paid to each beneficiary
Alice M. Long	509 Canal Street Red Bank, NJ 07701	Aunt	25%
Joseph P. Brady	360 Williams Street Red Bank, NJ 07701	Nephew	25%
Catherine L. Rowe	792 Broadway Whiting, IN 46394	Mother	50%

3. HOW TO DESIGNATE A CONTINGENT BENEFICIARY

First name, middle initial, and last name of each beneficiary	Address (Including ZIP code) of each beneficiary	Relationship	Share to be paid to each beneficiary
John M. Parrish, if living	810 West 180th Street New York, NY 10033	Father	100%
Otherwise to: Susan A. Parrish	810 West 180th Street New York, NY 10033	Sister	100%

4. HOW TO CANCEL A DESIGNATION OF BENEFICIARY AND EFFECT PAYMENT UNDER ORDER OF PRECEDENCE (See back of duplicate)

First name, middle initial, and last name of each beneficiary	Address (Including ZIP code) of each beneficiary	Relationship	Share to be paid to each beneficiary
Cancel prior designations			

PART D – Remarks by Requesting Office

(Note to Supervisors: Do you know of additional or conflicting reasons for the employee’s resignation/retirement?
If "YES", please state these facts on a separate sheet and attach to SF 52.)

YES NO

PART E – Employee Resignation/Retirement

Privacy Act Statement

You are requested to furnish a specific reason for your resignation or retirement and a forwarding address. Your reason may be considered in any future decision regarding your re-employment in the Federal service and may also be used to determine your eligibility for unemployment compensation benefits. Your forwarding address will be used primarily to mail you copies of any documents you should have or any pay or compensation to which you are entitled.

This information is requested under authority of sections 301, 3301, and 8506 of title 5, U.S. Code. Sections 301 and 3301 authorize OPM and agencies to issue

regulations with regard to employment of individuals in the Federal service and their records, while section 8506 requires agencies to furnish the specific reason for termination of Federal service to the Secretary of Labor or a State agency in connection with administration of unemployment compensation programs.

The furnishing of this information is voluntary; however, failure to provide it may result in your not receiving: (1) your copies of those documents you should have; (2) pay or other compensation due you; and (3) any unemployment compensation benefits to which you may be entitled.

1. Reasons for Resignation/Retirement (NOTE: Your reasons are used in determining possible unemployment benefits. Please be specific and avoid generalizations. Your resignation/retirement is effective at the end of the day – midnight – unless you specify otherwise.)

2. Effective Date	3. Your Signature	4. Date Signed	5. Forwarding Address (Number, Street, City, State, Zip Code)
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PART F – Remarks for SF 50