Use TAB key or Mouse to move between data fields

Approved Exception To SF 171
OMB No. 2900-0205
Estimated burden: 30 minutes

Department of Veterans Affairs

APPLICATION FOR RESIDENTS

SEE LAST PAGE FOR PAPERWORK REDUCTION ACT, PRIVACY ACT AND INFORMATION ABOUT DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER.

INSTRUCTIONS: Please submit this application furnishing all information in sufficient detail to enable the Department of Veterans Affairs to determine your eligibility for appointment in Veterans Health Administration.
Type, or print in ink. If additional space is required, please attach a separate sheet and refer to items being answered by number.

1. NAME (Last, First, Middle)

2. APPLICATION FOR *(Check one)*
☐ GENERAL PRACTICE ☐ SPECIALTY (Identify Below)

3. PRESENT ADDRESS (Street Address 1) STREET ADDRESS 2 APT. NO.
CITY STATE ZIP CODE COUNTRY

4. TELEPHONE NUMBER (Include Area Code)
4A. RESIDENCE
4B. BUSINESS

5. DATE OF BIRTH

6. PLACE OF BIRTH STATE COUNTRY

7. SOCIAL SECURITY NUMBER

8A. CITIZENSHIP
☐ U.S. CITIZEN BY BIRTH ☐ NATURALIZED U.S. CITIZEN ☐ NOT A U.S. CITIZEN (Complete item 8B)

8B. COUNTRY OF WHICH YOU ARE A CITIZEN

9. DESIRED STARTING DATE OF RESIDENCY

10. ARE YOU A PARTICIPANT IN THE CURRENT NATIONAL RESIDENT MATCHING PROGRAM
☐ YES ☐ NO

11A. ARE YOU A DIPLOMATE OF THE NATIONAL BOARD OF MEDICAL EXAMINERS
☐ YES ☐ NO (If "YES" complete items 11B and 11C)

11B. NUMBER OF DIPLOMA

11C. DATE OF DIPLOMA

NOTE: Complete item 12A, 12B, 12C, or 12D, ONLY if you are not a U.S. Citizen.

12A. IMMIGRANT	12B. EXCHANGE VISITOR		12C. OTHER NON-IMMIGRANT		12D. FORM IAP-66
"A" NUMBER	VISA TYPE	VISA NUMBER	VISA TYPE	VISA NUMBER	DO YOU HAVE A VALID FORM IAP-66 ☐ YES ☐ NO
DATE	ISSUE DATE	EXPIRATION DATE	ISSUE DATE	EXPIRATION DATE	DATE OF LAST VALIDATION

I - ACTIVE U.S. MILITARY DUTY

13A. DATE FROM	13B. DATE TO	13C. SERIAL OR SERVICE NO.	13D. BRANCH OF SERVICE	13E. TYPE OF DISCHARGE
				☐ HONORABLE ☐ OTHER (Explain on seperate sheet)

II - LICENSURE, DEA CERTIFICATION AND CLINICAL PRIVILEGES

14A. LIST ALL STATES/TERRITORIES IN WHICH YOU ARE NOW OR HAVE EVER BEEN LICENSED (If not held now, explain on separate sheet)	14B. LICENSE NO.	14C. CURRENT REGISTRATION (If "NO" explain on separate sheet)			14D. EXPIRATION DATE
		YES	NO	NOT REQUIRED	
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	

15. DO YOU HAVE OR HAVE YOU EVER HAD ANY LICENSE REVOKED, SUSPENDED, DENIED, RESTRICTED, LIMITED OR ISSUED/ PLACED IN A PROBATIONAL STATUS OR VOLUNTARILY RELINQUISHED
☐ YES ☐ NO (If "YES" explain on separate sheet)

16A. NUMBER OF CURRENT OR MOST RECENT DEA (DRUG ENFORCEMENT ADMINISTRATION) CERTIFICATE

16B. DATE OF EXPIRATION

17. HAVE YOU EVER HAD A DEA CERTIFICATE REVOKED, SUSPENDED, LIMITED, RESTRICTED IN ANY WAY OR VOLUNTARILY RELINQUISHED
☐ YES ☐ NO (If "YES" explain on separate sheet)

18A. DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD CLINICAL PRIVILEGES AT ANY HEALTH CARE INSTITUTION OR AGENCY
☐ YES ☐ NO (If "YES" complete Item 18B)

18B. NAME AND ADDRESS OF CURRENT OR MOST RECENT INSTITUTION, AGENCY OR ORGANIZATION WHERE HELD

18C. HAVE ANY OF YOUR CLINICAL PRIVILEGES EVER BEEN DENIED, REVOKED, SUSPENDED, REDUCED, LIMITED, NOT RENEWED, OR VOLUNTARILY RELINQUISHED
☐ YES ☐ NO (If "YES" explain on separate sheet)

III - THIS SECTION TO BE COMPLETED BY FACILITY DIRECTOR OR DESIGNEE

▶ **CERTIFICATION:** **I certify that I have verified licensure and registration with State boards, and sighted visa or evidence of citizenship. Board certification has been verified (if appropriate).**

19. EVIDENCE HAS BEEN SIGHTED IN REGARDS TO:
☐ NATURALIZED CITIZENSHIP
☐ VISA
☐ FULL LICENSURE / REGISTRATION
☐ ECFMG CERTIFICATION
☐ CLERKSHIPS TAKEN IN THE U.S.

OR

☐ RESIDENT CREDENTIAL VERIFICATION LETTER

20A. SIGNATURE OF FACILITY DIRECTOR OR DESIGNEE
Edward J. Sherwood, M. D.

20B. TITLE
Chief of Staff

20C. DATE

IV - PROFESSIONAL LIABILITY INSURANCE

21A. PRESENT PROFESSIONAL LIABILITY INSURANCE CARRIER	21B. DATE COVERAGE BEGAN	21C. NAME OF PRIOR CARRIERS	21D. DATES OF COVERAGE FROM	TO	22. HAS ANY CARRIER EVER CANCELLED, DENIED OR REFUSED TO RENEW YOUR INSURANCE
			1.		☐ YES ☐ NO (If "YES" explain on separate sheet)
			2.		
			3.		

V - MEDICAL/DENTAL SCHOOLS ATTENDED

23A. NAME OF SCHOOL	23B. ADDRESS (City, State and ZIP Code)	23C. SUBJECT/ MAJOR	23D. YEARS ATTENDED	23E. GRADUATED MONTH	YEAR	23F. DEGREE

24. IF YOU ARE NOT A UNITED STATES OR CANADIAN MEDICAL/DENTAL SCHOOL GRADUATE, HAVE YOU SUCCESSFULLY COMPLETED THE REQUIREMENTS OF A MEDICAL/DENTAL EDUCATION EQUIVALENCY PROGRAM (e.g., examination or "Fifth Pathway"). (If "YES", indicate name of program, date completed, and if applicable, certificate number, plus whether permanent or interim.)

☐ YES ☐ NO

NOTE: If you are not a United States or Canadian medical/dental school graduate, list on a separate sheet all clinical clerkships you have served, with institution (name and address), inclusive dates of service, program type, and program contact for each clerkship.

NOTE: For items 25 through 28, specify when service was as a paid Federal employee, including the VA, the U.S. Military, and the Public Health Service.

VI - DENTAL GENERAL PRACTICE RESIDENCIES

25A. NAME OF HOSPITAL	25B. ADDRESS (City, State and ZIP Code)	25C. DATE COMPLETED	25D. NO. OF MONTHS

VII - SPECIALTY/SUBSPECIALTY RESIDENCIES

26A. NAME OF HOSPITAL OR INSTITUTION (or military assignment and rank)	26B. ADDRESS (City, State and ZIP Code)	26C. SPECIALTY/ SUBSPECIALTY	26D. TRAINING COMPLETED MONTH	YEAR	26E. NO. OF MONTHS SERVED	26F. AMOUNT OF TIME APPROVED BY SPECIALTY BOARD

27A. HAVE YOU EVER SERVED AS AN ADMINISTRATIVE CHIEF RESIDENT	27B. DATES OF SERVICE
☐ YES ☐ NO	

VIII - PROFESSIONAL EXPERIENCE (IN OTHER THAN MEDICAL/DENTAL TRAINEE STATUS)

28A. EMPLOYER	28B. ADDRESS (City, State and ZIP Code)	28C. POSITION (Where applicable also specify whether General Practitioner or Specialist)	28D. FULL TIME	28E. PART-TIME (average hours per week)	28F. DATES EMPLOYED FROM	TO
			☐	☐		
			☐	☐		
			☐	☐		

IX - THIS SECTION TO BE COMPLETED BY APPROPRIATE COMMITTEE OR DESIGNATED OFFICIAL

HOUSE STAFF REVIEW COMMITTEE	31A. REMARKS	31B. CHAIRPERSON'S APPROVAL OF GENERAL QUALIFICATIONS	31C. DATE
		Kevin J. Carlin, MD, ACOS/Education	

DEANS COMMITTEE OR MEDICAL ADVISORY COMMITTEE	32A. RECOMMENDED FOR	32B. POST GRADUATE LEVEL RECOMMENDED	32C. LEVEL OF VACO APPROVAL REQUIRED	32D. APPLICANT/APPOINTEE MEETS ALL REQUIREMENTS AND REGULATIONS FOR APPOINTMENT OF HOUSE STAFF
	☐ CHIEF RESIDENT ☐ RESIDENCY IN:	☐ 1ST YR. ☐ 2ND YR. ☐ 3RD YR. ☐ 4TH YR. ☐ 5TH YR.	☐ LEVEL 6 ☐ LEVEL 7	☐ YES ☐ NO

32E. REMARKS	32F. SIGNATURE OF CHAIRPERSON OR DESIGNEE	32G. DATE

FINAL APPROVAL	33A. VA FACILITY Central TX Veterans Health Care System, Temple,TX	33B. NAME OF AFFILIATED MEDICAL OR DENTAL SCHOOL	33C. DATE OF APPOINTMENT
	33D. REMARKS	33E. SIGNATURE OF FACILITY DIRECTOR Bruce A. Gordon Director	33F. DATE

X - GENERAL INFORMATION

29. NAMES UNDER WHICH YOU WERE EMPLOYED, IF DIFFERENT FROM NAME GIVEN IN ITEM 1

1.
2.
3.
4.

30. LIST ALL PROFESSIONAL PUBLICATIONS, SCIENTIFIC PAPERS, HONORS, AWARDS, RESEARCH GRANTS AND FELLOWSHIPS (If additional space is required, attach separate sheet).

ITEM NO.	PLACE AN "X" IN APPROPRIATE SPACE. IF "YES" EXPLAIN DETAILS ON SEPARATE SHEET OF PAPER	YES	NO
34.	Do you receive or do you have a pending application for retirement or retainer pay, pension, or other compensation based upon military, Federal civilian, or District of Columbia service?	☐	☐
35.	Does the Department of Veterans Affairs employ any relative of yours (by blood or marriage)? If "YES" give separately such relative's (1) full name; (2) relationship; (3) VA position and employment location.	☐	☐
36.	ARE YOU NOW, OR HAVE YOU EVER BEEN, INVOLVED IN ADMINISTRATIVE, PROFESSIONAL OR JUDICIAL PROCEEDINGS IN WHICH MALPRACTICE ON YOUR PART IS OR WAS ALLEGED? (If "YES" give details including name of action or proceedings, date filed, court or reviewing agency, and the status or disposition of case concerning allegations, together with your explanation of the circumstances involved.) (As a provider of health care services, the VA has an obligation to exercise reasonable care in determining that applicants are properly qualified. It is recognized that many allegations of professional malpractice are proven groundless. Any conclusion concerning your answer as it relates to professional qualifications will be made only after a full evaluation of the circumstances involved.)	☐	☐

NOTE: A conviction or a discharge does not necessarily mean you cannot be appointed. The nature of the conviction or discharge and how long ago it occurred is important. Give all the facts so that a decision can be made. If your answer to question 39, 40 or 41 is "YES" give for each offense: (1) date; (2) charge; (3) place; (4) court and (5) action taken. When answering item 39 or 40, you may omit (1) traffic fines for which you paid a fine of $100.00 or less; (2) any offense committed before your 18th birthday which was finally adjudicated in a juvenile court or under a youth offender law; (3) any conviction the record of which has been expunged under Federal or State law; and (4) any conviction set aside under the Federal Youth Corrections Act or similar State authority.

37.	Within the last five years have you been discharged from any position for any reason?	☐	☐
38.	Within the last five years have you resigned or retired from a position after being notified you would be disciplined or discharged, or after questions about your clinical competence were raised?	☐	☐
39.	Have you ever been convicted, forfeited collateral, or are you now under charges for any felony or any firearms or explosives offense against the law? (A felony is defined as any offense punishable by imprisonment for a term exceeding one year, but does not include any offense classified as a misdemeanor under the laws of a State and punishable by a term of imprisonment of two years or less.)	☐	☐
40.	During the past seven years have you been convicted, imprisoned, on probation or parole, or forfeited collateral, or are you now under charges for any offense against the law not included in 39 above?	☐	☐
41.	While in the military service were you ever convicted by a general court-martial?	☐	☐
42.	If you were in the military service as a physician, dentist, podiatrist or optometrist, did you ever receive a non-judicial punishment (Article 15)?	☐	☐
43.	Are you delinquent on any Federal debt? (Include delinquencies arising from Federal taxes, loans, overpayment of benefits, and other debts to the U.S. Government, plus defaults on any Federally guaranteed or insured loans such as student and home mortgage loans.) If "Yes" explain on a separate sheet the type, length, and amount of the delinquency or default and steps you are taking to correct errors or repay the debt. Give any identification numbers associated with the debt and the address of the Federal agency involved.	☐	☐

XI - SIGNATURE OF APPLICANT

NOTE: A false statement on any part of your application may be grounds for not hiring you, or for terminating you after you begin work. Also, you may be punished by fine or imprisonment (U.S. Code, Title 18, Section 1001).

CERTIFICATION: **I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL OF MY STATEMENTS ARE TRUE, CORRECT, COMPLETE, AND MADE IN GOOD FAITH.**

44A. SIGNATURE OF APPLICANT (Sign in dark ink)	44B. DATE (Month, Day,Year)

AUTHORIZATION FOR RELEASE OF INFORMATION

In order for the Department of Veterans Affairs (VA) to assess and verify my educational background, professional qualifications and suitability for employment, I:

- ☐ Authorize VA to make inquiries concerning such information about me to my previous employer(s), current employer, educational institutions, State licensing boards, professional liability insurance carriers, national practitioner data bank, American Medical Association, Federation of State Medical Boards, other professional organizations and/or persons, agencies, organizations or institutions listed by me as references, and to any other appropriate sources to whom VA may be referred by those contacted or deemed appropriate;
- ☐ Authorize release of such information and copies of related records and/or documents to VA officials;
- ☐ Release from liability all those who provide information to VA in good faith and without malice in response to such inquiries; and
- ☐ Authorize VA to disclose to such persons, employers, institutions, boards or agencies identifying and other information about me to enable VA to make such inquiries.

SIGNATURE	DATE

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 30 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

AUTHORITY: The information requested on the attached application form and Authorization for Release of Information is solicited under Title 38, United States Code, Chapters 73 and 74.

PURPOSES AND USES: The information requested on the application is collected primarily to determine your qualifications and suitability for employment. If you are employed by the VA, the information will be used to make pay and benefit determinations and, as necessary, in personnel administration processes carried out in accordance with established regulations and the published notice of the system of records "Applicants for Employment under Title 38, U.S.C.-VA" (02VA135)

ROUTINE USES: Information on the form or the form itself may be released without your prior consent outside the VA to another Federal, State or local agency, to the National Practitioner Data Bank which is administered by the Department of Health and Human Services, to State licensing boards, and/or appropriate professional organizations or agencies to assist the VA in determining your suitability for hiring and for employment, to periodically verify, evaluate and update your clinical privileges and licensure status, to report apparent or potential violations of law, to provide statistical data upon proper request, or to provide information to a Congressional office in response to an inquiry made at your request. Such information may also be released without your prior consent to Federal agencies, State licensing boards, or similar boards or entities, in connection with the VA's reporting of information concerning your separation or resignation as a professional staff member under circumstances which raise serious concerns about your professional competence. Information concerning payments related to malpractice claims and adverse actions which affect clinical privileges also may be released to State licensing boards and the National Practitioner Data Bank. The information you supply may be verified through a computer matching program at any time.

EFFECTS OF NON-DISCLOSURE: See statement below concerning disclosure of your social security number. Disclosure of the other information is voluntary; however, failure to provide this information may delay or make impossible the proper application of Civil Service rules and regulations and VA personnel policies and thus may prevent you from obtaining employment, employees benefits, or other entitlements.

INFORMATION REGARDING DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER UNDER PUBLIC LAW 93-579 SECTION 7(b)

Disclosure of your SSN (social security number) is mandatory to obtain the employment and related benefits that you are seeking. Solicitation of the SSN is authorized under the provisions of Executive Order 9397, dated November 22, 1943. The SSN is used as an identifier throughout your Federal career from the time of application through retirement. It will be used primarily to identify your records. The SSN also will be used by Federal agencies in connection with lawful requests for information about you from your former employers, educational institutions, and financial or other organizations. The information gathered through the use of the number will be used only as necessary in personnel administration processes carried out in accordance with established regulations and published notices of systems of records. The SSN also will be used for the selection of persons to be included in statistical studies of personnel management matters. The use of the SSN is made necessary because of the large number of present and former Federal employees and applicants who have identical names and birth dates, and whose identities can only be distinguished by the SSN.