DEPARTMENT OF VETERANS AFFAIRS

Thank you for your interest
in applying for a **NURSING ASSISTANT** position
with the NURSING SERVICE at the VA BOSTON HEALTHCARE SYSTEM.

FOR SUBMISSION TO THE APPLICANT SUPPLY FILE ONLY

(To apply for advertised positions please apply on-line at www.usajobs.gov)

The VA BOSTON Healthcare System (VABHS) offers many options for Nursing Assistants to work in an innovative environment that supports excellence in clinical practice. State of the art technology, education and research combine to foster many professional growth opportunities. The VA Boston Healthcare System is comprised of three main campuses and five Community Based Out-Patient Clinics (CBOC) within a 40 mile radius of the greater Boston area that together, help us provide comprehensive, accessible care to our Veterans.

Checklist for Application:

_____ 1) You must be a **US Citizen.**
_____ 2) Submit a **resume** with length of work experience listed by month and year of start to month and year of finish as well as average weekly hours worked for each listed job.
_____ 3) Fill out the **Application for Associated Health Occupations (VA Form 10-2850c)** which is included in this packet.
_____ 4) Fill out the **Declaration for Federal Employment (Optional Form 306)** which is included in this packet.
_____ 5) Enclose a copy of your BLS or CPR card.
_____ 6) Enclose a copy of your Nursing Assistant certificate, if applicable.
_____ 7) If you are claiming Veterans Preference you must submit a copy of your **DD 214** that shows the character of service (Copy 4).

***** Please write legibly (or print clearly). Be complete in your answers, date and sign where indicated. Your application packet will be kept on file for 6 months. If you are eligible, your name will be put on a list and sent to the hiring manager to be reviewed as positions become available. This process can take many weeks. Thank you for your patience.**

Note: Incomplete packets will not be considered.

Completed application packages should be returned to:
VA Boston Healthcare System
940 Belmont Street (05D)
Brockton, MA 02301
Attn: Job Information

If you have any questions, please contact **Job Information** at:
Phone: **774-826-1269**
FAX: **774-826-3178**

ATTENTION APPLICANTS

To apply for a Nursing Assistant position with VA Boston Healthcare you need to include a resume and a copy of your current state issued Nursing Assistant Certificate.

Your resume needs to list the following for each employment experience you provide:

- length of work experience to include month and year.
- average number of hours worked per week
- a detailed description of the duties performed at each job that is listed

If you do not provide the information listed above in your resume and a current Nursing Assistant Certificate **YOU WILL NOT BE CONSIDERED FOR EMPLOYMENT.**

BOSTON HEALTHCARE SYSTEM
AVAILABILITY FORM

Name_____ Date_____

Note: Applicants please be advised that this application will stay on file for 6 months from the date of submission.

Please mark all that apply.

1. Please indicate your location preference for employment:
   Campuses
   - ☐ Brockton
   - ☐ Jamaica Plain
   - ☐ West Roxbury

   Outpatient Clinics:
   - ☐ Boston (Causeway Street)
   - ☐ Quincy
   - ☐ Plymouth
   - ☐ Lowell
   - ☐ Framingham

2. I will accept:
   - ☐ Full-time employment
   - ☐ Part-time employment
   - ☐ Temporary employment

3. I am available to work:
   - ☐ Monday – Friday Only
   - ☐ Alternating Weekends
   - ☐ Every Weekend
   - ☐ Overnight
   - ☐ Evenings
   - ☐ Rotating Schedule
   - ☐ As needed

4. Please indicate your lowest acceptable salary: $ _____

I understand if I am not able to work any of the above required schedules / rotations I will not be referred for an available position with such required schedules, but if qualified will be considered for other positions with a M-F Day schedule.

_____

Signature

APPLICANT SUPPLY FILE
DATA CAPTURE SHEET

(Please print legibly)

Social Security Number

___ - __ - ____

Last Name

First Name

Middle Name

E-mail

Street Address or PO Box

Town

State

ZIP

Primary Telephone Number

___ - ___ - ____

Ext (if applicable)

VA BOSTON HEALTHCARE SYSTEM

NURSING ASSISTANT SKILLS CHECKLIST

NAME_____

This is a list of duties that you may have performed while taking care of patients in your work. Please make a check next to those duties you have done. On the line below each duty, write the name of the workplace where you used this skill.

1._____ I take patient vital signs.

_____

2._____ I record the vital signs in the patient's records.

_____

3._____ I write about the patient's care and condition in the patient records.

_____

4._____ I measure and record the patient intake and output.

_____

5._____ I make the patient's bed (occupied or unoccupied).

_____

6._____ I feed patients and help to set up their tray.

_____

7._____ I give bedbaths/showers to patients.

_____

8._____ I lift, turn and position patients to prevent skin breakdown.

_____

9._____ I change simple dressings on patient wounds.

_____

10._____ I collect and label patient specimens (urine, stool, sputum).

_____

11._____ I know about infection control procedures.

_____

12._____ I weigh patients on different scales (wheelchair, standing, bedscale).

_____

13.____ I apply skin creams and ointments to the patient as ordered.

_____

(con'd on next page)

NAME_____ SS#_____

14._____ I do tube feedings.

_____

15._____ I set up oxygen tubing as ordered.

_____

16._____ I set up breathing treatments as ordered.

_____

17._____ I monitor bowel and bladder functions.

_____

18._____ I give enemas / suppositories.

_____

19._____ I help patients to transfer from bed to chair.

_____

20._____ I irrigate urine catheters.

_____

21._____ I can insert a urine catheter.

_____

22._____ I do post-mortem care.

_____

23._____ I can do an EKG on a patient.

_____

24._____ I suction patients as needed.

_____

25._____ I help the Doctor or the Nurse when they are doing a procedure.

_____

26._____ I help in medical emergencies.

_____

27._____ I care for patients with behavioral problems.

_____

28._____ I provide a safe environment for the patients.

_____

29._____ I report any changes in the patient condition or problems to my supervisor.

_____

* * * * * * * * * *

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

Department of Veterans Affairs

APPLICATION FOR ASSOCIATED HEALTH OCCUPATIONS

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. OCCUPATION FOR WHICH APPLYING

A ☐ CERTIFIED RESPIRATORY THERAPY TECHNICIAN
B ☐ REGISTERED RESPIRATORY THERAPIST
C ☐ LICENSED PHYSICAL THERAPIST
D ☐ LICENSED PRACTICAL/VOCATIONAL NURSE
E ☐ LICENSED PHARMACIST
F ☐ PHYSICIAN ASSISTANT
G ☐ EXPANDED-FUNCTION DENTAL AUXILIARY
H ☐ OCCUPATIONAL THERAPIST
☐ OTHER (Specify)

2. NAME (Last, First, Middle)

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

4. PRESENT ADDRESS (Include ZIP Code) STREET ADDRESS 2 APT. NO.
CITY STATE ZIP CODE COUNTRY

5. TELEPHONE NUMBER (Include Area Code)
5A. RESIDENCE
5B. BUSINESS

6. DATE OF BIRTH
7. PLACE OF BIRTH (City) STATE COUNTRY
8. SOCIAL SECURITY NUMBER

9A. CITIZENSHIP
☐ U.S. CITIZEN BY BIRTH ☐ NATURALIZED U.S. CITIZEN ☐ NOT A U.S. CITIZEN (Complete Item 9B)
9B. COUNTRY OF WHICH YOU ARE A CITIZEN

10A. HAVE YOU EVER FILED APPLICATION FOR APPOINTMENT IN THE VA
☐ YES ☐ NO (If "YES" complete Items 10B and 10C)
10B. NAME OF OFFICE WHERE FILED
10C. DATE FILED

11. WHEN MAY INQUIRY BE MADE OF YOUR PRESENT EMPLOYER
12. DATE AVAILABLE FOR EMPLOYMENT

I - ACTIVE 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 separate sheet)

II - LICENSURE, DEA CERTIFICATION, REGISTRATION AND CLINICAL PRIVILEGES (As applicable)

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	
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	

15A. ARE YOU FULLY LICENSED IN EVERY STATE IN WHICH YOU RECEIVED A LICENSE (If restricted, limited or probational in any State(s), explain on separate sheet)
☐ YES ☐ NO ☐ NOT APPLICABLE

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

15C. HAVE YOU EVER HELD A REGISTRATION TO PRACTICE THAT IS NO LONGER HELD OR CURRENT
☐ YES ☐ NO (If "YES" explain on separate sheet)

16A. NAME THE CERTIFYING BODY FOR YOUR HEALTH OCCUPATION
16B. DATE OF MOST RECENT REGISTRATION/ CERTIFICATION (Give Month and Year)
16C. WHAT IS YOUR REGISTRY/ CERTIFICATION NUMBER
16D. HAS ACTION EVER BEEN TAKEN AGAINST YOUR CERTIFICATION OR REGISTRATION
☐ YES ☐ NO (If "YES" explain on separate sheet)

17A. DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD CLINICAL PRIVILEGES AT ANY HEALTH CARE INSTITUTION, AGENCY OR ORGANIZATION
☐ YES ☐ NO (If "YES" complete Item 17B)

17B. NAME OF CURRENT OR MOST RECENT INSTITUTION, AGENCY OR ORGANIZATION WHERE HELD

17C. HAVE ANY OF YOUR STAFF APPOINTMENTS OR CLINICAL PRIVILEGES EVER BEEN DENIED, REVOKED, SUSPENDED, REDUCED, LIMITED, 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).

18. EVIDENCE HAS BEEN SIGHTED IN REGARDS TO:
☐ CERTIFICATION OR REGISTRATION
☐ NATURALIZED CITIZENSHIP
☐ LICENSURE/REGISTRATION FOR ALL STATES LISTED BY APPLICANT
☐ VISA
☐ CURRENT OR MOST RECENT CLINICAL PRIVILEGES
☐ NO CURRENT OR PREVIOUS CLINICAL PRIVILEGES

19A. SIGNATURE OF AUTHORIZED OFFICIAL
19B. TITLE
19C. DATE (MONTH, DAY, YEAR)

IV - LIABILITY INSURANCE (As applicable)

20A. PRESENT LIABILITY INSURANCE CARRIER	20B. DATE COVERAGE BEGAN	20C. NAMES OF PRIOR CARRIERS	20D. DATE OF COVERAGE		21. HAS ANY CARRIER EVER CANCELLED, DENIED OR REFUSED TO RENEW YOUR INSURANCE
			FROM	TO	☐ YES ☐ NO (If "YES" explain on separate sheet)

V - QUALIFICATIONS

BASIC ALLIED HEALTH EDUCATION (Continue on separate sheet, if necessary)

22A. NAME OF SCHOOL	22B. ADDRESS (City, State and ZIP Code)	22C. LENGTH OF PROGRAM	22D. DATE COMPLETED	22E. DIPLOMA OR DEGREE RECEIVED

ADDITIONAL EDUCATION (Continue on separate sheet, if necessary)

23A. NAME OF SCHOOL	23B. ADDRESS (City, State and ZIP Code)	23C. MAJOR	23D. DATE COMPLETED	23E. CREDITS	23F. DEGREE

VI - PROFESSIONAL EXPERIENCE

24A. EMPLOYER	24B. ADDRESS (City, State and ZIP Code)	24C. POSITION (Where applicable, also specify whether General Practitioner or Specialist)	26D. FULL-TIME	26E. PART-TIME AVERAGE HOURS PER WEEK	26F. DATES EMPLOYED	
					FROM	TO
			☐	☐		
			☐	☐		
			☐	☐		

VII - GENERAL INFORMATION

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

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

VIII - REFERENCES

27. REFERENCES: List at least four persons living in the United States who are not related to you by blood or marriage and who have been in a position to judge your qualifications during the past five years.

27A. NAME	27B. ADDRESS (Number, Street, City, State and ZIP Code)	27C. AREA CODE/PHONE NO.	27D. BUSINESS OR OCCUPATION

REFERENCES (Continued)			
27A. NAME	27B. ADDRESS (Number, Street, City, State and ZIP Code)	27C. AREA CODE/PHONE NO.	27D. BUSINESS OR OCCUPATION

ITEM NO.	PLACE AN "X" IN APPROPRIATE SPACE. IF "YES" EXPLAIN DETAILS ON SEPARATE SHEET	YES	NO
28.	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 ?	☐	☐
29.	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.	☐	☐
30.	ARE YOU NOW, OR HAVE YOU EVER BEEN, INVOLVED IN ADMINISTRATIVE 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 malpractice are proven groundless. Any conclusion concerning your answer as it relates to your 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 33, 34 or 35 is "YES" give for each offense: (1) date; (2) charge; (3) place; (4) court and (5) action taken. When answering item 33 or 34, 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.

31.	Within the last five years have you been discharged from any position for any reason?	☐	☐
32.	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?	☐	☐
33.	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.)	☐	☐
34.	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 33 above?	☐	☐
35.	While in the military service were you ever convicted by a general court-martial?	☐	☐
36.	If you were in the military service in one of these health occupations, did you ever receive a non-judicial punishment (Article 15)?	☐	☐
37.	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.	☐	☐

IX - 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.

38A. SIGNATURE OF APPLICANT (Sign in dark ink)	38B. 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.

AdobeFormsDesigner

Department of Veterans Affairs

CERTIFICATION OF LICENSURE, REGISTRATION, OR BAR MEMBERSHIP

PRIVACY ACT NOTICE: The information requested is voluntary and is solicited under authority of Chapter 73, Title 38, U.S.C., Sections 4105 and 4106, or Title 5, U.S.C., Sections 3301, 3302, 3304, and 3320. It will be used to determine your current qualifications for a specific position. If you decline to provide the information requested, it may result in disqualification for the position.

INSTRUCTION TO EMPLOYEE: Please complete items 8A through 10.

1. STATION NAME AND LOCATION	2. STATION NO.	3. DUTY STATION

4. EMPLOYEE NAME *(Last, first, middle)*	5. SOCIAL SECURITY NO.

6. POSITION TITLE

7. ORGANIZATION *(Department or staff office, service, division, etc.)*

CURRENT LICENSE, REGISTRATION, OR BAR MEMBERSHIP

8A. STATE	8B. NUMBER	8C. DATE ISSUED	8D. EXPIRATION DATE

CERTIFICATION: I certify that I have a current license, registration, or bar membership as described above.

9. SIGNATURE OF EMPLOYEE	10. DATE

The information above has been verified.

11. SIGNATURE AND TITLE OF VERIFYING OFFICIAL	12. DATE

VA FORM OCT 1994(R) 4682

Declaration for Federal Employment*

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

Form Approved:
OMB No. 3206-0182

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)

♦

3b. ARE YOU A U.S. CITIZEN?

☐ YES ☐ NO (If "NO", provide country of citizenship) ♦

4. DATE OF BIRTH (MM / DD / YYYY)

♦

5. OTHER NAMES EVER USED (For example, maiden name, nickname, etc)

♦

♦

6. PHONE NUMBERS (Include area codes)

Day ♦

Night ♦

Selective Service Registration

If you are a male born after December 31, 1959, and are at least 18 years of age, civil service employment law (5 U.S.C. 3328) requires that you must register with the Selective Service System, unless you meet certain exemptions.

7a. Are you a male born after December 31, 1959? ☐ YES ☐ NO (If "NO", proceed to 8.)

7b. Have you registered with the Selective Service System? ☐ YES (If "YES", proceed to 8.) ☐ NO (If "NO", proceed to 7c.)

7c. If "NO," describe your reason(s) in Item 16.

Military Service

8. Have you ever served in the United States military? ☐ YES (If "YES", provide information below) ☐ NO

If you answered "YES," list the branch, dates, and type of discharge for all active duty.
If your only active duty was training in the Reserves or National Guard, answer "NO."

Branch	From (MM/DD/YYYY)	To (MM/DD/YYYY)	Type of Discharge

Background Information

For all questions, provide all additional requested information under item 16 or on attached sheets. The circumstances of each event you list will be considered. However, in most cases you can still be considered for Federal jobs.

For questions 9,10, and 11, your answers should include convictions resulting from a plea of *nolo contendere* (no contest), but omit (1) traffic fines of $300 or less, (2) any violation of law committed before your 16th birthday, (3) any violation of law committed before your 18th birthday if finally decided in juvenile court or under a Youth Offender law, (4) any conviction set aside under the Federal Youth Corrections Act or similar state law; and (5) any conviction for which the record was expunged under Federal or state law.

9. During the last 7 years, have you been convicted, been imprisoned, been on probation, or been on parole? (Includes felonies, firearms or explosives violations, misdemeanors, and all other offenses.) *If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved.* ☐ YES ☐ NO

10. Have you been convicted by a military court-martial in the past 7 years? *(If no military service, answer "NO.") If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the military authority or court involved.* ☐ YES ☐ NO

11. Are you currently under charges for any violation of law? *If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved.* ☐ YES ☐ NO

12. During the last 5 years, have you been fired from any job for any reason, did you quit after being told that you would be fired, did you leave any job by mutual agreement because of specific problems, or were you debarred from Federal employment by the Office of Personnel Management or any other Federal agency? *If "YES," use item 16 to provide the date, an explanation of the problem, reason for leaving, and the employer's name and address.* ☐ YES ☐ NO

13. Are you delinquent on any Federal debt? (Includes delinquencies arising from Federal taxes, loans, overpayment of benefits, and other debts to the U.S. Government, plus defaults of Federally guaranteed or insured loans such as student and home mortgage loans.) *If "YES," use item 16 to provide the type, length, and amount of the delinquency or default, and steps that you are taking to correct the error or repay the debt.* ☐ YES ☐ NO

DEPARTMENT OF VETERANS AFFAIRS

VA Boston Healthcare System
Boston/Brockton/West Roxbury Campus

APPLICANT BRIEFING – MANDATORY DRUG TESTING

In 1992, the Department of Veterans Affairs implemented a Pre-employment Drug Testing program as part of its Drug-Free Workplace Plan. Effective March 1, 2016, VA furthered the commitment to a drug free workplace by implementing drug testing for 100% of applicants tentatively selected for employment in Testing Designated Positions (TDP).

The position you are applying for is a Testing Designated Position (TDP) and subject to mandatory pre-employment drug testing.

NOTE: A final offer of employment may not be extended to any applicant who:

1. Refuses to be tested
2. Alters or substitutes a specimen, or attempts to do so
3. Has a drug test which is verified positive by the Employee Health provider.

Selected applicants are responsible for furnishing the Employee Health provider with documentation of any prescription drugs they may be using, or any other situation which might affect the drug test results.

If laboratory analysis reveals that the specimen contains any drugs of abuse, the results will be disclosed only the Employee Health provider. Prior to making a final decision to verify a positive test result, the Employee Health provider will give the applicant the opportunity to discuss the test result and submit any medical documentation of legally prescribed medications.

Any questions regarding mandatory drug testing may be directed to the Human Resources Management Service, Job Information Center at (774) 826-1269.

REVIEWED:

Signature of Applicant	Signature of Nurse Recruiter
Date of Signature	Date Reviewed

REVISED: March 22, 2016

DEPARTMENT OF VETERANS AFFAIRS

VA Boston Healthcare System
Boston/Brockton/West Roxbury Campus

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REVIEWED:

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Signature of Applicant	Signature of Nurse Recruiter
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