



DEPARTMENT OF VETERANS AFFAIRS

Thank you for your interest
in applying for a **REGISTERED NURSE** position
with 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 nurses 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. The VABHS has received five Centers of Excellence awards: Cardiac Surgery, Surgery, Substance Abuse, Seriously Mentally Ill, PTSD and Woman's Health. It is also one of the few facilities with a CARF-accredited acute rehabilitation program.

Checklist for Application:

- _____ 1) You must be a **US Citizen**.
- _____ 2) Complete the application form, sign and date in the spaces indicated.
- _____ 3) Include a recent resume.
- _____ 4) Include copies of any recent certificates, BLS, ACLS, etc.
- _____ 5) New graduates who have passed their licensing exam include a copy of your GRADUATE transcript.
- _____ 6) Three reference letters from your supervisors and/or peers.
*** If you are a recent Graduate, include three (3) clinical evaluations from your instructors at your school, in lieu of the reference letters.

Completed application packages should be returned to:

**VA Boston Healthcare System
940 Belmont Street (05D)
Brockton, MA 02301
Attn: Job Information**

If you are contacted for an interview, you will need to bring your original Nursing License for verification. New Graduates who have passed their Board Certification may bring their letter of notification or the computer printout form.

If you have any questions, please contact **Job Information** at:

Phone: 508-583-4500 ext 61269
FAX: 508-826-1187

VA BOSTON HEALTHCARE SYSTEM

Full-time RN BENEFIT PACKAGE

(Part-time benefits are pro-rated)

VACATION

- 8 hours per pay period (26 vacation days a year)
- Maximum accrual of vacation time is 640 hours

SICK LEAVE

- ½ day (4 hours) per each bi-weekly pay period (2 weeks and 3 days per year for Full-time)
- Unlimited accrual

DIFFERENTIAL

- 10% evenings and nights
- 25% Saturday and Sunday
- Overtime is time and one half for hours worked over 40 in a work week
- Holidays worked are paid at double time

HOLIDAYS

- 10 Federal holidays

MEDICAL INSURANCE, LIFE INSURANCE

- Local and national plans available
- Savings bank-type life insurance for self, spouse, children. Up to 5X own base salary

RETIREMENT

- Three tiers: Social Security, Federal Employees Retirement System, Thrift Savings Plan with up to 5% matching contribution.

EDUCATIONAL BENEFITS

- Hospital orientation – 7 days at a minimum
- Unit orientation with preceptor: In-service programs
- 40 hours of Mandatory Medical Center Education for all employees, yearly
- Authorized Absence to attend off-site CEU offerings – get paid for the day

PERFORMANCE APPRAISAL

- Yearly, with mid-point conference to discuss progress, areas for improvement

CHILDCARE SUBSIDY PROGRAM

ON-SITE DAYCARE AVAILABLE

FREE ON-SITE PARKING



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



Department of Veterans Affairs

APPLICATION FOR NURSES AND NURSE ANESTHETISTS

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) <input type="checkbox"/> GENERAL PRACTICE <input type="checkbox"/> 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 <input type="checkbox"/> U.S. CITIZEN BY BIRTH <input type="checkbox"/> NATURALIZED U.S. CITIZEN <input type="checkbox"/> NOT A U.S. CITIZEN (Complete Item 8B)		8B. COUNTRY OF WHICH YOU ARE A CITIZEN	
9A. HAVE YOU EVER FILED APPLICATION FOR APPOINTMENT IN THE VA <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" complete Items 9B and 9C)		9B. NAME OF OFFICE WHERE FILED	9C. DATE FILED
10. WHEN MAY INQUIRY BE MADE OF YOUR PRESENT EMPLOYER		11. DATE AVAILABLE FOR EMPLOYMENT	

I - ACTIVE MILITARY DUTY

12A. DATE FROM	12B. DATE TO	12C. SERIAL OR SERVICE NO.	12D. BRANCH OF SERVICE	12E. TYPE OF DISCHARGE <input type="checkbox"/> HONORABLE <input type="checkbox"/> Other (Explain on separate sheet)
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II - REGISTRATION AND CLINICAL PRIVILEGES

13A. LIST ALL STATES/TERRITORIES IN WHICH YOU ARE NOW OR HAVE EVER BEEN REGISTERED AS A NURSE (If necessary, continue on separate sheet)	13B. REGISTRATION NUMBER	13C. EXPIRATION DATE

14. ARE YOU FULLY REGISTERED IN EVERY STATE IN WHICH YOU ARE NOW REGISTERED (If restricted, limited or probational in any State(s), explain on separate sheet) <input type="checkbox"/> YES <input type="checkbox"/> NO	15. DO YOU HAVE PENDING OR HAVE YOU EVER HAD ANY REGISTRATION TO PRACTICE REVOKED, SUSPENDED, DENIED, RESTRICTED, LIMITED, OR ISSUED/PLACED ON A PROBATIONAL STATUS OR VOLUNTARILY RELINQUISHED <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" explain on separate sheet)	16. HAVE YOU EVER HELD A REGISTRATION TO PRACTICE THAT IS NO LONGER HELD OR CURRENT <input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" explain on separate sheet)	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 <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" explain on separate sheet)

III - NURSE ANESTHETIST CERTIFICATION (To be completed by Nurse Anesthetists only)

18A. ARE YOU CERTIFIED AS A NURSE ANESTHETIST BY THE COUNCIL ON CERTIFICATION OF NURSE ANESTHETISTS (CCNA) <input type="checkbox"/> YES <input type="checkbox"/> NO	18B. WHAT IS THE DATE OF YOUR CERTIFICATION OR MOST RECENT RECERTIFICATION (GIVE MONTH AND YEAR)	18C. WHAT IS YOUR AMERICAN ASSOCIATION OF NURSE ANESTHETISTS (AANA) IDENTIFICATION NUMBER	18D. HAS YOUR CCNA CERTIFICATION EVER BEEN REVOKED <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" explain on separate sheet)
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IV - THIS SECTION TO BE COMPLETED BY FACILITY DIRECTOR OR DESIGNEE

<p>CERTIFICATION: I certify that I have verified registration with State boards, and sighted visa or evidence of citizenship. Board certification has been verified (if appropriate).</p>		
<p>19. EVIDENCE HAS BEEN SIGHTED IN REGARDS TO: <input type="checkbox"/> CERTIFICATION AS A NURSE ANESTHETIST <input type="checkbox"/> VISA <input type="checkbox"/> REGISTRATION FOR ALL STATES LISTED BY APPLICANT <input type="checkbox"/> NATURALIZED CITIZENSHIP <input type="checkbox"/> CURRENT OR MOST RECENT CLINICAL PRIVILEGES <input type="checkbox"/> NO CURRENT OR PREVIOUS CLINICAL PRIVILEGES</p>		
20A. SIGNATURE OF FACILITY DIRECTOR OR DESIGNEE	20B. TITLE	20C. DATE

V - PROFESSIONAL LIABILITY INSURANCE

21A. PRESENT PROFESSIONAL LIABILITY INSURANCE CARRIER	21B. DATE COVERAGE BEGAN	21C. NAME OF PRIOR CARRIER	21D. DATES OF COVERAGE		22. HAS ANY CARRIER EVER CANCELLED, DENIED OR REFUSED TO RENEW YOUR INSURANCE (If "YES" explain on separate sheet) <input type="checkbox"/> YES <input type="checkbox"/> NO
			FROM	TO	

VI - QUALIFICATIONS

BASIC NURSING EDUCATION (Continue on separate sheet if necessary)

23A. NAME OF SCHOOL	23B. ADDRESS (City, State and ZIP Code)	23C. LENGTH OF PROGRAM	23D. DATE COMPLETED	23E. DIPLOMA OR DEGREE RECEIVED

ADDITIONAL EDUCATION (Continue on separate sheet if necessary)

24A. NAME OF SCHOOL	24B. ADDRESS (City, State and ZIP Code)	24C. MAJOR	24D. DATE COMPLETED	24E. CREDITS	24F. DEGREE

25. IS YOUR PROFESSIONAL BIOGRAPHY COMPILED YES NO (If "YES", please forward a copy to the VA) NOTE: IF YOUR COLLEGE OR UNIVERSITY STUDY IS NOT A PART OF YOUR PROFESSIONAL BIOGRAPHY, PLEASE SEND OFFICIAL TRANSCRIPT(S)

VII - NURSING EXPERIENCE

26A. EMPLOYER	26B. ADDRESS (City, State and ZIP Code)	26C. POSITION	26D. FULL TIME <input type="checkbox"/>	26E. PART-TIME AVERAGE HOURS PER WEEK <input type="checkbox"/>	26F. DATES EMPLOYED	
					FROM	TO
			<input type="checkbox"/>	<input type="checkbox"/>		

NAME AND TITLE OF DIRECTOR OF NURSING OR OF OTHER DEPARTMENT TO WHICH YOU WERE ASSIGNED

			<input type="checkbox"/>	<input type="checkbox"/>		
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NAME AND TITLE OF DIRECTOR OF NURSING OR OF OTHER DEPARTMENT TO WHICH YOU WERE ASSIGNED

			<input type="checkbox"/>	<input type="checkbox"/>		
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NAME AND TITLE OF DIRECTOR OF NURSING OR OF OTHER DEPARTMENT TO WHICH YOU WERE ASSIGNED

VIII - GENERAL INFORMATION

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

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-
-
-

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

IX - REFERENCES

NOTE: LIST 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 PROFESSIONAL QUALIFICATIONS DURING THE PAST FIVE YEARS.

29A. NAME	29B. ADDRESS (Street, City, State and ZIP Code)	29C. AREA CODE/PHONE NO.	29D. BUSINESS OR OCCUPATION

ITEM NO.	PLACE AN "X" IN APPROPRIATE SPACE. IF "YES" EXPLAIN DETAILS ON SEPARATE SHEET OF PAPER	YES	NO
30.	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?	<input type="checkbox"/>	<input type="checkbox"/>
31.	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.	<input type="checkbox"/>	<input type="checkbox"/>
32.	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.)	<input type="checkbox"/>	<input type="checkbox"/>

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 35, 36 or 37 is "YES" give for each offense: (1) date; (2) charge; (3) place; (4) court and (5) action taken. When answering item 35 or 36, 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.

33.	Within the last five years have you been discharged from any position for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
34.	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?	<input type="checkbox"/>	<input type="checkbox"/>
35.	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.)	<input type="checkbox"/>	<input type="checkbox"/>
36.	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 35 above?	<input type="checkbox"/>	<input type="checkbox"/>
37.	While in the military service were you ever convicted by a general court-martial?	<input type="checkbox"/>	<input type="checkbox"/>
38.	If you were in the military service in one of these health occupations, did you ever receive a non-judicial punishment (Article 15)?	<input type="checkbox"/>	<input type="checkbox"/>
39.	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.	<input type="checkbox"/>	<input type="checkbox"/>

X - 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.

40A. SIGNATURE OF APPLICANT (Sign in dark ink)	40B. DATE (Month, Day, Year)
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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
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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.



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
<i>CERTIFICATION: I certify that I have a current license, registration, or bar membership as described above.</i>			
9. SIGNATURE OF EMPLOYEE		10. DATE	
<i>The information above has been verified.</i>			
11. SIGNATURE AND TITLE OF VERIFYING OFFICIAL		12. DATE	

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? <input type="checkbox"/> YES <input type="checkbox"/> 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

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OMB No. 3206-0182

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

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 to 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