Nursing CHECKLIST
WITHOUT COMPENSATION (WOC)

The following information is needed in the ACOS/Education Office for proper processing:

TRAINEE NAME: _____
LAST NAME, First Middle

AFFILIATE: CSU San Marcos

EMAIL:_____

SERVICE PGY LEVEL: _____

SERVICE ASSIGNED: Nursing

SUBSPECIALTY WITHIN SERVICE: _____

DATES OF Residency: FROM: _____ **TO:** _____
(mm/dd/yyyy) (mm/dd/yyyy)

In addition to completing this package, trainees must complete the following checklist and securely message all application additional materials before they can be credentialed:

1. If the trainee is **NOT** a US Citizen, the trainee MUST include one of the following:
   - ☐ An electronic copy of a J VISA (Exchange VISA) **OR**
   - ☐ An electronic copy of a permanent (Immigrant) VISA

2. **Does the trainee have a license to practice medicine during the dates of rotation?**
   - ☐ Yes ☑ No

3. Have you worked or trained at a VA? ☐ Yes ☑ No Location:
   Date FROM:

TABLE OF CONTENTS
Without Compensation (WOC)

OMB Number: 2900-0205
Estimated Burden: 30 minutes

Department of Veterans Affairs — APPLICATION FOR HEALTH PROFESSIONS TRAINEES

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 (VA) to determine your eligibility for appointment. Type or print in ink. If additional space is needed, please attach a separate sheet and refer to items being answered by number. Applications for clinical training programs may require additional information. All information required by the training program to which you are applying, as well as information requested on all application forms, must be included.

VA must protect the safety of our patients. Therefore, at some point in the appointment process, you will be asked questions about your physical and mental health. This includes questions as to whether you have received tuberculin testing, hepatitis B vaccinations or any other vaccinations.

1A. NAME (Last, First, Middle)	1B. OTHER NAMES USED		
2. PRESENT ADDRESS (Include ZIP Code)	3A - PRIMARY PHONE (Include area code) 3B - ALTERNATE PHONE (Include area code)		
4. SOCIAL SECURITY NUMBER	5A. PRIMARY EMAIL ADDRESS	5B. ALTERNATE EMAIL ADDRESS	6. DATE OF BIRTH (mm/dd/yyyy)
7A. VA TRAINING FACILITY (City, State) San Diego	7B. VA TRAINING START DATE (mm/dd/yyyy) ☐ UNKNOWN	7C. VA TRAINING END DATE (mm/dd/yyyy) ☐ UNKNOWN	

II - U.S. MILITARY DUTY STATUS

8A. ARE YOU NOW IN U.S. MILITARY?	8B. ARE YOU IN THE RESERVES OR NATIONAL GUARD?	8C. BRANCH OF SERVICE
☐ YES *(If YES, complete 8c)* ☒ NO	☐ YES *(If YES, complete 8c)* ☒ NO	

III - CITIZENSHIP

9A. CITIZENSHIP	9B. COUNTRY OF CITIZENSHIP
☐ U.S. CITIZEN BY BIRTH ☐ NATURALIZED U.S. CITIZEN ☐ NOT A U.S. CITIZEN (Complete item 9B)	

NOTE: Complete items 10A, 10B, 10C, or 10D ONLY if you are NOT a U.S. citizen.

10A. IMMIGRANT	10B. EXCHANGE VISITOR		10C. OTHER NON-IMMIGRANT		10D. FORM DS2019
"A" NUMBER	VISA TYPE	VISA NUMBER	VISA TYPE	VISA NUMBER	DO YOU HAVE A VALID DS2019? ☐ YES ☐ NO
DATE	ISSUE DATE	EXPIRATION DATE	ISSUE DATE	EXPIRATION DATE	DATE OF LAST VALIDATION (MM/DD/YYYY)

IV- THIS SECTION TO BE COMPLETED BY DESIGNATED EDUCATION OFFICER (DEO) OR DESIGNEE

11A. The trainee has met all of the criteria of the Trainee Qualifications & Credentials Verification Letter (TQCVL).	☐ YES ☐ NO
11B. Incomplete items on the TQCVL have been addressed and resolved.	☐ YES ☐ NO
11C. Special attention has been given to the following items from the application forms.	
11D. Comments:	
11E. This applicant has been approved for appointment.	☐ YES ☐ NO
11F. Comments:	

12A. SIGNATURE OF FACILITY DESIGNATED EDUCATION OFFICER OR DESIGNEE	12B. TITLE	12C. DATE
Francis Gabbai, MD	Acting ACOS/Education	

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER

V- LICENSE, CERTIFICATION, OR REGISTRATION IN CURRENT CLINICAL PROFESSION

13A. LIST ALL LICENSES, CERTIFICATIONS,AND REGISTRATIONS, INCLUDING THE DRUG ENFORCEMENT AGENCY (DEA), THAT YOU HAVE NOW OR HAVE HAD AS A HEALTH PROFESSIONAL, I.E. MEDICAL, NURSING, PHARMACY, ETC.	13B. STATE ISSUING LICENSE	13C. LICENSE, CERTIFICATION OR REGISTRATION NUMBER	13D. EXPIRATION DATE (MM/DD/YYYY)

VI- LICENSE, CERTIFICATION, OR REGISTRATION IN OTHER/PREVIOUS CLINICAL PROFESSION(S)

14A. LIST ALL LICENSES, CERTIFICATIONS, AND REGISTRATIONS, INCLUDING DEA, THAT YOU HAVE EVER HAD AS A HEALTH PROFESSIONAL, I.E. MEDICAL, NURSING, PHARMACY, ETC.	14B. STATE ISSUING LICENSE	14C. LICENSE, CERTIFICATION OR REGISTRATION NUMBER	14D. EXPIRATION DATE (MM/DD/YYYY)

15. ENTER YOUR NATIONAL PROVIDER IDENTIFIER (NPI)

The following two questions apply to both your current health profession and any prior health profession.

16. DO YOU HAVE PENDING, OR HAVE YOU EVER HAD ANY LICENSE, CERTIFICATION, OR REGISTRATION TO PRACTICE (INCLUDING DEA CERTIFICATE) REVOKED, SUSPENDED, DENIED, RESTRICTED, OR PLACED ON A PROBATIONARY STATUS, OR HAVE YOU EVER VOLUNTARILY RELINQUISHED A LICENSE, CERTIFICATION, OR REGISTRATION IN LIEU OF FORMAL ACTION? ☐ YES - EXPLAIN IN PART XI ☐ NO

17. DO YOU HAVE PENDING, OR HAVE YOU EVER HAD CLINICAL PRIVILEGES AT ANY HEALTH CARE INSTITUTION OR AGENCY REVOKED, SUSPENDED, DENIED, RESTRICTED, LIMITED, OR PLACED ON A PROBATIONARY STATUS, OR HAVE YOU EVER VOLUNTARILY RELINQUISHED CLINICAL PRIVILEGES IN LIEU OF FORMAL ACTION? ☐ YES - EXPLAIN IN PART XI ☐ NO

VII - EDUCATION AND TRAINING AFTER HIGH SCHOOL THROUGH GRADUATE / PROFESSIONAL SCHOOL (Continue in Part XI if necessary)

18A. NAME OF SCHOOL	18B. ADDRESS (City, State, and Zip Code)	18C. START DATE (MM/YY)	18D. (EXPECTED) COMPLETION DATE (MM/YY)	18E.DIPLOMA, DEGREE, OR CERTIFICATE AWARDED OR IN PROGRESS	18F. MAJOR FIELD OF STUDY

VIII - GRADUATES OF AN INTERNATIONAL MEDICAL SCHOOL

19A. ARE YOU A GRADUATE OF AN INTERNATIONAL MEDICAL SCHOOL? ☐ YES ☒ NO	19B. EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG) CERTIFICATE NUMBER	19C. ECFMG CERTIFICATE DATE

IX- INTERNSHIP, RESIDENCY AND FELLOWSHIP TRAINING

20A. NAME OF HOSPITAL OR INSTITUTION	20B. ADDRESS (City, State and ZIP Code)	20C. SPECIALTY	20D. START DATE (MM/YY)	20E.(EXPECTED) COMPLETION DATE (MM/YY)	20F. NUMBER OF MONTHS COMPLETED

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER

X - ADDITIONAL QUESTIONS

ITEM	PLACE AN 'x' IN APPROPRIATE SPACE. IF YES, EXPLAIN DETAILS IN PART XI	YES	NO
21	AS A PARTICIPANT IN THE MEDICARE AND MEDICAID PROGRAMS, HAVE YOU EVER BEEN CONVICTED OF OR INVESTIGATED FOR MAKING FALSE, FICTITIOUS, OR FRAUDULENT STATEMENTS, REPRESENTATIONS, WRITINGS, OR DOCUMENTS REGARDING THE DELIVERY OF OR PAYMENT FOR HEALTH CARE BENEFITS, ITEMS OR SERVICES THAT WOULD BE IN VIOLATION OF THE CRIMINAL FALSE CLAIMS ACT?	☐	☐
22	ARE YOU NOW, OR HAVE YOU EVER BEEN, INVOLVED IN ADMINISTRATIVE, PROFESSIONAL, OR JUDICIAL PROCEEDINGS IN WHICH MALPRACTICE ON YOUR PART WAS ALLEGED? If yes, give details in Part XI, including name of action or proceedings, date filed, court or reviewing agency, and the status or outcome of the case concerning those allegations. Please also provide your explanation of what occurred. 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.	☐	☐
23	Do you need accommodations to perform the procedures and essential functions of the training position for which you have applied?	☐	☐

XI - REMARKS

ITEM NO.	(Include additional information requested in items above. Be sure to indicate Item number on Form to which the comment refers.)

XII - 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.

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).

24A. SIGNATURE OF APPLICANT (sign in dark ink)	24B. DATE (mm/dd/yyyy)
TIME STAMP DIGITAL Signature Only	

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER

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 about me to current and previous employers, educational institutions, state licensing boards, professional liability insurance carriers, other professional organizations or persons, agencies, organizations, or institutions listed by me as references, and to any other sources which VA may deem appropriate or be referred by those contacted;
- ☐ Authorize release of such information and copies of related records and 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;
- ☐ 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; and
- ☐ Authorize VA to share any information about me with the affiliated institution or training program official.

SIGNATURE OF APPLICANT TIME STAMP DIGITAL SIGNATURE ONLY	DATE

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE

Public reporting burden for this collection of information is estimated to average 30 minutes, including the time for reviewing instructions, searching existing data sources, gathering data, completing, and reviewing the information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to VA Clearance Officer (005R1B), 810 Vermont Avenue NW, Washington, DC 20420. Do not send applications to this address.

AUTHORITY: The information requested on this 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 to determine your qualifications and suitability for appointment to a VA clinical training program. If you are appointed by VA, the information will be used to make pay and benefit determinations and in personnel administration processes carried out in accordance with established regulations and systems of records.

ROUTINE USES: Information on the form may be released without your prior consent outside the VA to another federal, state or local agency. It may be used to check the National Practitioner Health Integrity and Protection Data Bank (HIPDB) or the List of Excluded Individuals and Entities (LEIE) maintained by Health and Human Services (HHS), Office of Inspector General (OIG), or to verify information with state licensing boards and other professional organizations or agencies to assist VA in determining your suitability for a clinical training appointment. This information may also be used periodically to verify, evaluate, and update your clinical privileges, credentials, and licensure status, to report apparent violations of law, to provide statistical data, or to provide information to a Congressional office in response to an inquiry made at your request. Such information may 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. Information will be stored in a confidential and secure VA database for purposes of processing your application and may be verified through a computer matching program. Information from this form may also be used to survey you regarding employment opportunities in VA and to solicit you perceptions about your clinical training experiences at VA and non-VA facilities.

EFFECTS OF NON-DISCLOSURE: See statement below concerning disclosure of your social security number. Completion of this form is mandatory for consideration of your application for a clinical training position in VA; failure to provide this information may make impossible the proper application of Civil Service rules and regulations and VA personnel policies and may prevent you from obtaining employment, employee benefits, or other entitlements.

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

Disclosure of your Social Security Number (SSN) is mandatory to obtain the employment and benefits that you are seeking. Solicitation of the SSN is authorized under provisions of Executive Order 9397 dated November 22, 1943. The SSN is used as an identifier throughout your Federal career. 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 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, 'Applicants for Employment' under Title 38, U.S.C.-VA (02VA135), in the 2003 Compilation of Privacy Act Issuances. The SSN will also be used for the selection of persons to be included in statistical studies of personnel management matters. The use of the SSN is necessary because of the large number of Federal employees and applicants with identical names and birth dates whose identities can only be distinguished by the SSN.

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?	4. DATE OF BIRTH (MM / DD / YYYY)
(•) YES ( ) NO (If "NO", provide country of citizenship) ♦	♦
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*

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

Form Approved:
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: _____ (Sign in ink) Date _____

17b. Appointee's Signature: _____ (Sign in ink) Date _____

Appointing Officer:
Enter Date of Appointment or Conversion
MM / DD / YYYY

PLEASE SIGN 17a and 17b

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

In Reply Refer To: WOCAPPT
Contact Person: Bunna Suy
WOC Status: New
Patient Contact: Yes

Name:

VA Service: Nursing

Affiliate: CSU San Marcos

Program:

Welcome to the Department of Veterans Affairs and the VA San Diego Healthcare System! You will be assigned to our facility as a Without Compensation (WOC), health professions trainee, from until under the authority of Title 38 United States Code (U.S.C.) 7405(a) (1).

During your period of affiliation with our facility, you are authorized to perform services as directed by your program director, VA Site Director and the VA Designated Education Officer.

In accepting this assignment, you will receive no monetary compensation and you will not be entitled to those benefits normally given to regularly paid employees of the Veterans Health Administration (VHA).

If you agree to these conditions, please sign the statement below. Either party may terminate this agreement at any time by written notice of such intent.

Sincerely,

Kathryn D. Flores
Chief, Human Resources Management Service

I agree to serve in the above capacity under the conditions indicated.

Signature: _____ Date: _____

Printed Name:

Enclosure SF 61

DEPARTMENT OF VETERANS AFFAIRS
VA San Diego Health Care System
3350 La Jolla Village Dr.
San Diego, CA 92161

APPOINTMENT AFFIDAVITS

Nursing Student
(*Position to which Appointed)*

(*Date Appointed)*

Department of Veterans Affairs | Veterans Health Administration | VA San Diego Healthcare System

(*Department or Agency)* | (*Bureau or Division)* | (*Place of Employment)*

I, do solemnly swear (or affirm) that--

A. OATH OF OFFICE

I will support and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties of the office on which I am about to enter. So help me God.

B. AFFIDAVIT AS TO STRIKING AGAINST THE FEDERAL GOVERNMENT

I am not participating in any strike against the Government of the United States or any agency thereof, and I will not so participate while an employee of the Government of the United States or any agency thereof.

C. AFFIDAVIT AS TO THE PURCHASE AND SALE OF OFFICE

I have not, nor has anyone acting in my behalf, given, transferred, promised or paid any consideration for or in expectation or hope of receiving assistance in securing this appointment.

_____
(Signature of Appointee)

Subscribed and sworn (or affirmed) before me this___ day of _____, 2___

at _____ _____
(City) (State)

(SEAL)

Commission expires_____
(If by a Notary Public, the date of his/her Commission should be shown)

_____
(Title)

Note - If the appointee objects to the form of the oath on religious grounds, certain modifications may be permitted pursuant to the Religious Freedom Restoration Act. Please contact your agency's legal counsel for advice.

Department of Veterans Affairs

Memorandum

From: VHA Office of Academic Affiliations (OAA)

Subj: Random Drug Testing Notification and Acknowledgement

To: Health Professions Trainee (HPT) in a Testing Designated Positions (TDP)

1. On September 15, 1986, President Reagan signed Executive Order 12564, Drug-Free Federal Workplace, establishing a policy against the use of illegal drugs by Federal employees, whether on or off duty. In accordance with the Executive Order, VA has established a Drug-Free Workplace Program to include random testing for the use of illegal drugs by employees (to include trainees) in sensitive positions.

2. This is to notify you that as an HPT in a sensitive position you may be subject to random drug testing. The testing procedures, including the collection of a urine specimen, will be conducted in accordance with Department of Health and Human Services (HHS) Guidelines for Drug Testing Programs.

    a. The only VHA Training Programs exempt from Random Drug Testing per policy are: Clinical Pastoral Education (Chaplain), Social Work, Dietetics, Occupational Therapy, Optometry, Audiology, Speech Pathology, Non-Clinical and Administrative

3. You can be assured that the quality of testing procedures is tightly controlled, that the test used to confirm use of illegal drugs is highly reliable and that the test results will be handled with maximum respect for individual confidentiality, consistent with safety and security.

4. As a trainee subject to random drug testing you should be aware of the following:

    - Counseling and rehabilitation assistance are available to all trainees through existing Employee Assistance Programs (EAP) at VA facilities (information on EAP can be obtained from your local Human Resources office).
    - You will be given the opportunity to submit supplemental medical documentation of lawful use of an otherwise illegal drug to a Medical Review Officer (MRO).
    - VA will initiate termination of VA appointment and/or dismissal from VA rotation proceedings against any trainee who is found to use illegal drugs on the basis of a verified positive drug test.
    - Termination and/or dismissal from VA rotation proceedings will be initiated against any trainee who refuses to be tested.

5. Random testing will begin no sooner than 30 days from the date you sign this acknowledgement.

6. Visit the US Office of Personnel Management (OPM) Work-Life webpage for information on Services Available for You, Guidance & Legislation as well as Substance User Disorder. https://www.opm.gov/policy-data-oversight/worklife/employee-assistance-programs/

I acknowledge receiving and reading the notice which states that my position may be designated for random drug testing, and that, if selected, refusal to submit to testing will result in termination and/or dismissal from the VA.

CSU San Marcos

Training Program and Affiliate

Print Name and Date Signed

Signature

U.S. Department of Veterans Affairs
VA San Diego Healthcare System

AY21-22 Trainee Processing Checklist for Nursing Service

Last Name	First Name	Middle Name	SSN (no dashes)	Date of Birth	Place of Birth (City, State)

Sex	Race	Height	Weight	Eye Color	Hair Color

School:	Semester:	Current Year:	Instructor:

School Email:	Cell Phone:

Unit/Area:	Preceptor (if applicable):	Clinical Day(s):	Expected Grad (MM/YYYY):

On-Boarding Process	Instructions	Student's Initials
1. Complete and submit the Clinical Trainee Appointment Letter and Affidavit.	Sign and Date the Appointment Letter and Affidavit. You **do not need to notarize** the form.	
2. Complete and submit the following (*version 2011*) VA forms found on the internet: • Declaration for Federal Employment Form (OF-306) • Application for Health Professions Trainees (VA 10-2850d)	**TYPE** all items on the forms and sign as **Applicant *and* Appointee** (items 17a & 17b) on the OF-306. ***Handwritten documents will not be accepted***	

3. Complete TMS Self-Enrollment as "Health Professions Trainee" https://www.tms.va.gov/SecureAuth35/
• Click "**Create New Non-Employee User**"
• Choose "**Veterans Health Administration (VHA)**"
• Choose "**Health Professions Trainee**"
• Time Zone ID: **Pacific Standard Time (America/Los Angeles)**
• VA Location Code: Click on funnel and search for and select "**SDC**"
• Trainee Type: "**Nursing**"
• Specialty/Discipline:
  ○ RN students: Registered Nurse
  ○ LVN students: Licensed Vocational Nurse
  ○ CNS students: Clinical Nurse Specialist
  ○ NP students: Nurse Practitioner
• VA POC: Suzanne Carranza
• VA POC Email: suzanne.carranza@va.gov
• VA POC Phone: 8585528585
	Contact suzanne.carranza@va.gov to activate an existing TMS account.	

4. Complete the following TMS online training: • "VHA Mandatory Training for Trainees" • "BCMA Web-Based Training for Clinical Staff" (if passing meds) 5. Complete the Omnicell Access Form (if passing meds) 6. Complete and submit the "Random Drug Testing Notification and Acknowledgement" Form	Submit the following **6-8 documents** to Nursing Education: **1-*Trainee Processing Checklist,* 2-*Clinical Trainee Appointment Letter and Affidavit*** *(Item 1),* **3-*OF-306*** *and* **4-*VA 10-2850d*** *(Item 2),* **5-*VHA Mandatory Training for Trainees Certificate of Completion*** *(Item 4),* **6-*BCMA Certificate of Completion****, if passing meds (Item 4),* **7-*Omnicell Access Form****, if passing meds (item 5),* **8-*Random Drug Testing Form*** *(Item 6)* ***Handwritten documents will not accepted***	
7. Fingerprint at VA PIV Office (Walk-In Process Only) Location: VA La Jolla Medical Center, 1st Floor, Room 1508 Hours: 0700-1500 (M-F)	**TYPE** all highlighted items on the Fingerprint Form then submit form to staff in the PIV Office along with a government issued ID at time of fingerprinting.	

I certify that I have received the Mandatory Training information and will comply with the contents thereof.

_____ _____

Trainee's Signature Date

VA SAN DIEGO HEALTHCARE SYSTEM
OMNICELL ACCESS

BIO ID / PASSWORD CONFIDENTIALITY AGREEMENT AND ASSIGNMENT FORM

I, _____, understand that my User ID, Password **(4-12 characters)** and Biometric ID will be my electronic signature for all my Omnicell transactions while accessing patient medications in my assigned nursing unit(s). A time stamp and date will also be affixed to all my transactions. I will be required to enter a new and confidential password the first time I access Omnicell. I will be held accountable for all transactions performed utilizing my User ID, Password and Biometric ID. These records will be maintained and archived in the pharmacy as per the policies of the VA Healthcare System. These records will be available for inspection by the Drug Enforcement Administration (DEA) and other federal investigating organizations, as is currently the case with my handwritten records for controlled substances.

I also understand that to maintain the integrity of my electronic signature, **I must not and will not share this Password to any other individual**. Unauthorized access, release, or dissemination of this information may be subject to disciplinary action. Should I have any suspicion that my personal Password has become known to another individual, I will change it immediately and, if deemed appropriate, will immediately report such to my supervisor.

_____ _____
Signature **Date**

RN Student
_____ _____
Position (RN, LVN, SNT Valor/Extern, RT, CSD, CNS, RX TECH, CS Inspector, MD, RPh, etc.) **Department / Unit**

_____/_____
If student, start date/end date

****

***Authorized by*:**

Suzanne Carranza
_____ _____
Supervisor or Designee **Signature**

***Username will be first 5 letters of last name and first letter of first name; if last name has fewer than 5 letters, all letters will be used plus the first letter of first name (Ex: DoeJ for John Doe)