APPLICATION
&
REFERENCE FORMS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Program Support Center

Rockville MD 20857

To Applicants for Appointment in the Commissioned Corps of the Public Health Service:

Thank you for your interest in the Commissioned Corps of the United States Public Health Service.

The enclosed application may be used to apply for all programs of the Public Health Service which are staffed through the commissioned corps personnel system. Individuals appointed to the commissioned corps must agree to serve in any area or position in accordance with the needs of the Public Health Service.

Read and follow carefully the "Instructions for Submitting an Application for Appointment as a Commissioned Officer in the United States Public Health Service" enclosed with the material. Your compliance with these instructions will impact on the receipt, review, and evaluation of your application.

Thank you for considering the commissioned corps and service to your country.

Sincerely yours,

Terry Golden

CAPT Terry Golden
Chief, Recruitment and Assignment Branch
Division of Commissioned Personnel

Enclosures

7/2000

NOTE: ONLY UNITED STATES CITIZENS WHO MEET THE REQUISITE AGE, EDUCATIONAL, AND MEDICAL REQUIREMENTS MAY BE CONSIDERED FOR APPOINTMENT IN THE COMMISSIONED CORPS OF THE PUBLIC HEALTH SERVICE. CONSCIENTIOUS OBJECTORS WILL NOT BE CONSIDERED FOR APPOINTMENT UNLESS THEY ARE WILLING TO PERFORM NONCOMBATANT DUTY. ADDITIONAL INFORMATION MAY BE REQUESTED TO VERIFY STATEMENTS MADE IN THE APPLICATION.

The following materials are enclosed. **PLEASE** adhere to the specific instructions which follow:

1. Large manila envelope, pre-addressed to the Division of Commissioned Personnel.

2. Form PHS-50, "Application for Appointment as a Commissioned Officer in the U.S. Public Health Service Commissioned Corps" (2 copies).

3. Form PHS-1813, "Reference Request for Applicants to the U.S. Public Health Service Commissioned Corps," and letter-size envelopes, pre-addressed to the Division of Commissioned Personnel (4 sets).

Specific Instructions for Use of Provided Materials

1. Large Manila Envelope Pre-Addressed to the Division of Commissioned Personnel.

Complete and return all materials listed above (except for the references) in this envelope. Reference forms should be mailed by your listed references directly to the Division of Commissioned Personnel in the envelopes provided. **MAIL THESE MATERIALS DIRECTLY - DO NOT GIVE THIS APPLICATION TO ANY INDIVIDUAL FOR FORWARDING. DO NOT MAIL TO ANY OTHER ADDRESS. BE CERTAIN THAT SUFFICIENT POSTAGE AND YOUR RETURN ADDRESS ARE ON THIS ENVELOPE BEFORE MAILING.**

2. Form PHS-50, "Application for Appointment as a Commissioned Officer in the U.S. Public Health Service Commissioned Corps."

a. Complete either by typing or legibly printing in black ink. Submit signed original and a clearly readable copy (photocopy acceptable) with original signature. One copy will be used for administrative processing and the other copy will be used simultaneously by the appropriate program specialist.

b. Read each item carefully. *Items 13 through 20, Items 23 B and 23 C, and Item 25* must be answered with a yes or no. If you enter "not applicable" or leave these questions blank, your application may not be processed. You may use "not applicable" or "NA" for other questions that do not apply to you. Give complete answers. Do not leave any question blank.

c. You must not delete or modify any of the items.

Item 1a. Give your full name, including maiden name, if any.

Item 1b. Other names are needed to assure that all records (e.g., transcripts, references, etc.) are available in the same applicant's file.

Item 2. Enter your Social Security Number (SSN). See attached Privacy Act Notice regarding disclosure of your SSN.

Item 3a. Your date of birth indicates whether you are eligible for appointment.

Item 3b. Enter your place of birth (City and State).

Item 4. Enter your profession.

Item 5. Provide information required to determine citizenship. Only United States citizens can be appointed in the Commissioned Corps of the Public Health Service. If you are appointed to the Commissioned Corps of the Public Health Service, you will be required to furnish proof of your United States citizenship. If you were born in a country other than the United States, you must provide sufficient information to permit verification of your citizenship and to conduct the suitability investigation required for all applicants by Public Health Service regulations.

a. Applicants Born in a Country Other Than the United States Whose Parents Were U.S. Citizens.

Submit a copy (**DO NOT SEND ORIGINAL**) of a Consulate Report of Birth (Foreign Service Form 240).

b. Naturalized Citizen Applicants.

You must possess a Certificate of Naturalization to be considered for commissioning. **DO NOT SEND ORIGINAL OR COPY OF CERTIFICATE**. Provide information as requested.

Item 6. Indicate the types of duty for which you are applying and provide availability date, as required. You may apply for both the Junior Commissioned Officer Student Training and Extern Program (COSTEP) and the Senior COSTEP if you are within 18 months of graduation. Note: You will not be eligible for Senior COSTEP if you have less than 8 months until graduation (at the time of your appointment).

Item 7. The address where you can currently be reached is needed. Also telephone numbers (area code, number, and extension) and fax number where you can be reached during business hours - whether at home, at work, or in school, and an e-mail address, if available, should be provided.

Please furnish zip codes for all addresses.

Item 8. If the current address where you can be reached is temporary, please provide "permanent" locator information. This information should also include telephone numbers (area code, number, and extension) and fax number where you can be reached during business hours - whether at home, at work, or in school. Please furnish zip codes for all addresses.

Item 9. Give full name of college, university, or other institution, including location (City, State, and zip code). Do not abbreviate name of college, university, etc.

OFFICIAL TRANSCRIPTS ARE REQUIRED. **Student copies are not acceptable**. If available, submit with your application. You must have your official transcripts forwarded to the address shown on the large manila envelope enclosed. **NO APPOINTMENTS TO THE COMMISSIONED CORPS CAN BE MADE WITHOUT RECEIPT OF ALL OFFICIAL TRANSCRIPTS.**

NOTE: Only individuals whose education and professional training were in a program accredited by the appropriate accreditation body can be considered for appointment in the Commissioned Corps of the Public Health Service. The program must have been accredited at the time you graduated. The applicant is cautioned that "approved" does not necessarily mean accredited. Use space in Item 30, if necessary.

a. Be sure to list your major and number of hours, since they may be used in the selection and appointment process.

b. Individuals who received training in internship and residency programs should indicate full information here. Since allowable credit is based on specific time spent in training, include month and year for your periods of training.

Item 10. Service in any of the Uniformed Services of the United States may be creditable toward pay, allowances, and retirement as an officer in the Public Health Service Commissioned Corps. Please be sure to indicate whether your service was "Active" or "Inactive." After your application has been reviewed, you will be asked to obtain a Statement of Service to officially document all of your creditable service.

Item 11. Needed for the selection process; also assures that all records are available in the applicant's file.

Item 12. List all of your dependents. Dependents of officers are entitled to certain benefits so it is important that you list each of your dependents.

Item 13. Indicate whether or not you have received any Federal Government scholarships. If so, check appropriately and indicate your service obligation in years.

Items 14, 15. Needed for selection process. A conviction does not necessarily mean you cannot be appointed. The nature of the conviction and how long ago it occurred are important. Give all the facts so

that a decision can be made. A suitability background investigation is conducted on each applicant.

Item 16. You must indicate whether or not you have any outstanding Federal debts.

Items 17, 18. Conscientious objectors will not be considered for appointment unless they are willing to perform noncombatant duty. The Commissioned Corps of the Public Health Service is one of the Uniformed Services of the United States. Read carefully the 'Note' in Item 18.

Items 19, 20. A conviction does not necessarily mean you cannot be appointed. The nature of the conviction and how long ago it occurred are important. Give all the facts so that a decision can be made. A background investigation is conducted on each applicant.

Item 21. You must use as references those individuals who are knowledgeable about your professional work or training. Your clergyman, high school teacher, relatives, etc., are not acceptable. Note that you must list your most recent employer; also list other professionals who are familiar with your recent work or training and who are in the same professional category as the one for which you are applying. Preferred references are those from the Dean of the College, Dean of Graduate or Professional School, Director of Training Programs, Chairpersons of Departments, and employment supervisors. Please furnish complete addresses.

If you are or have been in private practice, use institutional references where appropriate. You should list the Clinical Director, Director of the Service, etc., of the health care facility where you practiced.

Item 22. List only active, full, and unrestricted professional licenses/certificates/registrations. NOTE: Only members of the professional categories listed below must submit copies of their licenses/certificates/registrations. If not licensed, give date you expect to take examination for professional licensure/certification/registration.

At the present time the following categories or disciplines require licensure, certification, or registration: Physician, Dentist, Nurse, Clinical Psychologist, Veterinarian, Pharmacist, Dietitian or Nutritionist, Physical Therapist, Occupational Therapist, Speech-Language Pathologist, Audiologist, Dental Hygienist, Physician Assistant, Podiatrist, Optometrist, Social Worker, Medical Record Administrator, and Medical Technologist.

Item 23. List your current Drug Enforcement Administration (DEA) controlled substances registration number if you have one. Details of A. - C. are needed for processing your application. If any "Yes" answers, explain in the space provided in Item 30.

Item 24. If you have received an Educational Commission for Foreign Medical Graduates (ECFMG) certificate, please submit a photocopy.

Item 25. Details of A. - H. are needed for processing your application. If you answer "Yes" to any question, please give details in the space provided in Item 30.

Item 26. Needed for processing your application.

Item 27. Provide complete information about your employment history. Note that employment prior to commencing undergraduate school is not required. Specify the average number of hours worked per week. Include zip code for all addresses. NOTE: Attaching a curriculum vitae or resume is helpful; however it does not substitute for completing Item 27.

Item 28. Selected assignments may require the ability to communicate in a foreign language. List additional information which may be useful in the selection process.

Item 29. Your indication of the type of assignment which interests you and the geographic areas in which you prefer to serve are of importance in the selection process. Please respond in priority order, i.e., (1) first choice, (2) second choice, etc.

Item 30. Provide details to questions here. If more space is required use 8½ by 11 inch sheets of paper on which you place your name, present mailing address, Social Security Number, and reference to the pertinent item numbers.

NOTE: There is a statement to be signed by each applicant regardless of the program for which you are applying. Your specific attention is directed to the certification which you are asked to sign. Note that you are making an application to one of the Uniformed Services of the United States.

BE SURE TO SIGN YOUR FULL NAME ON BOTH COPIES OF THE APPLICATION FORM AND DATE BOTH COPIES. EACH COPY MUST BEAR AN ORIGINAL SIGNATURE AND DATE.

3. **Form PHS-1813, "Reference Request for Applicants to the U.S. Public Health Service Commissioned Corps," and letter-size envelope with return address.**

   a. Re-read instructions for Item 21, References, on PHS-50, application form.

   b. Type or print in black ink your name on the form PHS-1813 in the space provided. If you were known to your reference by another name, i.e., a maiden or other name, please supply that name in the provided box. You must do this; if not, we may not be able to identify you as the applicant when the completed forms are received. *Note*: Do **not** put your reference's name in this box.

   c. Forward in your own envelope to each person listed in Item 21 of the form PHS-50, one copy of form PHS-1813, "Reference Request for Applicants to the U.S. Public Health Service Commissioned Corps," together with one of the enclosed pre-addressed envelopes. You should add postage to the pre-addressed envelopes before you forward them to the individuals listed as references. You should request these persons to complete the form and forward it directly in the pre-addressed envelope provided.

   d. The Public Health Service will **NOT** contact listed individuals to ensure they forward the reference forms, PHS-1813. It is your responsibility to follow up with these individuals. Evaluation of your application cannot be completed without these forms.

4. **SF-93, "Report of Medical History" and SF-88, "Report of Medical Examination."**

You will be advised at a later date concerning the physical examination and arrangements therefor. **Do not make any arrangements until requested to do so**.

5. **Information for Applicants with Military Commitments (Active Duty, Reserve, etc.).**

Subject: Transfer of Commissioned Officers to the Commissioned Corps of the U.S. Public Health Service

Primary References:
(a) DoD Directive 1300.4, subject as above, dated April 2, 1984
(b) INSTRUCTION 5, Subchapter CC23.3, "Inter-Service Transfer of Commissioned Officers," of the Commissioned Corps Personnel Manual (CCPM)
(c) INSTRUCTION 4, Subchapter CC23.3, "Appointment Standards and Appointment Boards," of the CCPM

a. **Basic Standards**

The Public Health Service Commissioned Corps will accept your application for appointment on form PHS-50, "Appointment as a Commissioned Officer in the U.S. Public Health Service Commissioned Corps," **without** a conditional release, if the Division of Commissioned Personnel determines that you meet the basic criteria for appointment as follows:

(1) Age. Be less than 44 years of age at the time of appointment. Time spent in active service with one of the seven Uniformed Services (excludes weekend drill time for reservists) is counted as off-setting service. For example, a 47-year-old applicant with 4 years of active Federal military service with the U.S. Army would be viewed as 43 years of age with the off-setting active service. Also, applicants with up to 5 years active service with the Public Health Service Commissioned Corps, other than as a commissioned officer, which the Surgeon General determines is comparable to service performed by a commissioned officer of the Public Health Service, will have this time counted as off-setting service.
(2) Military Service. Cannot exceed 8 years of active Federal military service.
(3) Citizenship. Must be a U.S. citizen.
(4) Must have a qualifying degree (which varies by category). A qualifying degree is one which has been accredited or approved by a nationally recognized professional accrediting body or bodies acceptable to the Director, Division of Commissioned Personnel. Accrediting bodies acceptable to the Director, Division of Commissioned Personnel, are found on page 17 of INSTRUCTION 4, Subchapter CC23.3 of the CCPM.
(5) Suitability Issues. Must be no obvious pending suitability issues which might preclude commissioning.
(6) Medical Issues. Must be no obvious pending medical issues which might preclude commissioning.

b. **Release from Military**

However, prior to being called to active duty, you must, in addition to meeting all of the basic appointment standards listed above, obtain one of the following forms of release from the military:

(1) Inter-Service Transfer: Regular component commissioned officers and reserve component commissioned officers, serving full-time active duty.
A concurrence for inter-service transfer from the respective Service Secretary is required. The officer applies for an inter-service transfer in accordance with the losing Service's procedures. At the same time, the officer should apply for commissioning with the Public Health Service Commissioned Corps using form PHS-50, "Application for Appointment as a Commissioned Officer in the U.S. Public Health Service Commissioned Corps." If the Service Secretary concurs and the military officer is fully cleared for appointment with the Public Health Service Commissioned Corps and Division of Commissioned Personnel has received form PHS-1662, "Request for Personnel Action - Commissioned Officer," from an Agency/Operating Division/ Program, the Division of Commissioned Personnel can prepare the inter-service transfer call-to-active-duty personnel order.

(2) Conditional Release: Regular component commissioned officers and reserve component commissioned officers, serving full-time active duty.

For personal reasons, some full-time active-duty military applicants opt to resign their commission with their military service in lieu of executing an inter-service transfer. It is recommended that an officer in this category obtain a conditional release. Your application can be processed while your request for conditional release is being initiated. Once the military officer is fully cleared for appointment with the Public Health Service Commissioned Corps and the Division of Commissioned Personnel has received form PHS-1662, "Request for Personnel Action - Commissioned Officer," from an Agency/Operating Division/ Program, the officer will be advised to obtain a discharge from the military service. The Division of Commissioned Personnel does not recommend that you obtain your actual discharge until the Division of Commissioned Personnel has issued you an offer of commission via an "acceptance letter."

As a possible alternative to a conditional release, you may wish to consult with your military personnel officer about the possibility of rendering an unqualified resignation, **contingent upon acceptance into the Public Health Service Commissioned Corps**. This allows you to retain your military commission in the event that the Division of Commissioned Personnel does not call you to active duty. It also reduces delays in obtaining your military discharge in the event that you meet all of the Public Health Service Commissioned Corps' criteria for appointment and call-to-active-duty.

(3) Conditional Release: Reserve component, not full-time active duty.
Conditional release is sufficient for all officers in a reserve component who are not on full-time active duty. When applicants in this category are fully cleared for

commissioning and the Division of Commissioned Personnel is in receipt of a conditional release, along with all other required documents, the Division of Commissioned Personnel will prepare the call-to-active-duty personnel order, sending a copy of it along with a copy of the Appointment Affidavit (Oath) to the reserve command. The reserve command then issues the discharge order effective the date prior to the Public Health Service's call-to-active-duty date.

c. **Additional Information/Time Frames/Contacts**

(1) The inter-service transfer offers the following advantages:

- you are guaranteed your current military pay grade;
- there will be no break in service or change in basic pay, retirement eligibility date, etc.;
- you receive the dislocation allowance entitlement if a permanent change of station move occurs; and
- all unused leave is transferred.

(2) DoD Directive 1300.4 dated April 2, 1984, is the authority for inter-service transfers and applies to all of the Military Departments and by agreement with the Secretaries of Transportation, Commerce, and Health and Human Services, to the Coast Guard, the Commissioned Corps of the National Oceanic and Atmospheric Administration, and the Commissioned Corps of the Public Health Service.

(3) The military services typically require 3 to 5 months to process a request for inter-service transfer and 2 to 3 months to process a request for resignation/discharge. It may take several weeks to several months to obtain a conditional release from the reserve component (e.g., Individual Ready Reserve, Troop Program Unit, National Guard, etc.)

If you have questions about a commission with the Public Health Service Commissioned Corps, you may phone the technicians in the Recruitment and Applications Branch, Division of Commissioned Personnel. The phone number is 301-594-3544 (or toll-free at 1-877-INFO-DCP, listen to the prompts, select option #1, dial 43544). The technicians work on an alphabet system; simply give your last name to the individual answering the phone and you will be referred to the correct technician for assistance.

6. **Information for Persons Conscientiously Opposed to Military Service.**

Individuals willing to perform noncombatant duty with a branch of the military service can be considered for appointment in the Commissioned Corps of the Public Health Service. Persons whose conscientious objection extends to being opposed to participation in war or military service in any form are not eligible for appointment in the Commissioned Corps of the Public Health Service.

The rationale for denial of appointment to persons opposed to both combatant and noncombatant service is rooted in the inclusion of the Public Health Service in the Military Service Act of 1967, and earlier versions of the Act, and the authority of the President to declare, by Executive Order, the Commissioned Corps of the Public Health Service to be a military service in time of war or national emergency.

Many Public Health Service commissioned officers are assigned to the U.S. Coast Guard, while others are detailed to other branches of the Armed Forces. In accepting an appointment in the Commissioned Corps of the Public Health Service, one agrees to serve wherever the needs of the Service may require. We cannot assure candidates that the Public Health Service will not be militarized nor that they will not be assigned or detailed to a military service.

7. **ADDRESS ALL FUTURE COMMUNICATIONS/CORRESPONDENCE WITH RESPECT TO THE STATUS OF YOUR APPLICATION TO:**

Division of Commissioned Personnel
ATTN: Recruitment and Assignment Branch
5600 Fishers Lane, Room 4-20
Rockville, MD 20857-0001
Phone: 301-594-3544 (or toll-free at 1-877-INFO-DCP,
listen to the prompts, select option #1, dial 43544)

Paperwork Reduction Act Statement

A Federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Public reporting burden for this collection of information is estimated to vary from 45 to 75 minutes with an average of 1 hour per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the necessary data, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information to the Reports Clearance Officer, Program Support Center, Department of Health and Human Services, Room 17A-18, Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857. **Please do not send completed applications to the public burden statement address.**

Privacy Act Notice for Public Health Service Commissioned Corps Application Forms, Including:

PHS-50	- Application for Appointment as a Commissioned Officer in the U.S. Public Health Service Commissioned Corps
PHS-1813	- Reference Request for Applicants to the U.S. Public Health Service Commissioned Corps
PHS-5141	- Public Health Service Commissioned Corps Appointment Affidavit – Reserve Corps (Oath of Office)
SF-88	- Report of Medical Examination
SF-93	- Report of Medical History

NOTE: Not all of the above forms may be included in your application packet (i.e., some are designed for specific programs, and others may be forwarded at a later date as your application is processed).

This information is provided pursuant to the Privacy Act of 1974, to help you understand why we need the information on the enclosed forms, to explain the way this information is used, and to inform you of your rights of personal privacy and access to this data.

Authority for collecting this information: The Public Health Service Act (42 U.S.C. 202 et seq.) and commissioned corps regulations (INSTRUCTION 1, Subchapter CC43.7 of the Commissioned Corps Personnel Manual).

Uses of the information you provide: You provide this information to allow us to determine your eligibility for commissioning in the Public Health Service. If you are commissioned, the information collected will be used for subsequent personnel actions such as transfer, promotion, determining eligibility for benefits and other routine purposes related to personnel administration. Information you provide may also be disclosed, but only to the extent necessary, to agencies and organizations outside the Department of Health and Human Services when those agencies need the information for one of the routine uses listed in Privacy Act System Notice 09-40-0001, "Public Health Service Commissioned Corps General Personnel Records," HHS/PSC/HRS. Except in these specific incidences, information about you will be disclosed to no one without your express written permission. For a copy of the Privacy Act System Notice cited above, contact the office to which you send these forms.

Information regarding disclosure of your Social Security Number (SSN): Disclosure of your SSN is mandatory pursuant to the Social Security Act, since Social Security taxes must be deducted from your salary. The SSN is also used as an identifier throughout your career in accordance with Executive Order 9397, "Numbering System for Federal Accounts Relating to Individual Persons."

Effects of nondisclosure: Failure to provide the information requested will eliminate your application from further consideration or may be cause for separation if you are commissioned on the grounds of false or incomplete information. All statements are subject to investigation including a check of your fingerprints, police records, and former employers. If you are commissioned, failure to supply requested information accurately and expeditiously may result in loss of your benefits and rights as a commissioned officer.

DCP USE ONLY: Date Avail: _____ Cat: _____ Trn Code: _____ Appt Type: _____ Age: _____ Grad Date: _____

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service

OMB No. 0937-0025
Expiration: 7/31/2003

APPLICATION FOR APPOINTMENT AS A COMMISSIONED OFFICER IN THE U.S. PUBLIC HEALTH SERVICE COMMISSIONED CORPS

BEFORE COMPLETING THE APPLICATION, READ ATTACHED INSTRUCTIONS CAREFULLY. GIVE COMPLETE ANSWERS TO ALL ITEMS.

TYPE OR PRINT IN INK. If additional space is needed, attach an 8 ½ x 11 inch sheet of paper. Include your name, address, social security number, and the pertinent item numbers on each sheet so used. All material submitted becomes the property of the Federal Government and will not be returned. Part of the information will be used for a suitability/background investigation. **YOU MUST SIGN THIS APPLICATION ON PAGE 5 OR YOUR APPLICATION WILL NOT BE PROCESSED.**

Submit signed original and a clearly readable copy (photocopy acceptable) with **original signature** to: Division of Commissioned Personnel, 5600 Fishers Lane, Room 4-20, Rockville, MD 20857-0001.

1a. FULL NAME *(Last, First, Middle)* *(Maiden, if any)*

2. SOCIAL SECURITY NUMBER ___ ___ ___ - ___ ___ - ___ ___ ___ ___

3a. DATE OF BIRTH *(MM/DD/YYYY)* ___ ___ / ___ ___ / ___ ___ ___ ___

1b. OTHER NAMES USED *(Continue in Item # 30 if needed)* From: *(MM/YYYY)* Through: *(MM/YYYY)*

_____ ___ ___ / ___ ___ ___ ___ ___ ___ / ___ ___ ___ ___

_____ ___ ___ / ___ ___ ___ ___ ___ ___ / ___ ___ ___ ___

3b. PLACE OF BIRTH ***(City and State)***

4. PROFESSION ***(e.g., Chemist, Nurse, Physician)***

5. CITIZENSHIP *(Only United States Citizens may be appointed to the Commissioned Corps of the Public Health Service)*

☐ NATIVE ☐ If NATURALIZED *(Answer A, B, C, D, E)*

A. Entered: Month_____ Day_____ Year_____
B. Naturalized: Month_____ Day_____ Year_____
C. Naturalization Number: _____
D. Person to whom number was issued: _____
Place Naturalized: _____
E. Is your name on the certificate? ☐ Yes ☐ No

6. TYPES OF DUTY(IES) FOR WHICH YOU ARE APPLYING: *(Indicate all that are applicable and appropriate, Dates MM/YYYY)*

☐ General Duty (extended Active Duty)
Available for Active Duty:
___ ___ / ___ ___ ___ ___

☐ Junior COSTEP *(Applicant must be a full-time student)*
From: ___ ___ / ___ ___ ___ ___
To: ___ ___ / ___ ___ ___ ___

☐ Senior COSTEP *(Applicant must be a full-time student)*
From: ___ ___ / ___ ___ ___ ___
To: ___ ___ / ___ ___ ___ ___

7. CURRENT INFORMATION FOR CONTACTING YOU: ***(YOU MUST NOTIFY THE DIVISION OF COMMISSIONED PERSONNEL (DCP) IMMEDIATELY OF ANY CHANGES)***

Mail: Contact Name: _____
Street: _____
City: _____
State: ___ ZIP: ___ ___ ___ ___ ___ + ___ ___ ___ ___
Telephone (Include Area Code):
Current: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
Business: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Ext._____
FAX: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
E-Mail: _____

8. "PERMANENT" INFORMATION FOR CONTACTING YOU:

Mail: Contact Name: _____
Street: _____
City: _____
State: ___ ZIP: ___ ___ ___ ___ ___ + ___ ___ ___ ___
Telephone (Include Area Code):
Current: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
Business: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Ext._____
FAX: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
Any additional information should be listed in Item #30.

9. BASIC EDUCATION AND PROFESSIONAL TRAINING *(Include below, all degrees you have earned or training you will have completed by the time you are available for appointment. Official transcripts to include final or latest grading period for all college, graduate, and professional training MUST BE SUBMITTED BEFORE YOU CAN BE APPOINTED.)*

COLLEGE, UNIVERSITY, OR OTHER INSTITUTION *(Include City, State, and ZIP)*	DATES ATTENDED FROM *(MM/DD/YYYY)*	TO *(MM/DD/YYYY)*	TOTAL HOURS CREDIT *(Specify)* Qtr. or Sem.	MAJOR	DEGREE	OFFICIAL NUMBER YEARS IN PROGRAM	DEGREE REQUIREMENTS FULFILLED *(MM/YYYY)*	DEGREE CONFERRED OR WILL BE CONFERRED *(MM/YYYY)*

INTERNSHIP OR RESIDENCY COMPLETED (MUST PROVIDE CERTIFICATE), CURRENTLY SERVING, OR SCHEDULED TO COMMENCE

HOSPITAL OR INSTITUTION *(Include City, State, and ZIP)*	FROM *(MM/YYYY)*	TO *(MM/YYYY)*	SPECIFY TYPE AND SPECIALTY *(if applicable)* (e.g. Rotating, Mixed, or Straight, Categorical, Surgery, Family Practice)

Created by: PSC Media Arts (301) 443-2454 EF

10. UNIFORMED SERVICE: List below in chronological order all service you have had in the ARMY, NAVY, AIR FORCE, MARINE CORPS, COAST GUARD, COMMISSIONED CORPS OF THE NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION, and COMMISSIONED CORPS OF THE U.S. PUBLIC HEALTH SERVICE (PHS). Include any present Uniformed Services affiliations: PHS, Reserve Unit, ROTC commitment, etc. **Except for PHS affiliation, you will soon be asked to initiate a request for inter-service transfer, conditional release, or to provide proof of discharge, as may be applicable to your situation. No immediate action is required.**

SERVICE COMPONENT	REGULAR OR RESERVE	HIGHEST RANK HELD	DUTY FROM *(MM/DD/YYYY)*	TO *(MM/DD/YYYY)*	ACTIVE OR INACTIVE DUTY	TOTAL ACTIVE NON-PUBLIC HEALTH SERVICE TIME *(In years and months)*

11. Were you ever rejected for duty in any branch of a Uniformed Service?
☐ Yes ☐ No If "Yes," state when and where rejected and cause: _____

12. DEPENDENTS INFORMATION (Full name of spouse and full name(s) and date(s) of birth of child(ren) and/or other dependent(s)): *(Continue in Item #30 if needed)*

(Name)	*(Relationship)*	*(Date of Birth: MM/DD/YYY)*
	SPOUSE	__ __ / __ __ / __ __ __ __
		__ __ / __ __ / __ __ __ __
		__ __ / __ __ / __ __ __ __

Indicate Answers by Placing an "X" in the Appropriate Column.	YES	NO
13. Have you ever received a Federal Government scholarship? If Yes, check appropriately: ☐ Indian Health Service ☐ National Health Service Corps ☐ Other *Describe:* _____ Length of Service obligation: _____ Years		
14. Have you ever been convicted, forfeited collateral, or are you now under charges for any felony or for any firearms or explosives violations? (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.)		
15. 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 item 14 above? (When answering items 14 and 15, you may omit: (a) traffic fines for which you paid a fine of $150.00 or less, (b) any offense committed before your 18th birthday which was finally adjudicated in a juvenile court or under a youth offender law, (c) any conviction the record of which has been expunged under Federal or State law, and (d) any conviction set aside under the Federal Youth Corrections Act or similar State authority.)		
16. Are you delinquent on the repayment of any Federal debt(s)? If your answer is "Yes," please provide an explanation in item 30. (Examples of Federal debt include delinquent taxes, audit disallowances, guaranteed or direct student loans, FHA loans, and other miscellaneous administrative debts. The definition of delinquency for the purposes of direct and guaranteed loans are any loan(s) more than 31 days past due on a scheduled payment. Deferred loans are not considered delinquent.)		
17. Are you a conscientious objector to military service? (If "No," go to question 19.)		
18. If you are a conscientious objector, are you willing to serve in a noncombatant position? (**NOTE:** By Executive Order, the PHS Commissioned Corps may be militarized during times of national emergency and does have officers serving in support roles at all times. If in this item (18) you state an objection, you will be precluded from appointment in the Commissioned Corps of the Public Health Service.)		
19. If you served in the military service, were you ever convicted by a general court martial or have you ever received less than an honorable discharge?		
20. Have you ever been charged with, or are currently facing charges, of a violation of any State law pertaining to habit-forming drugs, narcotics, or intoxicating liquor? (**NOTE:** If your answer to items 14, 15, 16, 19, or 20 is "Yes," give details in item 30. Show for each offense: (a) date, (b) charge, (c) place, (d) court, and (e) action taken.)		

21. REFERENCES: List the names of four individuals, including your most recent employer, with whom you have had professional affiliation or training at some time during the past seven years. Include, where applicable, Dean of College; Dean of Graduate or Professional school; Director of Intern Training Program; Director of Graduate, Post-Graduate, Residency, or Specialty training; chairperson of departments in which graduate or professional work was taken; or employment supervisors.

	FULL NAME	PROFESSIONAL RELATIONSHIP TO APPLICANT	BUSINESS ADDRESS *(Organization and Street, City, State, ZIP, Telephone)*
1)			( ) -
2)			( ) -
3)			( ) -
4)			( ) -

22. LIST STATES GRANTING FULL/UNRESTRICTED PROFESSIONAL LICENSES/CERTIFICATES/REGISTRATIONS *(Include license or registry number and expiration date and* ***provide a copy of the license/certificate/registration.****)*

23. DRUG ENFORCEMENT ADMINISTRATION (DEA) CONTROLLED SUBSTANCE REGISTRATION INFORMATION

(If you were never registered, so state)

A. List all jurisdictions (past and present) where you are or were registered under Title 21, U.S. Controlled Substances Act, and provide your DEA controlled substance registration number for each jurisdiction.

(Explain all "Yes" answers in Item 30)	YES	NO
B. Has your registration under this Act ever been denied, suspended, revoked, refused renewal, or voluntarily surrendered?		
C. Have you ever been charged with, or are currently facing charges of, a violation of this Act?		

24. STATUS IN PROFESSIONAL BOARDS *(Indicate date and type of board, and whether Board Eligible, Board Certified, or Board Examination has been taken.* ***Submit copy of ECFMG Certificate and Board Certification, if any.****)*

25. EXPLAIN ALL "YES" ANSWERS IN ITEM 30.

	YES	NO
A. Have you ever been denied membership or renewal thereof, or been subject to disciplinary proceedings by any medical or professional organization?		
B. Have you ever lost or had your professional practice license revoked?		
C. Have liability claims been filed against you, or against a hospital, corporation, or government based on a case under your care?		
D. Have judgements or settlements been made against you, or against a hospital, corporation, or government based on a case directly under your care?		
E. Have you ever had, or are you about to have, your professional liability insurance declined, canceled, issued on special terms, or refused renewal?		
F. Have you ever been censured or reprimanded by a licensing board, hospital medical board/staff, or any other professional organization?		
G. Have you ever been sanctioned by the Medicare or Medicaid Programs or by any other Federal agency?		
H. Have any or all of your privileges at any health care facility ever been, or are about to be, limited, suspended, revoked, refused renewal, or voluntarily surrendered?		

26. Provide the names and addresses (past and present) of all of your professional liability insurers and your policy numbers.

27. EMPLOYMENT HISTORY

Begin with current or most recent work or volunteer experience and work back. Account for any periods of unemployment on the last line of the experience blocks in order of occurrence. Do not list any employment prior to commencing undergraduate school. For your PROFESSIONAL EXPERIENCE AND WORK RECORD, include professional training positions not reflected in item 9. Include assistantships, apprenticeships, and fellowships. Describe your duties, including: (a) professional skills involved; (b) degree of responsibility; (c) complexity of duties; (d) extent of supervision received and exercised; (e) extent of public contact; and (f) extent of influence on policy.

DATES EMPLOYED *(MM/YY:Y)* From: __ __ / __ __ __ __ To: __ __ / __ __ __ __	EMPLOYER / VERIFIER NAME / MILITARY DUTY LOCATION			YOUR POSITION TITLE / MILITARY RANK
EMPLOYER 'S / VERIFIER'S STREET ADDRESS	CITY *(Country)*	STATE	ZIP *(+4)* __ __ __ __ __ + __ __ __ __	TELEPHONE NUMBER ( )
STREET ADDRESS OF JOB LOCATION	CITY *(Country)*	STATE	ZIP *(+4)* __ __ __ __ __ + __ __ __ __	TELEPHONE NUMBER ( )
SUPERVISOR'S NAME & STREET ADDRESS *(If different than Job Location)*	CITY *(Country)*	STATE	ZIP *(+4)* __ __ __ __ __ + __ __ __ __	TELEPHONE NUMBER ( )
AVERAGE NUMBER OF HOURS PER WEEK	KIND OF BUSINESS OR ORGANIZATION *(e.g., education, health, social services, etc.)*			

REASON FOR LEAVING OR WISHING TO LEAVE

DESCRIPTION OF WORK *(Describe your specific duties, responsibilities, and accomplishments in this job.)*

27. EMPLOYMENT HISTORY (Continued)

DATES EMPLOYED *(MM/YYYY)* From: __ __ / __ __ __ __ To: __ __ / __ __ __ __	EMPLOYER / VERIFIER NAME / MILITARY DUTY LOCATION			YOUR POSITION TITLE / MILITARY RANK
EMPLOYER 'S / VERIFIER'S STREET ADDRESS	CITY *(Country)*	STATE	ZIP *(+4)* __ __ __ __ __ + __ __ __ __	TELEPHONE NUMBER ( )
STREET ADDRESS OF JOB LOCATION	**CITY *(Country)***	STATE	ZIP *(+4)* __ __ __ __ __ + __ __ __ __	TELEPHONE NUMBER ( )
SUPERVISOR'S NAME & STREET ADDRESS *(If different than Job Location)*	CITY *(Country)*	STATE	ZIP *(+4)* __ __ __ __ __ + __ __ __ __	TELEPHONE NUMBER ( )
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DESCRIPTION OF WORK *(Describe your specific duties, responsibilities, and accomplishments in this job.)*

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STREET ADDRESS OF JOB LOCATION	CITY *(Country)*	STATE	ZIP *(+4)* __ __ __ __ __ + __ __ __ __	TELEPHONE NUMBER ( )
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AVERAGE NUMBER OF HOURS PER WEEK	KIND OF BUSINESS OR ORGANIZATION *(e.g., education, health, social services, etc.)*			

REASON FOR LEAVING OR WISHING TO LEAVE

DESCRIPTION OF WORK *(Describe your specific duties, responsibilities, and accomplishments in this job.)*

28. ADDITIONAL SKILLS AND QUALIFICATIONS

FOREIGN LANGUAGE: Do you have adequate competency to use any language(s) in performance of duty? ☐ YES ☐ NO, If "Yes," specify language and proficiency level. **1** = Elementary Proficiency, **2** = General Professional Proficiency, **3** = Functionally Native Proficiency

Language	Proficiency	Language	Proficiency

HONORS AND AWARDS (Acquired by academic or non-academic experience.)

NONDEGREE RELATED TRAINING (e.g., computer skills, public speaking, leadership recognition, American Council of Learned Societies (ACLS) fellowship program, Basic Life Support (BLS), CardioPulmonary Resuscitation (CPR), Emergency Medical Services, etc.)

LIST CURRENT OR FORMER MEMBERSHIP IN PROFESSIONAL ASSOCIATIONS (Also indicate office(s) held and committee membership(s).)

29. TYPES OF ASSIGNMENTS IN WHICH YOU ARE INTERESTED

Officers are required to serve in any area or climate or wherever the needs of the Public Health Service Commissioned Corps may require.

Do you have a preference for assignment to a particular program? ☐ YES ☐ NO If "Yes," which program? (e.g., Indian Health Service, Federal Bureau of Prisons, etc.)

GEOGRAPHIC AREAS IN WHICH YOU PREFER TO SERVE (e.g., Southwest U.S., Northeast U.S., name of State)

30. SPACE FOR DETAILED ANSWERS

(Indicate item numbers to which the answers apply. If more space is required, attach an 8 ½ x 11 inch sheet of paper. Write your name, present mailing address, and Social Security Number on each sheet.)

ATTENTION - THIS STATEMENT MUST BE SIGNED BY ALL APPLICANTS
Read the following paragraphs carefully before signing this Statement.

A false answer to any question in this Statement may be grounds for not appointing you, or for dismissing you after appointment, and may be punishable by fine or imprisonment (U.S.Code, Title, 18, Section 1001). All the information you give will be considered in reviewing your application.

AUTHORITY FOR RELEASE OF INFORMATION

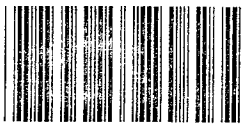
I have completed this Statement with the knowledge and understanding that any or all items contained herein may be subject to investigation prescribed by law or Presidential directive and I consent to the release of information concerning my capacity and fitness by employers, educational institutions, law enforcement agencies, and other individuals and agencies, to duly accredited investigators, Personnel Staffing Specialists, and other authorized employees of the Federal Government for that purpose. I hereby release from liability all representatives of the Federal Government for their acts performed in good faith and without malice in connection with evaluating my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to these representatives in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for appointment in the Commissioned Corps of the United States Public Health Service.

CERTIFICATION

I certify that all of the statements made by me are true, complete, and correct to the best of my knowledge and belief and are made in good faith. I am willing to serve in any area or climate or wherever the needs of the Public Health Service Commissioned Corps may require.

PRINT OR TYPE NAME AND SIGN IN INK	DATE

DCP USE ONLY: Date Avail: _____ Cat: _____ Trn Code: _____ Appt Type: _____ Age: _____ Grad Date: _____



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service

OMB No. 0937-0025
Expiration: 7/31/2003

APPLICATION FOR APPOINTMENT AS A COMMISSIONED OFFICER IN THE U.S. PUBLIC HEALTH SERVICE COMMISSIONED CORPS

BEFORE COMPLETING THE APPLICATION, READ ATTACHED INSTRUCTIONS CAREFULLY. GIVE COMPLETE ANSWERS TO ALL ITEMS.

TYPE OR PRINT IN INK. If additional space is needed, attach an 8 ½ x 11 inch sheet of paper. Include your name, address, social security number, and the pertinent item numbers on each sheet so used. All material submitted becomes the property of the Federal Government and will not be returned. Part of the information will be used for a suitability/background investigation. **YOU MUST SIGN THIS APPLICATION ON PAGE 5 OR YOUR APPLICATION WILL NOT BE PROCESSED.**

Submit signed original and a clearly readable copy (photocopy acceptable) with **original signature** to: Division of Commissioned Personnel, 5600 Fishers Lane, Room 4-20, Rockville, MD 20857-0001.

1a. FULL NAME *(Last, First, Middle)* *(Maiden, if any)*

2. SOCIAL SECURITY NUMBER ___ ___ ___ - ___ ___ - ___ ___ ___ ___

3a. DATE OF BIRTH *(MM/DD/YYYY)* ___ ___ / ___ ___ / ___ ___ ___ ___

1b. OTHER NAMES USED *(Continue in Item # 30 if needed)* From: *(MM/YYYY)* Through: *(MM/YYYY)*

_____ ___ ___ / ___ ___ ___ ___ ___ / ___ ___ ___ ___

_____ ___ ___ / ___ ___ ___ ___ ___ / ___ ___ ___ ___

3b. PLACE OF BIRTH ***(City and State)***

4. PROFESSION ***(e.g., Chemist, Nurse, Physician)***

5. CITIZENSHIP *(Only United States Citizens may be appointed to the Commissioned Corps of the Public Health Service)*

☐ NATIVE ☐ If NATURALIZED *(Answer A, B, C, D, E)*

A. Entered: Month_____ Day_____ Year_____
B. Naturalized: Month_____ Day_____ Year_____
C. Naturalization Number: _____
D. Person to whom number was issued: _____
Place Naturalized: _____
E. Is your name on the certificate? ☐ Yes ☐ No

6. TYPES OF DUTY(IES) FOR WHICH YOU ARE APPLYING: *(Indicate all that are applicable and appropriate, Dates MM/YYYY)*

☐ General Duty (extended Active Duty)
Available for Active Duty:
___ ___ / ___ ___ ___ ___

☐ Junior COSTEP *(Applicant must be a full-time student)*
From: ___ ___ / ___ ___ ___ ___
To: ___ ___ / ___ ___ ___ ___

☐ Senior COSTEP *(Applicant must be a full-time student)*
From: ___ ___ / ___ ___ ___ ___
To: ___ ___ / ___ ___ ___ ___

7. CURRENT INFORMATION FOR CONTACTING YOU: ***(YOU MUST NOTIFY THE DIVISION OF COMMISSIONED PERSONNEL (DCP) IMMEDIATELY OF ANY CHANGES)***

Mail: Contact Name: _____
Street: _____
City: _____
State: ___ ___ ZIP: ___ ___ ___ ___ ___ + ___ ___ ___ ___
Telephone (Include Area Code):
Current: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
Business: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Ext. _____
FAX: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
E-Mail: _____

8. "PERMANENT" INFORMATION FOR CONTACTING YOU:

Mail: Contact Name: _____
Street: _____
City: _____
State: ___ ___ ZIP: ___ ___ ___ ___ ___ + ___ ___ ___ ___
Telephone (Include Area Code):
Current: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
Business: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Ext. _____
FAX: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
Any additional information should be listed in Item #30.

9. BASIC EDUCATION AND PROFESSIONAL TRAINING *(Include below, all degrees you have earned or training you will have completed by the time you are available for appointment. Official transcripts to include final or latest grading period for all college, graduate, and professional training MUST BE SUBMITTED BEFORE YOU CAN BE APPOINTED.)*

COLLEGE, UNIVERSITY, OR OTHER INSTITUTION *(Include City, State, and ZIP)*	DATES ATTENDED FROM *(MM/DD/YYYY)*	TO *(MM/DD/YYYY)*	TOTAL HOURS CREDIT *(Specify)* Qtr. or Sem.	MAJOR	DEGREE	OFFICIAL NUMBER YEARS IN PROGRAM	DEGREE REQUIREMENTS FULFILLED *(MM/YYYY)*	DEGREE CONFERRED OR WILL BE CONFERRED *(MM/YYYY)*

INTERNSHIP OR RESIDENCY COMPLETED (MUST PROVIDE CERTIFICATE), CURRENTLY SERVING, OR SCHEDULED TO COMMENCE

HOSPITAL OR INSTITUTION *(Include City, State, and ZIP)*	FROM *(MM/YYYY)*	TO *(MM/YYYY)*	SPECIFY TYPE AND SPECIALTY *(if applicable)* (e.g. Rotating, Mixed, or Straight, Categorical, Surgery, Family Practice)

10. UNIFORMED SERVICE: List below in chronological order all service you have had in the ARMY, NAVY, AIR FORCE, MARINE CORPS, COAST GUARD, COMMISSIONED CORPS OF THE NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION, and COMMISSIONED CORPS OF THE U.S. PUBLIC HEALTH SERVICE (PHS). Include any present Uniformed Services affiliations: PHS, Reserve Unit, ROTC commitment, etc. **Except for PHS affiliation, you will soon be asked to initiate a request for inter-service transfer, conditional release, or to provide proof of discharge, as may be applicable to your situation. No immediate action is required.**

SERVICE COMPONENT	REGULAR OR RESERVE	HIGHEST RANK HELD	DUTY FROM *(MM/DD/YYYY)*	TO *(MM/DD/YYYY)*	ACTIVE OR INACTIVE DUTY	TOTAL ACTIVE NON-PUBLIC HEALTH SERVICE TIME *(In years and months)*

11. Were you ever rejected for duty in any branch of a Uniformed Service?
☐ Yes ☐ No If "Yes," state when and where rejected and cause: _____

12. DEPENDENTS INFORMATION (Full name of spouse and full name(s) and date(s) of birth of child(ren) and/or other dependent(s)): *(Continue in Item #30 if needed)*

(Name)	*(Relationship)*	*(Date of Birth: MM/DD/YYY)*
	SPOUSE	__ / __ / ____
		__ / __ / ____
		__ / __ / ____

Indicate Answers by Placing an "X" in the Appropriate Column.	YES	NO
13. Have you ever received a Federal Government scholarship? If Yes, check appropriately: ☐ Indian Health Service ☐ National Health Service Corps ☐ Other *Describe:* _____ Length of Service obligation: _____ Years		
14. Have you ever been convicted, forfeited collateral, or are you now under charges for any felony or for any firearms or explosives violations? (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.)		
15. 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 item 14 above? (When answering items 14 and 15, you may omit: (a) traffic fines for which you paid a fine of $150.00 or less, (b) any offense committed before your 18th birthday which was finally adjudicated in a juvenile court or under a youth offender law, (c) any conviction the record of which has been expunged under Federal or State law, and (d) any conviction set aside under the Federal Youth Corrections Act or similar State authority.)		
16. Are you delinquent on the repayment of any Federal debt(s)? If your answer is "Yes," please provide an explanation in item 30. (Examples of Federal debt include delinquent taxes, audit disallowances, guaranteed or direct student loans, FHA loans, and other miscellaneous administrative debts. The definition of delinquency for the purposes of direct and guaranteed loans are any loan(s) more than 31 days past due on a scheduled payment. Deferred loans are not considered delinquent.)		
17. Are you a conscientious objector to military service? (If "No," go to question 19.)		
18. If you are a conscientious objector, are you willing to serve in a noncombatant position? (**NOTE:** By Executive Order, the PHS Commissioned Corps may be militarized during times of national emergency and does have officers serving in support roles at all times. If in this item (18) you state an objection, you will be precluded from appointment in the Commissioned Corps of the Public Health Service.)		
19. If you served in the military service, were you ever convicted by a general court martial or have you ever received less than an honorable discharge?		
20. Have you ever been charged with, or are currently facing charges, of a violation of any State law pertaining to habit-forming drugs, narcotics, or intoxicating liquor? (**NOTE:** If your answer to items 14, 15, 16, 19, or 20 is "Yes," give details in item 30. Show for each offense: (a) date, (b) charge, (c) place, (d) court, and (e) action taken.)		

21. REFERENCES: List the names of four individuals, including your most recent employer, with whom you have had professional affiliation or training at some time during the past seven years. Include, where applicable, Dean of College; Dean of Graduate or Professional school; Director of Intern Training Program; Director of Graduate, Post-Graduate, Residency, or Specialty training; chairperson of departments in which graduate or professional work was taken; or employment supervisors.

FULL NAME	PROFESSIONAL RELATIONSHIP TO APPLICANT	BUSINESS ADDRESS *(Organization and Street, City, State, ZIP, Telephone)*
1)		( ) -
2)		( ) -
3)		( ) -
4)		( ) -

22. LIST STATES GRANTING FULL/UNRESTRICTED PROFESSIONAL LICENSES/CERTIFICATES/REGISTRATIONS *(Include license or registry number and expiration date and* ***provide a copy of the license/certificate/registration.****)*

23. DRUG ENFORCEMENT ADMINISTRATION (DEA) CONTROLLED SUBSTANCE REGISTRATION INFORMATION

(If you were never registered, so state)

A. List all jurisdictions (past and present) where you are or were registered under Title 21, U.S. Controlled Substances Act, and provide your DEA controlled substance registration number for each jurisdiction.

(Explain all "Yes" answers in Item 30)	YES	NO
B. Has your registration under this Act ever been denied, suspended, revoked, refused renewal, or voluntarily surrendered?		
C. Have you ever been charged with, or are currently facing charges of, a violation of this Act?		

24. STATUS IN PROFESSIONAL BOARDS *(Indicate date and type of board, and whether Board Eligible, Board Certified, or Board Examination has been taken.* ***Submit copy of ECFMG Certificate and Board Certification, if any.****)*

25. EXPLAIN ALL "YES" ANSWERS IN ITEM 30.

	YES	NO
A. Have you ever been denied membership or renewal thereof, or been subject to disciplinary proceedings by any medical or professional organization?		
B. Have you ever lost or had your professional practice license revoked?		
C. Have liability claims been filed against you, or against a hospital, corporation, or government based on a case under your care?		
D. Have judgements or settlements been made against you, or against a hospital, corporation, or government based on a case directly under your care?		
E. Have you ever had, or are you about to have, your professional liability insurance declined, canceled, issued on special terms, or refused renewal?		
F. Have you ever been censured or reprimanded by a licensing board, hospital medical board/staff, or any other professional organization?		
G. Have you ever been sanctioned by the Medicare or Medicaid Programs or by any other Federal agency?		
H. Have any or all of your privileges at any health care facility ever been, or are about to be, limited, suspended, revoked, refused renewal, or voluntarily surrendered?		

26. Provide the names and addresses (past and present) of all of your professional liability insurers and your policy numbers.

27. EMPLOYMENT HISTORY

Begin with current or most recent work or volunteer experience and work back. Account for any periods of unemployment on the last line of the experience blocks in order of occurrence. Do not list any employment prior to commencing undergraduate school. For your PROFESSIONAL EXPERIENCE AND WORK RECORD, include professional training positions not reflected in item 9. Include assistantships, apprenticeships, and fellowships. Describe your duties, including: (a) professional skills involved; (b) degree of responsibility; (c) complexity of duties; (d) extent of supervision received and exercised; (e) extent of public contact; and (f) extent of influence on policy.

DATES EMPLOYED *(MM/YYYY)* From: __ __ / __ __ __ __ To: __ __ / __ __ __ __	EMPLOYER / VERIFIER NAME / MILITARY DUTY LOCATION			YOUR POSITION TITLE / MILITARY RANK
EMPLOYER'S / VERIFIER'S STREET ADDRESS	CITY *(Country)*	STATE	ZIP *(+4)* __ __ __ __ __ + __ __ __ __	TELEPHONE NUMBER ( )
STREET ADDRESS OF JOB LOCATION	CITY *(Country)*	STATE	ZIP *(+4)* __ __ __ __ __ + __ __ __ __	TELEPHONE NUMBER ( )
SUPERVISOR'S NAME & STREET ADDRESS *(If different than Job Location)*	CITY *(Country)*	STATE	ZIP *(+4)* __ __ __ __ __ + __ __ __ __	TELEPHONE NUMBER ( )
AVERAGE NUMBER OF HOURS PER WEEK	KIND OF BUSINESS OR ORGANIZATION *(e.g., education, health, social services, etc.)*			

REASON FOR LEAVING OR WISHING TO LEAVE

DESCRIPTION OF WORK *(Describe your specific duties, responsibilities, and accomplishments in this job.)*

27. EMPLOYMENT HISTORY (Continued)

DATES EMPLOYED *(MM/YYYY)* From: __ __ / __ __ __ __ To: __ __ / __ __ __ __	EMPLOYER / VERIFIER NAME / MILITARY DUTY LOCATION			YOUR POSITION TITLE / MILITARY RANK
EMPLOYER 'S / VERIFIER'S STREET ADDRESS	CITY *(Country)*	STATE	ZIP *(+4)* __ __ __ __ __ + __ __ __ __	TELEPHONE NUMBER ( )
STREET ADDRESS OF JOB LOCATION	CITY *(Country)*	STATE	ZIP *(+4)* __ __ __ __ __ + __ __ __ __	TELEPHONE NUMBER ( )
SUPERVISOR'S NAME & STREET ADDRESS *(If different than Job Location)*	CITY *(Country)*	STATE	ZIP *(+4)* __ __ __ __ __ + __ __ __ __	TELEPHONE NUMBER ( )
AVERAGE NUMBER OF HOURS PER WEEK	KIND OF BUSINESS OR ORGANIZATION *(e.g., education, health, social services, etc.)*			

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STREET ADDRESS OF JOB LOCATION	CITY *(Country)*	STATE	ZIP *(+4)* __ __ __ __ __ + __ __ __ __	TELEPHONE NUMBER ( )
SUPERVISOR'S NAME & STREET ADDRESS *(If different than Job Location)*	CITY *(Country)*	STATE	ZIP *(+4)* __ __ __ __ __ + __ __ __ __	TELEPHONE NUMBER ( )
AVERAGE NUMBER OF HOURS PER WEEK	KIND OF BUSINESS OR ORGANIZATION *(e.g., education, health, social services, etc.)*			

REASON FOR LEAVING OR WISHING TO LEAVE

DESCRIPTION OF WORK *(Describe your specific duties, responsibilities, and accomplishments in this job.)*

28. ADDITIONAL SKILLS AND QUALIFICATIONS

FOREIGN LANGUAGE: Do you have adequate competency to use any language(s) in performance of duty? ☐ YES ☐ NO, If "Yes," specify language and proficiency level. **1** = Elementary Proficiency, **2** = General Professional Proficiency, **3** = Functionally Native Proficiency

Language	Proficiency	Language	Proficiency

HONORS AND AWARDS (Acquired by academic or non-academic experience.)

NONDEGREE RELATED TRAINING (e.g., computer skills, public speaking, leadership recognition, American Council of Learned Societies (ACLS) fellowship program, Basic Life Support (BLS), CardioPulmonary Resuscitation (CPR), Emergency Medical Services, etc.)

LIST CURRENT OR FORMER MEMBERSHIP IN PROFESSIONAL ASSOCIATIONS (Also indicate office(s) held and committee membership(s).)

29. TYPES OF ASSIGNMENTS IN WHICH YOU ARE INTERESTED

Officers are required to serve in any area or climate or wherever the needs of the Public Health Service Commissioned Corps may require.

Do you have a preference for assignment to a particular program? ☐ YES ☐ NO If "Yes," which program? (e.g., Indian Health Service, Federal Bureau of Prisons, etc.)

GEOGRAPHIC AREAS IN WHICH YOU PREFER TO SERVE (e.g., Southwest U.S., Northeast U.S., name of State)

30. SPACE FOR DETAILED ANSWERS

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ATTENTION - THIS STATEMENT MUST BE SIGNED BY ALL APPLICANTS
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AUTHORITY FOR RELEASE OF INFORMATION

I have completed this Statement with the knowledge and understanding that any or all items contained herein may be subject to investigation prescribed by law or Presidential directive and I consent to the release of information concerning my capacity and fitness by employers, educational institutions, law enforcement agencies, and other individuals and agencies, to duly accredited investigators, Personnel Staffing Specialists, and other authorized employees of the Federal Government for that purpose. I hereby release from liability all representatives of the Federal Government for their acts performed in good faith and without malice in connection with evaluating my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to these representatives in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for appointment in the Commissioned Corps of the United States Public Health Service.

CERTIFICATION

I certify that all of the statements made by me are true, complete, and correct to the best of my knowledge and belief and are made in good faith. I am willing to serve in any area or climate or wherever the needs of the Public Health Service Commissioned Corps may require.

PRINT OR TYPE NAME AND SIGN IN INK	DATE

PHS-1813
Rev. 7/00

FORM APPROVED:
OMB No. 0937-0025
Exp. Date: 7/31/2003

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Commissioned Corps of the United States Public Health Service

Division of Commissioned Personnel
5600 Fishers Lane, Room 4-20
Rockville, MD 20857-0001

REFERENCE REQUEST FOR APPLICANTS TO THE U.S. PUBLIC HEALTH SERVICE COMMISSIONED CORPS

_____
Applicant's Name *(Last, First, Middle initial)*

If the reference knows you by any other name, e.g., maiden name, please indicate that name here:

_____

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Division of Commissioned Personnel

1. PERIOD OF ASSOCIATION

From To
(MM/YYYY)
__ __/__ __ __ __ __ __/__ __ __ __

2. PROFESSIONAL RELATIONSHIP TO APPLICANT *(CHECK APPROPRIATE BOXES)*

☐ EMPLOYER ☐ TEACHER ☐ FACULTY ADVISOR
☐ SUPERVISOR ☐ DEAN ☐ OTHER *(SPECIFY)*_____

3. EVALUATION OF APPLICANT

ELEMENTS	OUTSTANDING	BETTER THAN AVERAGE	AVERAGE	BELOW AVERAGE	NO BASIS FOR JUDGMENT	ELEMENTS	OUTSTANDING	BETTER THAN AVERAGE	AVERAGE	BELOW AVERAGE	NO BASIS FOR JUDGMENT
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ABILITY TO WORK INDEPENDENTLY						FLEXIBILITY -- ADAPTABILITY					
INITIATIVE						ABILITY TO SOLVE PROBLEMS -- RESOURCEFULNESS					
APPLICATION OF SKILLS AND KNOWLEDGE											
CAPACITY FOR DEVELOPMENT						ORIGINALITY					
ATTENDANCE						JUDGMENT					
DEPENDABILITY IN CARRYING OUT ASSIGNMENT						ABILITY TO COMMUNICATE					
						SUPERVISORY ABILITY					

4. APPLICANT IS BEST SUITED FOR WHAT SPECIALIZATION, FIELD, OR POSITION

_____

5. DO YOU KNOW OF ANY LIMITATIONS OR OTHER INFORMATION WHICH MIGHT IMPACT ON THE EFFECTIVENESS OR STABILITY OF THIS PERSON?
(Training, Personality, Emotional, Ethical)

☐ NO ☐ YES *(Give Details in this Space)*

(Continue on reverse side)

6. **WOULD YOU BE WILLING TO EMPLOY OR RE-EMPLOY THIS PERSON IF YOU HAD AN OPENING REQUIRING THE GENERAL PROFESSIONAL LEVEL AND PROFESSION OF THIS INDIVIDUAL?**

☐ YES *(IN WHAT CAPACITY?)*

☐ NO *(GIVE REASONS)*

7. **COMMENTS** *(Please use this space to supply any further information, comments, and evaluation.)*

8. **SIGNATURE**		12. **INSTITUTION OR FIRM ADDRESS** *(Include ZIP Code)*
9. **NAME** *(Type or Print)*		
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PHS-1813
Rev. 7/00

FORM APPROVED:
OMB No. 0937-0025
Exp. Date: 7/31/2003

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Commissioned Corps of the United States Public Health Service

Division of Commissioned Personnel
5600 Fishers Lane, Room 4-20
Rockville, MD 20857-0001

REFERENCE REQUEST FOR APPLICANTS TO THE U.S. PUBLIC HEALTH SERVICE COMMISSIONED CORPS

_____
Applicant's Name *(Last, First, Middle initial)*

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PHS-1813
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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Commissioned Corps of the United States Public Health Service

Division of Commissioned Personnel
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Rockville, MD 20857-0001

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DEPARTMENT OF
HEALTH & HUMAN SERVICES

Program Support Center

Rockville MD 20857-0001

AFFIX
POSTAGE
HERE

Division of Commissioned Personnel
ATTN: Recruitment and Assignment Branch
5600 Fishers Lane, Room 4-20
Rockville MD 20857-0001

MEDICAL PACKET

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Program Support Center

Recruitment and Assignment Branch
Division of Commissioned Personnel
5600 Fishers Lane, Room 4A-18
Rockville, MD 20857-0001

SPECIAL MEDICAL ALERT

Applicants Planning to Obtain Physical Examinations from Military Entrance Processing Stations (MEPS)

PLEASE NOTE: Our policy does permit you to bypass the physical at a MEPS station (please see below). However, we do not have the authority to pay for that physical examination. If you would like to expedite processing of your application, you may choose to pay for the examination. The U.S. Public Health Service is not financially responsible if you choose this option.

Recently some applicants to the Commissioned Corps of the Public Health Service (PHS) have been denied appointments for authorized pre-appointment physical examinations by some MEPS, or have been denied examination after being given an appointment. We believe this may be due to unfamiliarity of some MEPS personnel with regulations governing MEPS.

If you are denied an appointment or an examination, please try to negotiate courteously as follows:

1. Show your letter of authorization from the Recruitment and Assignment Branch, Division of Commissioned Personnel (DCP). Explain that you are an applicant to the Commissioned Corps of the PHS, one of the seven Uniformed Services of the Federal Government. State that you have been told that you are entitled to this examination in accordance with USMEPCOM Reg 40-01, IMC 11, Paragraph 8-2 for initial entry, effective 30 August 1999, and that the PHS Commissioned Corps has been assured by MEPCOM in Great Lakes, IL, that MEPS will perform examinations on applicants to the Commissioned Corps of the PHS.

2. If the above is not successful, courteously ask for, and record the name and rank of the individual denying you the examination. Then ask to speak with this individual's supervisor. If you are allowed to speak with the supervisor, **repeat step 1 above.** If the supervisor denies you the examination, record his/her name also.

3. If you are unable to get the examination, report this to the Medical Evaluations Staff, Recruitment and Assignment Branch, DCP, at 301-594-3360 (or toll-free at 1-877-463-6327, listen to the prompts, select option #1, dial 43360). Give the staff person the location of the MEPS, the date, time, names of MEPS personnel you dealt with, and other important details of the encounter. Also provide telephone numbers at which you may be reached in the event that the local MEPS reverses its denial, and wishes to contact you for an appointment.

4. If you have prior military service, be sure to have a copy of your form DD-214 available.

Please be aware, however, that the MEPS may not be able to give you an appointment as soon as you want/need it, since military examinations have higher priority.

Terry J. Golden DO

Terry J. Golden, D.O.
CAPT, USPHS
Senior Medical Evaluations Officer

EXAMINING FACILITIES LISTING

MEPS = Military Entrance Processing Station. Other facilities where application physical examinations can be accomplished include: **BoP** = Bureau of Prisons and **IHS** = Indian Health Service. Some military and U.S. Coast Guard medical facilities may perform application physical examinations at their discretion.

STATE	CITY	TYPE	STREET ADDRESS	ZIP CODE	PHONE NUMBER
AK	ANCHORAGE	IHS	THIRD AND GAMBELL STS.	99501	907-279-6661
AK	ANCHORAGE	MEPS	1717 "C" STREET	99501	907-274-9142
AL	MONTGOMERY	MEPS	705 MCDONALD ST, BLDG 1512 MAFB GUNTER ANNEX	36114-3110	334-416-6377
AR	LITTLE ROCK	MEPS	100 MAIN STREET, STE. 500	72201-1519	501-324-6322
AZ	PHOENIX	IHS	4212 NORTH 16TH STREET	85016	602-263-1200
AZ	PHOENIX	MEPS	ONE NORTH 1ST ST, RM 613	85004-2357	602-258-1703
CA	LOS ANGELES	MEPS	5051 RODEO ROAD	90016	323-293-3245
CA	OAKLAND	MEPS	1500 BROADWAY	94612	510-452-4973
CA	SAN DIEGO	MEPS	4181 RUFFIN ROAD	92123	858-277-4344
CA	SAN JOSE	MEPS	546 VERNON AVENUE MOUNTAIN VIEW	94043	650-603-8236
CA	SACRAMENTO	MEPS	3870 ROSIN COURT, STE. 105	95834	916-564-0253
CO	AURORA	MEPS	HQ WESTERN SECTOR 3350 PEORIA STREET, STE. 150	80010-1408	303-623-1020
CO	DENVER	MEPS	275 NEW CUSTOM HOUSE 19TH & STOUT STREET	80202-2515	303-623-1020
CO	ENGLEWOOD	BoP	9595 WEST QUINCY	80110	303-985-1566
FL	JACKSONVILLE	MEPS	4051 PHILLIPS HIGHWAY	32207-7299	904-737-6860
FL	MIAMI	MEPS	7785 NW 48TH STREET, STE.150	33166-4611	305-463-0891 or 594-4257
FL	TAMPA	MEPS	3520 WEST WATERS AVENUE	33614-2716	813-932-0079
GA	ATLANTA	MEPS	1500 Hood Ave., Bldg. 720	30297-5000	404-362-3090
HI	HONOLULU	MEPS	490 CENTRAL AVENUE PEARL HARBOR	96860	808-471-8725
IA	DES MOINES	MEPS	2500 UNIVERSITY AVENUE	50266	515-224-0259
ID	BOISE	MEPS	550 WEST FORT STREET	83724-0101	208-343-7881
IL	CHICAGO	MEPS	1700 SOUTH WOLF ROAD	60018-1960	847-803-6111
IN	INDIANAPOLIS	MEPS	5541 HERBERT LORD DRIVE	46216-2055	317-554-0564 or 0531
KY	LEXINGTON	BoP	FEDERAL CORRECTIONS INST. LEESTOWN ROAD	40507	606-255-6812
KY	LOUISVILLE	MEPS	600 DR. MARTIN LUTHER KING JR. PLACE, ROOM 477	40202-2230	502-582-5921
LA	NEW ORLEANS	MEPS	4400 DAUPHINE STREET	70146	504-943-0470
LA	SHREVEPORT	MEPS	2715 ALKAY DRIVE	71118	318-425-1715
MA	BOSTON	MEPS	495 SUMMER STREET	02210-2109	617-753-3112

MA	SPRINGFIELD	MEPS	1550 MAIN STREET	01103	413-732-2609 or 0500
MD	BALTIMORE	MEPS	6845 DEERPATH ROAD DORSEY BUSINESS CENTER	21227	410-379-9015
ME	PORTLAND	MEPS	510 CONGRESS ST., 3RD FLOOR	04101-3403	207-775-3409
MI	DETROIT	MEPS	1172 KIRTS BLVD. TROY, MI	48084-4846	248–244-9131
MI	LANSING	MEPS	120 EAST JOLLY ROAD	48910-6611	517-887-2292 or 9160
MN	MINNEAPOLIS	MEPS	212 3RD AVE. S, ROOM 108	55401-2584	612-340-0202
MO	KANSAS CITY	MEPS	10300 NW PRAIRIE VIEW RD.	64153	816-891-7415
MO	SPRINGFIELD	BoP	FEDERAL MEDICAL CENTER	65802	417-862-7041
MO	ST LOUIS	MEPS	1222 SPRUCE STREET	63103	314-331-4039
MS	JACKSON	MEPS	664 SOUTH STATE STREET	39201-5611	601-355-3835
MT	BUTTE	MEPS	22 WEST PARK STREET	59701	406-723-8883
NC	CHARLOTTE	MEPS	401 WEST TRADE STREET	28202	704 344-6419
NC	RALEIGH	MEPS	2625 APPLIANCE COURT	27604-2468	919-834-0652
ND	FARGO	MEPS	225 4TH AVENUE NORTH	58102	701-234-0740
NE	OMAHA	MEPS	5303 F STREET	68117-2805	402-733-7474
NM	ALBUQUERQUE	MEPS	505 CENTRAL AVENUE, NW, SUITE A	87102-3113	505-246-8028
NM	GALLUP	IHS	516 EAST NIZHONI BLVD.	87301	505-722-1260
NM	SANTA FE	IHS	1700 CERRILLOS ROAD	87501	505-988-9821
NJ	FORT DIX	MEPS	BLDG. 5645 TEXAS AVE	08640	609562-6050
NY	ALBANY	MEPS	LEO W. O'BRIEN FED. BLDG. NORTH PEARL & CLINTON ST.	12207-2334	518-455-8921
NY	BROOKLYN	MEPS	BLDG. 116, FORT HAMILTON	11252	718-630-4646
NY	BUFFALO	MEPS	1007 FEDERAL BLDG. 111 WEST HURON STREET	14202-2383	716-551-4065
NY	SYRACUSE	MEPS	100 SOUTH CLINTON ST. P.O. BOX 7368	13261-7368	315-448-0331
OH	CLEVELAND	MEPS	9199 MARKET PLACE, BROADVIEW HGTS	44147-2834	216-706-5025
OH	COLUMBUS	MEPS	775 TAYLOR ROAD, GAHANNA, OH	43230-6203	614-868-8430
OK	ADA	IHS	1001 NORTH COUNTRY CLUB DRIVE	74820	580-436-3980
OK	OKLAHOMA CITY	MEPS	4400 SW 21ST STREET	73108	405-681-8673
OK	TAHLEQUAH	IHS	1120 GRAND	74464	918-458-3100
OR	PORTLAND	MEPS	2107 NE COLUMBIA BLVD.	97211-1987	503-282-3071
PA	HARRISBURG	MEPS	4641 WESTPORT DR. MECHANICSBURG	17055-4843	717-691-6180
PA	PITTSBURG	MEPS	1000 LIBERTY AVE., 17TH FLOOR	15222-4101	412-395-5876
PR	SAN JUAN	MEPS	HWY 28, GSA, P.O. BOX 34108	00934-0108	787-277-7506
SC	FORT JACKSON	MEPS	2435 MARION AVE.	29207-6025	803-751-5112
SD	SIOUX FALLS	MEPS	2801 S. KIWANIS AVENUE, SUITE 200	57105-4236	605-334-0280
TN	KNOXVILLE	MEPS	9745 PARKSIDE DRIVE	37922-2204	423-531-8093
TN	MEMPHIS	MEPS	480 BEALE STREET	38103-3232	901-526-2100
TN	NASHVILLE	MEPS	4751 TROUSDALE DRIVE. EXEC PARK	37220-1378	615-833-1872
TX	AMARILLO	MEPS	1100 S. FILMORE STREET, SUITE 100	79101-4318	806-376-9891

TX	DALLAS	MEPS	207 S. HOUSTON, 4TH FLOOR, LOCK BOX #15	75202-4709	214-655-3200
TX	EL PASO	MEPS	BLDG. 6380, SUITE E, 6380 MORGAN AVE	79906-4610	915-568-3505
TX	FORT WORTH	BoP	FMC CARSWELL, STREET, BLDG.3000	76127	817-782-4000
TX	FORT WORTH	BoP	FMC FORT WORTH, 3150 HORTON ROAD	76119	817-534-8400
TX	HOUSTON	MEPS	701 SAN JACINTO, PO BOX 52309	77052-2309	713-718-4240
TX	SAN ANTONIO	MEPS	8310 VICAR DRIVE	78218	210-655-0722
UT	SALT LAKE CITY	MEPS	2830 SOUTH REDWOOD ROAD	84119	801-975-3701
VA	RICHMOND	MEPS	400 N 8TH STREET, PO BOX 10187	23240-0187	804-782-2710
WA	SEATTLE	MEPS	4735 E. MARGINAL WAY SOUTH	98134-2385	206-766-6400
WA	SPOKANE	MEPS	US COURT HOUSE, 920 W. RIVERSIDE AVENUE	99201-1008	509-353-3105/6/7
WI	MILWAUKEE	MEPS	310 WEST WISCONSIN AVENUE	53203	414-297-3813
WV	BECKLEY	MEPS	200 VALUE CITY CENTER	25801-3797	304-256-3944

IF YOU HAVE TROUBLE MAKING AN APPOINTMENT, ASK FOR THE OPERATIONS OFFICE OR MEDICAL NCOIC. IF PROBLEMS REMAIN, PLEASE CALL THE RECRUITMENT AND ASSIGNMENT BRANCH, DIVISION OF COMMISSIONED PERSONNEL AT 1-800-279-1605 or 301-594-3360.

* Military Entrance Processing Stations (MEPS)) do not provide required Complete Blood Count (CBC) Tuberculin skin test (PPD) dental examination, or (for females) PAP smear. If you use MEPS, you may be able to obtain these additional tests at Physical Examination Sections of military medical facilities.

YOU MAY GO TO YOUR PRIVATE PHYSICIAN AT YOUR OWN EXPENSE.

Department of Health and Human Services
Public Health Service Commissioned Corps
Division of Commissioned Personnel

ACTIVE-DUTY APPLICANT PHYSICAL EXAMINATION CHECKLIST *(✔ all items):*

DD Form 2807-1 (Report of Medical History): All items must be completed by active-duty applicants.

- ❑ Item 8 – List current medications used.
- ❑ Items 10 through 28 – Explain all "Yes" answers in detail in section 29.
- ❑ Please sign, insert Social Security Number, and date form (top of page 3).
- ❑ Examiner must complete Item 30 by explaining in detail all "Yes" answers made by the applicant (to include inclusive dates, treatment, and present status).
- ❑ Complete form **PHS-6379 (Supplemental Medical History Record Required of Applicants to the Public Health Service Commissioned Corps)**.
- ❑ Complete form **PHS-6380 (Request for Uniformed Services Medical Records)**.
- ❑ Complete form **PHS-6355 (Report of Dental Examination of Applicants to the Commissioned Corps of the Public Health Service)**.

DD Form 2808 (Report of Medical Examination): COMPLETE ALL ITEMS except 56, 57, 64 through 69, and 74b which may be omitted unless indicated by history or physical findings.

- ❑ Item 30 – Digital prostate examination required on all male applicants 40 years or older.
- ❑ Item 41 – Pelvic examination required on all female applicants.
- ❑ Item 45 – Urinalysis.
- ❑ Item 47 – Other tests: Complete Blood Count (CBC) Hemoglobin or Hematocrit.
- ❑ Item 48 – Blood type and Rh factor are required for ID card.
- ❑ PPD within last 12 months (unless known positive). If positive, give date of conversion, history of treatment, and report of chest x-ray since conversion.
- ❑ Item 61 – If not correctable to 20/20, an examination and diagnosis by an ophthalmologist or optometrist are required.
- ❑ Item 62 – If vision aided, eye refraction (preferred) or current lens prescription required. If greater than -6.00 diopters, detailed funduscopic examination by ophthalmologist or optometrist is required.
- ❑ Item 71a – Standard audiogram (with actual numerical values).

CHECKLIST CONTINUED ON REVERSE SIDE ⇨⇨⇨⇨⇨⇨

Additional Tests Required in Special Circumstances (✔ *only if applicable to you*):

- ☐ All applicants 40 years or older, FBS and SGOT (AST), and EKG (electrocardiogram).
- ☐ Male applicants 35 years or older, fasting serum lipids (TG, TC, HDL, LDL).
- ☐ Female applicants – PAP smear within last 12 months.
- ☐ Female applicants 40 years or older, mammogram within the last 24 months.
- ☐ Female applicants 45 years or older, fasting serum lipids (TG, TC, HDL, LDL).
- ☐ History of asthma requiring regular medication, screening Pulmonary Function Testing (PFT).
- ☐ Any abnormal laboratory finding(s) should be repeated and/or investigated. Reports of repeated tests and/or investigations should be attached to DD Form 2808.

Applicants must notify the Medical Evaluations Section, Medical Affairs Branch, Division of Commissioned Personnel, 1-800-368-2777 option #3 or 301-594-3297 of any change in health status or any change in anticipated use of or need for health services.

Timely submission of all required information will facilitate the application process.

RETURN THIS COMPLETED CHECKLIST WITH ALL OTHER APPLICATION FORMS.

***Applicant's Signature*_____ *Date Signed*____/____/_____**

Department of Health and Human Services
Public Health Service Commissioned Corps
Division of Commissioned Personnel

PUBLIC HEALTH SERVICE COMMISSIONED CORPS PRIVACY ACT STATEMENT FOR DD Form 2807-1, "Report of Medical History" and DD Form 2808, "Report of Medical Examination"

Authority: This statement is provided pursuant to the Privacy Act of 1974 (5 U.S.C. 552a). Our authority to collect this information is 42 U.S.C. 202 et seq. and Executive Order 9397, "Numbering System for Federal Accounts Relating to Individual Persons."

Principal Purpose: This information is used by the Department of Health and Human Services to obtain medical data for determination of medical fitness for appointment and retention for applicants to the Public Health Service (PHS) Commissioned Corps. The information will also be used for medical boards and separation of Service members from the PHS Commissioned Corps.

Information Regarding Disclosure of Your Social Security Number (SSN): Under Executive Order 9397, Agencies are required to use the SSN as a means of identifying individuals in Agency personnel information systems. Thus, solicitation of your SSN is authorized by this order so that Agencies, by being able to identify you, can ensure that the data furnished is accurately recorded for each employee in the personnel system. It will be used for this purpose only.

Records System: The information provided on this form will become part of record system 09-40-0002, PHS Commissioned Corps Medical Records, HHS/PSC/HRS. A copy of this system notice can be obtained from the office to which you submit these forms.

Disclosure: Completion of these forms is mandatory. Failure by an applicant to provide the information may result in delay or rejection of the individual's application to enter the PHS Commissioned Corps. For an active-duty member, failure to provide information may result in denial of promotion, denial of assimilation, and placement in a not deployable status.

REPORT OF MEDICAL HISTORY

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

Form Approved
OMB No. 0704-0413
Expires Aug 31, 2003

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0704-0413), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.
PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.
ROUTINE USE(S): None.
DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a $10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	2. SOCIAL SECURITY NUMBER	3. TODAY'S DATE *(YYYYMMDD)*

4.a. HOME ADDRESS *(Street, Apartment No., City, State, and ZIP Code)*	5. EXAMINING LOCATION AND ADDRESS *(Include ZIP Code)*
b. HOME TELEPHONE *(Include Area Code)*	

X ALL APPLICABLE BOXES:

6.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION		
☐ Army ☐ Coast Guard	☐ Active Duty	☐ Enlistment	☐ Medical Board ☐ Other *(Specify)*	
☐ Navy	☐ Reserve	☐ Commission	☐ Retirement	
☐ Marine Corps	☐ National Guard	☐ Retention	☐ U.S. Service Academy	
☐ Air Force		☐ Separation	☐ ROTC Scholarship Program	

7.a. POSITION *(Title, Grade, Component)*

b. USUAL OCCUPATION

8. CURRENT MEDICATIONS *(Prescription and Over-the-counter)*	9. ALLERGIES *(Including insect bites/stings, foods, medicine or other substance)*

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
10.a. Tuberculosis	○	○
b. Lived with someone who had tuberculosis	○	○
c. Coughed up blood	○	○
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	○	○
e. Shortness of breath	○	○
f. Bronchitis	○	○
g. Wheezing or problems with wheezing	○	○
h. Been prescribed or used an inhaler	○	○
i. A chronic cough or cough at night	○	○
j. Sinusitis	○	○
k. Hay fever	○	○
l. Chronic or frequent colds	○	○
11.a. Severe tooth or gum trouble	○	○
b. Thyroid trouble or goiter	○	○
c. Eye disorder or trouble	○	○
d. Ear, nose, or throat trouble	○	○
e. Loss of vision in either eye	○	○
f. Worn contact lenses or glasses	○	○
g. A hearing loss or wear a hearing aid	○	○
h. Surgery to correct vision *(RK, PRK, LASIK, etc.)*	○	○
12.a. Painful shoulder, elbow or wrist *(e.g. pain, dislocation, etc.)*	○	○
b. Arthritis, rheumatism, or bursitis	○	○
c. Recurrent back pain or any back problem	○	○
d. Numbness or tingling	○	○
e. Loss of finger or toe	○	○

12. *(Continued)*	YES	NO
f. Foot trouble *(e.g., pain, corns, bunions, etc.)*	○	○
g. Impaired use of arms, legs, hands, or feet	○	○
h. Swollen or painful joint(s)	○	○
i. Knee trouble *(e.g., locking, giving out, pain or ligament injury, etc.)*	○	○
j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	○	○
k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	○	○
l. Bone, joint, or other deformity	○	○
m. Plate(s), screw(s), rod(s) or pin(s) in any bone	○	○
n. Broken bone(s) *(cracked or fractured)*	○	○
13.a. Frequent indigestion or heartburn	○	○
b. Stomach, liver, intestinal trouble, or ulcer	○	○
c. Gall bladder trouble or gallstones	○	○
d. Jaundice or hepatitis *(liver disease)*	○	○
e. Rupture/hernia	○	○
f. Rectal disease, hemorrhoids or blood from the rectum	○	○
g. Skin diseases *(e.g. acne, eczema, psoriasis, etc.)*	○	○
h. Frequent or painful urination	○	○
i. High or low blood sugar	○	○
j. Kidney stone or blood in urine	○	○
k. Sugar or protein in urine	○	○
l. Sexually transmitted disease *(syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)*	○	○
14.a. Adverse reaction to serum, food, insect stings or medicine	○	○
b. Recent unexplained gain or loss of weight	○	○
c. Currently in good health *(If no, explain in Item 29 on Page 2.)*	○	○
d. Tumor, growth, cyst, or cancer	○	○

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
15.a. Dizziness or fainting spells	O	O
b. Frequent or severe headache	O	O
c. A head injury, memory loss or amnesia	O	O
d. Paralysis	O	O
e. Seizures, convulsions, epilepsy or fits	O	O
f. Car, train, sea, or air sickness	O	O
g. A period of unconsciousness or concussion	O	O
h. Meningitis, encephalitis, or other neurological problems	O	O
16.a. Rheumatic fever	O	O
b. Prolonged bleeding *(as after an injury or tooth extraction, etc.)*	O	O
c. Pain or pressure in the chest	O	O
d. Palpitation, pounding heart or abnormal heartbeat	O	O
e. Heart trouble or murmur	O	O
f. High or low blood pressure	O	O
17.a. Nervous trouble of any sort *(anxiety or panic attacks)*	O	O
b. Habitual stammering or stuttering	O	O
c. Loss of memory or amnesia, or neurological symptoms	O	O
d. Frequent trouble sleeping	O	O
e. Received counseling of any type	O	O
f. Depression or excessive worry	O	O
g. Been evaluated or treated for a mental condition	O	O
h. Attempted suicide	O	O
i. Used illegal drugs or abused prescription drugs	O	O
18. FEMALES ONLY. Have you ever had or do you now have:		
a. Treatment for a gynecological (female) disorder	O	O
b. A change of menstrual pattern	O	O
c. Any abnormal PAP smears	O	O
d. First day of last menstrual period *(YYYYMMDD)*		
e. Date of last PAP smear *(YYYYMMDD)*		

	YES	NO
19. Have you been refused employment or been unable to hold a job or stay in school because of:		
a. Sensitivity to chemicals, dust, sunlight, etc.	O	O
b. Inability to perform certain motions	O	O
c. Inability to stand, sit, kneel, lie down, etc.	O	O
d. Other medical reasons *(If yes, give reasons.)*	O	O
20. Have you ever been treated in an Emergency Room? *(If yes, for what?)*	O	O
21. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*	O	O
22. Have you ever had, or have you been advised to have any operations or surgery? *(If yes, describe and give age at which occurred.)*	O	O
23. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*	O	O
24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*	O	O
25. Have you ever been rejected for military service for any reason? *(If yes, give date and reason for rejection.)*	O	O
26. Have you ever been discharged from military service for any reason? *(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)*	O	O
27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? *(If yes, specify what kind, granted by whom, and what amount, when, why.)*	O	O
28. Have you ever been denied life insurance?	O	O

29. EXPLANATION OF "YES" ANSWER(S) *(Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)*

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)*

a. COMMENTS

b. TYPED OR PRINTED NAME OF EXAMINER *(Last, First, Middle Initial)*	c. SIGNATURE	d. DATE SIGNED *(YYYYMMDD)*

REPORT OF MEDICAL EXAMINATION

1. DATE OF EXAMINATION *(YYYYMMDD)*	2. SOCIAL SECURITY NUMBER

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.
PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.
ROUTINE USE(S): None.
DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

3. LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	4. HOME ADDRESS *(Street, Apartment Number, City, State and ZIP Code)*	5. HOME TELEPHONE NUMBER *(Include Area Code)*

6. GRADE	7. DATE OF BIRTH *(YYYYMMDD)*	8. AGE	9. SEX	10. RACE
			☐ Female ☐ Male	☐ American Indian/Alaskan Native ☐ Black ☐ Asian/Pacific Islander ☐ White

11. TOTAL YEARS GOVERNMENT SERVICE		12. AGENCY *(Non-Service Members Only)*	13. ORGANIZATION UNIT AND UIC/CODE
a. MILITARY	b. CIVILIAN		

14.a. RATING OR SPECIALTY *(Aviators Only)*	b. TOTAL FLYING TIME	c. LAST SIX MONTHS

15.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION		16. NAME OF EXAMINING LOCATION, AND ADDRESS *(Include ZIP Code)*
☐ Army ☐ Coast Guard ☐ Navy ☐ Marine Corps ☐ Air Force	☐ Active Duty ☐ Reserve ☐ National Guard	☐ Enlistment ☐ Commission ☐ Retention ☐ Separation	☐ Medical Board ☐ Other ☐ Retirement ☐ U.S. Service Academy ☐ ROTC Scholarship Program	

CLINICAL EVALUATION *(Check each item in appropriate column. Enter "NE" if not evaluated.)*

	Normal	Abnorm	NE
17. Head, face, neck, and scalp			
18. Nose			
19. Sinuses			
20. Mouth and throat			
21. Ears - General *(Int. and ext. canals/Auditory acuity under item 71)*			
22. Drums *(Perforation)*			
23. Eyes - General *(Visual acuity and refraction under items 61 - 63)*			
24. Ophthalmoscopic			
25. Pupils *(Equality and reaction)*			
26. Ocular motility *(Associated parallel movements, nystagmus)*			
27. Heart *(Thrust, size, rhythm, sounds)*			
28. Lungs and chest *(Include breasts)*			
29. Vascular system *(Varicosities, etc.)*			
30. Anus and rectum *(Hemorrhoids, Fistulae) (Prostate if indicated)*			
31. Abdomen and viscera *(Include hernia)*			
32. External genitalia *(Genitourinary)*			
33. Upper extremities			
34. Lower extremities *(Except feet)*			
35. Feet *(See Item 35 Continued)*			
36. Spine, other musculoskeletal			
37. Identifying body marks, scars, tattoos			
38. Skin, lymphatics			
39. Neurologic			
40. Psychiatric *(Specify any personality deviation)*			
41. Pelvic *(Females only)*			
42. Endocrine			

44. NOTES: *(Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)*

43. DENTAL DEFECTS AND DISEASE *(Please explain. Use dental form if completed by dentist. If dental examination not done by dental officer, explain in Item 44.)*

☐ Acceptable
☐ Not Acceptable Class _____

35. FEET *(Continued) (Circle category)*

Normal Arch	Mild	Asymptomatic
Pes Cavus	Moderate	
Pes Planus	Severe	Symptomatic

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

LABORATORY FINDINGS

45. URINALYSIS	a. Albumin	46. URINE HCG	47. H/H	48. BLOOD TYPE
	b. Sugar			

TESTS	RESULTS	HIV SPECIMEN ID LABEL	DRUG TEST SPECIMEN ID LABEL
49. HIV			
50. DRUGS			
51. ALCOHOL			
52. OTHER			
a. PAP SMEAR			
b.			
c.			

MEASUREMENTS AND OTHER FINDINGS

53. HEIGHT	54. WEIGHT lbs.	55. MIN WGT - MAX WGT	MAX BF %	56. TEMPERATURE	57. PULSE

58. BLOOD PRESSURE			59. RED/GREEN *(Army Only)*	60. OTHER VISION TEST
a. 1ST	b. 2ND	c. 3RD		
SYS.	SYS.	SYS.		
DIAS.	DIAS.	DIAS.		

61. DISTANT VISION		62. REFRACTION BY AUTOREFRACTION OR MANIFEST			63. NEAR VISION		
Right 20/	Corr. to 20/	By	S.	CX	Right 20/	Corr. to 20/	by
Left 20/	Corr. to 20/	By	S.	CX	Left 20/	Corr. to 20/	by

64. HETEROPHORIA *(Specify distance)*

ES° EX° R.H. L.H. Prism div. Prism Conv CT NPR PD

65. ACCOMMODATION		66. COLOR VISION *(Test used and result)*		67. DEPTH PERCEPTION *(Test used and score)* AFVT	
Right	Left	PIP	/14	Uncorrected	Corrected

68. FIELD OF VISION	69. NIGHT VISION *(Test used and score)*	70. INTRAOCULAR TENSION	
		O.D.	O.S.

71a. AUDIOMETER	Unit Serial Number						71b. Unit Serial Number							72a. READING ALOUD TEST
Date Calibrated *(YYYYMMDD)*							Date Calibrated *(YYYYMMDD)*							
HZ	500	1000	2000	3000	4000	6000	HZ	500	1000	2000	3000	4000	6000	☐ SAT ☐ UNSAT
Right							Right							72b. VALSALVA
Left							Left							☐ SAT ☐ UNSAT

73. NOTES *(Continued)* AND SIGNIFICANT OR INTERVAL HISTORY *(Use additional sheets if necessary.)*

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

74.a. EXAMINEE/APPLICANT *(check one)*

- [ ] IS QUALIFIED FOR SERVICE
- [ ] IS NOT QUALIFIED FOR SERVICE

75. I have been advised of my disqualifying condition.

a. SIGNATURE OF EXAMINEE	b. DATE *(YYYYMMDD)*

b. PHYSICAL PROFILE

P	U	L	H	E	S	X	PROFILER INITIALS	DATE *(YYYYMMDD)*

76. SIGNIFICANT OR DISQUALIFYING DEFECTS

ITEM NO.	MEDICAL CONDITION/DIAGNOSIS	ICD CODE	PROFILE SERIAL	RBJ DATE *(YYYYMMDD)*	QUALI-FIED	DIS-QUALI-FIED	EXAMINER INITIALS	WAIVER RECEIVED	
								SERVICE	DATE *(YYYYMMDD)*

77. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers) (Use additional sheets if necessary.)*

78. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED *(Specify) (Use additional sheets if necessary.)*

79. MEPS WORKLOAD *(For MEPS use only)*

WKID	ST	DATE *(YYYYMMDD)*	INITIAL	WKID	ST	DATE *(YYYYMMDD)*	INITIAL

80. MEDICAL INSPECTION DATE	HT	WT	%BF	MAX WT	HCG	QUAL	DISQ	PHYSICIAN'S SIGNATURE

81.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE
82.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE
83.a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)*	b. SIGNATURE
84.a. TYPED OR PRINTED NAME OF REVIEWING OFFICER/APPROVING AUTHORITY	b. SIGNATURE

85. This examination has been administratively reviewed for completeness and accuracy.

a. SIGNATURE	b. GRADE	c. DATE *(YYYYMMDD)*

86. WAIVER GRANTED *(If yes, date and by whom)*

- [ ] YES
- [ ] NO

87. NUMBER OF ATTACHED SHEETS

Department of Health and Human Services
Public Health Service Commissioned Corps

REPORT OF DENTAL EXAMINATION OF APPLICANTS TO THE COMMISSIONED CORPS OF THE PUBLIC HEALTH SERVICE

(See Privacy Act Statement for Form PHS-6355)

NAME *(Last, First, Middle)* *(Please type or print)*	SOCIAL SECURITY NUMBER

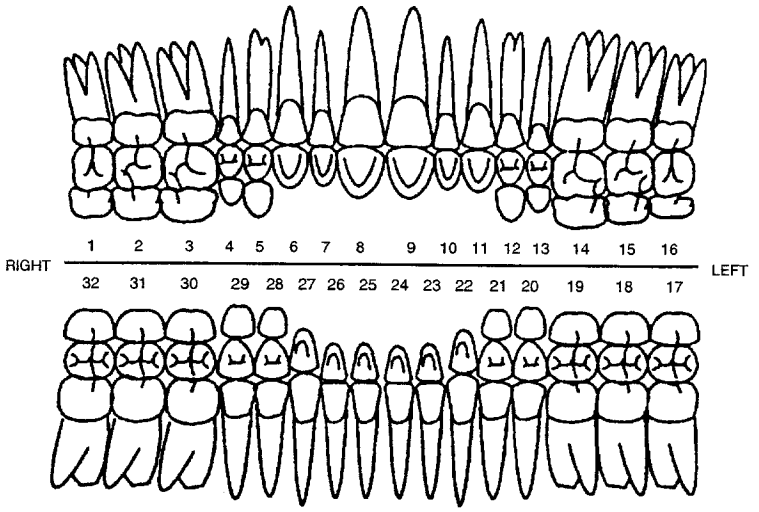
INSTRUCTIONS TO APPLICANT

Present this form to your examining dentist for completion. Failure by you or your examiner to comply completely will delay medical clearance, which is required prior to call to active duty. You may be able to obtain a dental examination at dental examination sections of military medical facilities. **If done privately, it must be done at your own expense.**

INSTRUCTIONS TO EXAMINING DENTIST

A complete examination is required in order that *all* questions listed below can be completed. If there are a number of "Yes" responses to questions listed below, or if otherwise clinically indicated, bitewing and panoramic (or diagnostic quality full mouth) radiographs should be performed. If examinee has a questionable occlusal relationship, forward diagnostic casts to the address at the end of this form.

(1) Indicate on the chart below restorable teeth with an "R," non-restorable teeth with an "N," missing teeth with an "X," teeth replaced by a fixed or removable prosthetics by a "continuous line," and any other defects or abnormalities. Do not chart restorations.



(2) GENERAL *("X" Yes or No for each question)*

Yes	No	
		a. DENTAL CARIES *(Indicate on chart, do not chart incipiencies)*
		b. MISSING TEETH, OTHER THAN THIRD MOLARS *(Indicate on chart by marking "X" through the roots)*
		c. NON-RESTORABLE TEETH *(Indicate on chart by marking "N" through tooth)*
		d. UNERUPTED TEETH *(Draw circle around the tooth on the chart and indicate position by an arrow)*
		e. DEVELOPMENTAL DISTURBANCES IN TEETH *(Significant enamel hypoplasias, amelogenesis imperfecta, dentinogenesis imperfecta, etc.)*
		f. STAINED TEETH *(Instrisic) (unsightly)*

(3) HISTORY OR ORAL DISEASE, TUMOR OR ANY OTHER ABNORMALITY OF THE ORAL CAVITY
("X" Yes or No for each question. If additional space is needed use "REMARKS" section)

Yes	No	
		a. HAS THE EXAMINEE EVER HAD A CYST OR TUMOR REMOVED FROM THE MOUTH OR JAWS *(If so, describe)*
		b. HISTORY OF ABNORMAL BLEEDING OF THE ORAL TISSUES *(Describe)*
		c. ORAL ULCERATIONS, SOFT TISSUE LESIONS, ETC. *(Describe)*
		d. HISTORY OF CLEFT LIP
		e. HISTORY OF CLEFT PALATE
		(1) If yes, is there an oro-nasal or oro-antral fistula present?
		f. HISTORY OF TMJ DISEASE OR PAIN *(Describe)*

(Continued on Page 2)

(4) OCCLUSAL RELATIONSHIP *("X" Yes or No for each question) (If additional space is needed, use "REMARKS" section)*

Yes	No	
		a. ANTERIOR VERTICAL OPEN BITE GREATER THAN 1mm.
		b. ANTERIOR OVERBITE IN EXCESS OF 4mm.
		c. ANTERIOR HORIZONTAL OVERJET IN EXCESS OF 4 mm.
		d. SOFT TISSUE IMPINGEMENT OF THE LOWER ANTERIOR TEETH INTO THE HARD PALATE, OR THE UPPER ANTERIOR TEETH INTO THE LOWER LABIAL GINGIVAE
		e. ANTERIOR CROSSBITE *(Describe)*
		f. MANDIBULAR PROGNATHISM
		g. POSTERIOR OPEN BITE *(Bilateral involving more than one tooth)*
		h. POSTERIOR CROSSBITE *(Entire quadrant)*
		i. UNSIGHTLY CROWDING OF THE ANTERIOR TEETH
		J. MULTIPLE CONGENITALLY MISSING TEETH

(5) ORTHODONTICS *("X" Yes or No for each question)*

Yes	No	
		a. PAST HISTORY OF ORTHODONTIC TREATMENT *(If "Yes," date completed: _____)*
		b. WAS INDICATION FOR ORTHODONTIC TREATMENT STRICTLY COSMETIC? *(If functional corrections were made, please describe)*
		c. WAS THERE EVER OR IS THERE NOW, ANY INDICATION OF POST TREATMENT ADVERSE SEQUELAE? *(If "Yes," please explain)*
		d. PRESENTLY UNDERGOING ACTIVE ORTHODONTIC TREATMENT *(Specify fixed or removable)*
		e. WEARING RETAINER APPLIANCES

(6) PROSTHODONTICS *("X" Yes or No for each question) (If additional space is needed, use "REMARKS" section)*

Yes	No	
		a. MISSING TEETH *(Prosthesis required) (Describe)*
		b. MISSING TEETH REPLACED BY AN UNSERVICEABLE PROSTHESIS *(Describe)*
		c. ARE THERE LESS THAN EIGHT, SERVICEABLE, NATURAL TEETH IN EACH ARCH?

(7) PERIODONTAL STATUS *("X" Yes or No for each question)*

Yes	No	
		a. MODERATE TO HEAVY CALCULUS *(Supra and/or sub-gingival)*
		b. GINGIVITIS *(Generalized)*
		c. ACUTE NECROTIZING ULCERATIVE GINGIVITIS
		d. LOCAL OR GENERALIZED PERIODONTITIS *(With associated bone loss)*
		e. JUVENILE PERIODONTITIS
		f. PERIOCORONITIS

(8) RESULTS OF RADIOGRAPHIC EXAMINATION, IF PERFORMED *("X" Yes or No for each question)*
(If additional space is needed, use "REMARKS" section)

Yes	No	
		a. ABNORMAL RADIOLUCENT/RADIOPAQUE AREA *(Describe)*
		b. IMPACTED TEETH WITH PATHOLOGY *(Describe)*
		c. IMPACTED TEETH WITH OTHER THAN THIRD MOLARS *(Describe)*
		d. OTHER RADIOGRAPHIC ABNORMALITIES *(Describe)*

(9) OTHER ABNORMAL CONDITIONS OF THE ORAL CAVITY NOT PREVIOUSLY MENTIONED *("X" Yes or No)*

Yes	No	

(10) REMARKS *(Indicate item of reference) (Use additional sheet if necessary)*

NAME AND ADDRESS OF EXAMINING DENTIST *(Please type or print)*	SIGNATURE OF DENTIST	DATE

FORWARD COMPLETED FORM AND ANY ATTACHMENTS TO: Division of Commissioned Personnel
Attn: RAB/Medical Evaluation Staff
5600 Fishers Lane, Room 4A-15
Rockville, MD 20857-0001

Privacy Act Statement
PHS-6355 "Report of Dental Examination of Applicants to the Commissioned Corps of the Public Health Service"

Authority:
Our authority to collect this information is 42 U.S.C. 202 et seq and Executive Order 10450.

Purpose and Use of Information: The information you and your dentist provide on this form will be used to determine whether you meet the medical standards that apply to Public Health Service (PHS) Commissioned Corps officers. This is a critical evaluation because you must be physically and mentally fit to perform satisfactorily in national or worldwide health and defense emergencies. In addition, the information will be used to begin monitoring your health and fitness for duty on an ongoing basis if you are appointed. It may be provided to other Federal Agencies that furnish you medical care, when needed to ensure continuity of care or to evaluate your eligibility for benefits from that Agency based on your medical condition. It may also be provided to health care practitioners in the private sector in the event you receive emergency medical care or to ensure continuity of care.

In very rare circumstances this information may be provided to: a congressional office at your request; officials of this Department or the Department of Justice to prepare an effective defense when the Department or any of its employees are the subject of litigation; or your legal guardian if you are found mentally incompetent by a court of law.

More information about how these records are maintained is contained in the Privacy Act System Notice of Records number 09-40-0002, PHS Commissioned Corps Medical Records, HHS/PSC/HRS, a copy of which may be obtained from the office to which you submit this form.

Information Regarding Disclosure of Your Social Security Number (SSN): Disclosure of the SSN is mandatory under provisions of the Social Security Act, since PHS Commissioned Corps officers are under social security covered employment and taxes must be withheld from their salaries. The SSN is also used as an identifier throughout an officer's career. It is used primarily to identify an officer's personnel, leave, and pay records and to related one to the other. The SSN is also used in connection with lawful requests for information 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. The use of the SSN is made necessary because of the large number of present and former active, inactive, and retired officers and applicants who have identical names and birth dates, and whose identities can only be distinguished by the SSN.

Effects of Nondisclosure: Failure to provide the information requested on these forms will eliminate your application from further consideration. If you withhold or falsify information about your medical condition, your appointment will be terminated, you will lose any benefits provided to you based on the false information, and you may be subject to criminal or civil prosecution.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service Commissioned Corps

SUPPLEMENTAL MEDICAL HISTORY RECORD REQUIRED OF APPLICANTS TO THE PUBLIC HEALTH SERVICE COMMISSIONED CORPS

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)
(See Privacy Act Statement for Form PHS-6379)

(Please Print)

Last Name	First Name	Middle Initial	Social Security No.

CHECK EACH ITEM "YES" OR "NO".
EVERY ITEM CHECKED "YES" MUST BE FULLY EXPLAINED IN THE BLANK SPACE PROVIDED BELOW.

YES	*NO*		
☐	☐	1.	Have you had a high risk exposure to HIV (AIDS virus)?
☐	☐	2.	Have you ever had a positive test for HIV antibody (test positive for AIDS virus infection)?
☐	☐	3.	Do you now use or have you used within the last 10 years without prescription: marijuana, cocaine, hashish, narcotics, stimulants, depressants, hallucinogenics, or other dangerous or illegal drugs?

IN THE LAST 10 YEARS:

☐	☐	4.	Have you ever felt you ought to cut down on your drinking?
☐	☐	5.	Have people annoyed you by criticizing your drinking?
☐	☐	6.	Have you ever felt bad or guilty about your drinking?
☐	☐	7.	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
☐	☐	8.	Has your alcohol use ever interfered with your performance or attendance at school or work?
☐	☐	9.	Has your alcohol use ever caused you to have an accident or contribute to your arrest?

HAVE YOU NOW OR HAVE YOU EVER:

☐	☐	10.	Had a history of alcohol or drug or substance abuse?
☐	☐	11.	Had, or been advised to have, evaluation or treatment for alcohol or drug or substance abuse?

HAVE YOU EVER:

☐	☐	12.	Had any illness/injury other than those noted on form DD-2807-1, "Report of Medical History," which may require future evaluation and treatment? If yes, please specify when and where and provide details in the space below. *Note: Should you have a question whether a medical condition will require evaluation or treatment in the future, please list it so that the Medical Evaluation Staff, Division of Commissioned Personnel, can determine its significance.*

EXPLAIN IN DETAIL ALL "YES" RESPONSES TO QUESTIONS HERE: *(Use reverse side if necessary)*

Return this completed form to: Division of Commissioned Personnel, ATTN: RAB/Medical Evaluation Staff, Room 4A-15, 5600 Fishers Lane, Rockville, MD 20857-0001.

I certify that I have reviewed all information supplied on this form and that it is true and complete to the best of my knowledge. (Nondisclosure or falsification can be cause for disqualification or termination of appointment.)

Applicant Signature	Date

Created by PSC Media Arts: (301) 443-2454 EF

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service Commissioned Corps

Privacy Act Statement
PHS-6379 "Supplemental Medical History Record Required of Applicants to the Public Health Service Commissioned Corps"

Authority:
Our authority to collect this information is 42 U.S.C. 202 et seq and Executive Order 10450.

Purpose and Use of Information: The information you provide on this form will be used to determine whether you meet the medical standards that apply to Public Health Service (PHS) Commissioned Corps officers. This is a critical evaluation because you must be physically and mentally fit to perform satisfactorily in national or worldwide health and defense emergencies. In addition, the information will be used to begin monitoring your health and fitness for duty on an ongoing basis if you are appointed. It may be provided to other Federal Agencies that furnish you medical care, when needed to ensure continuity of care or to evaluate your eligibility for benefits from that Agency based on your medical condition. It may also be provided to health care practitioners in the private sector in the event you receive emergency medical care or to ensure continuity of care.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service Commissioned Corps

REQUEST FOR UNIFORMED SERVICES MEDICAL RECORDS

SUBJECT: Request for Uniformed Services Medical Records

To: _____

_____

_____

As a requirement of the application process for the U.S. Public Health Service Commissioned Corps, I request that you send to the address below *a copy of my separation physical examination and the last preceding periodic physical examination* (SF-88, SF-93, DD Form 2807-1, DD Form 2808, and supporting laboratory, radiology, and consultation reports).

These must be sent to:

Division of Commissioned Personnel
Attn: RAB/Medical Evaluation Staff
5600 Fishers Lane, Room 4A-15
Rockville, MD 20857-0001

1. NAME *(Type or print)*	2. NAME OF SERVICE	3. DATE

4. DATES OF LAST TOUR OF ACTIVE DUTY	5. SOCIAL SECURITY NUMBER

6. NAME USED WHEN ON ACTIVE DUTY IF OTHER THAN 1. ABOVE	7. SIGNATURE

Please also note *IF* signed below:

Because I was awarded disability or was separated for medical reasons, I further request *a copy of my entire medical record for the last 3 years on active duty be sent to the above address.*

Signature	Type or Printed Name	Date

See Instructions on Page 2
PSC Media Arts (301) 443-2454 EF

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service Commissioned Corps
Division of Commissioned Personnel

REQUEST FOR UNIFORMED SERVICES MEDICAL RECORDS

(See Privacy Act for Form PHS-6380)

(To be completed by those applicants to the Commissioned Corps of the Public Health Service who have previously served or are currently serving with a military service, the U.S. Coast Guard, or the Commissioned Corps of the National Oceanic and Atmospheric Administration.)

INSTRUCTIONS TO APPLICANT

If you are SEPARATED from a military service, the U.S. Coast Guard, or the Commissioned Corps of the National Oceanic and Atmospheric Administration:

(1) Enter address of the National Personnel Records Center (below) in the "To" section of form PHS-6380 and mail to same.

National Personnel Records Center
9700 Page Boulevard
St. Louis, MO 63132-5100

(2) Complete Items 1 through 7 on form PHS-6380.

(3) If you were awarded disability, sign the bottom paragraph of form PHS-6380.

(4) Submit a completed photocopy of this form with your other medical and dental forms to:

Division of Commissioned Personnel
Attn: RAB/Medical Evaluation Staff
5600 Fishers Lane, Room 4A-15
Rockville, MD 20857-0001

If you are CURRENTLY SERVING with a military service, the U.S. Coast Guard, or the Commissioned Corps of the National Oceanic and Atmospheric Administration:

(1) Enter address of your hospital/clinic medical records department in the "To" section of form PHS-6380 and mail or hand carry to same.

(2) Complete Items 1 through 7 on form PHS-6380.

(3) Submit a completed photocopy of this form with your other medical and dental forms to:

Division of Commissioned Personnel
Attn: RAB/Medical Evaluation Staff
5600 Fishers Lane, Room 4A-15
Rockville, MD 20857-0001

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service Commissioned Corps
Division of Commissioned Personnel

Privacy Act Statement
PHS-6380 "Request for Uniformed Services Medical Records"

Authority:
Our authority to collect this information is 42 U.S.C. 202 et seq and Executive Order 10450.

Purpose and Use of Information: The medical information provided will be used to determine whether you meet the medical standards that apply to Public Health Service (PHS) Commissioned Corps officers. This is a critical evaluation because you must be physically and mentally fit to perform satisfactorily in national or worldwide health and defense emergencies. In addition, the information will be used to begin monitoring your health and fitness for duty on an ongoing basis if you are appointed. It may be provided to other Federal Agencies that furnish you medical care, when needed to ensure continuity of care or to evaluate your eligibility for benefits from that Agency based on your medical condition. It may also be provided to health care practitioners in the private sector in the event you receive emergency medical care or to ensure continuity of care.

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DEPARTMENT OF
HEALTH & HUMAN SERVICES

Program Support Center

Rockville MD 20857

Official Business
Penalty for Private Use $300

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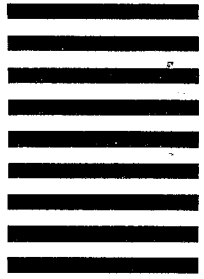
IF MAILED
IN THE
UNITED STATES



BUSINESS REPLY MAIL

FIRST CLASS MAIL PERMIT NO. 1749 ROCKVILLE MD

POSTAGE WILL BE PAID BY PROGRAM SUPPORT CENTER

Division of Commissioned Personnel
ATTN: Medical Evaluations Staff/MAB
5600 Fishers Lane, Room ~~4C-06~~ 4A-18
Rockville, MD 20852-9785

CONFIDENTIAL - MEDICAL