



# OPTIONAL APPLICATION FOR FEDERAL EMPLOYMENT - OF 612

You may apply for most jobs with a resume, this form, or other written format. If your resume or application does not provide all the information requested on this form and in the job vacancy announcement, you may lose consideration for a job.

<b>1</b> Job title in announcement		<b>2</b> Grade(s) applying for	<b>3</b> Announcement number
<b>4</b> Last name	First and middle names		<b>5</b> Social Security Number
<b>6</b> Mailing address			<b>7</b> Phone numbers (include area code) Daytime (     ) Evening (     )
City	State	ZIP Code	

## WORK EXPERIENCE

**8** Describe your paid and nonpaid work experience related to the job for which you are applying. Do **not** attach job descriptions.

**1)** Job title (if Federal, include series and grade)

From (MM/YY)	To (MM/YY)	Salary \$	per	Hours per week
Employer's name and address				Supervisor's name and phone number  (     )
Describe your duties and accomplishments				

**2)** Job title (if Federal, include series and grade)

From (MM/YY)	To (MM/YY)	Salary \$	per	Hours per week
Employer's name and address				Supervisor's name and phone number  (     )
Describe your duties and accomplishments				

9 May we contact your current supervisor?

YES [ ] NO [ ] ▶ If we need to contact your current supervisor before making an offer, we will contact you first.

**EDUCATION**

10 Mark highest level completed. Some HS [ ] HS/GED [ ] Associate [ ] Bachelor [ ] Master [ ] Doctoral [ ]

11 Last high school (HS) or GED school. Give the school's name, city, State, ZIP Code (if known), and year diploma or GED received.

12 Colleges and universities attended. Do not attach a copy of your transcript unless requested.

Name	Total Credits Earned		Major(s)	Degree - (if any)	Year Received
	Semester	Quarter			
1) _____ City _____ State _____ ZIP Code _____					
2) _____					
3) _____					

**OTHER QUALIFICATIONS**

13 Job-related training courses (give title and year). Job-related skills (other languages, computer software/hardware, tools, machinery, typing speed, etc. Job-related certificates and licenses (current only). Job-related honors, awards, and special accomplishments (publications, memberships in professional/honor societies, leadership activities, public speaking, and performance awards.) Give dates, but do not send documents unless requested.

**GENERAL**

14 Are you a U.S. citizen? YES [ ] NO [ ] ▶ Give the country of your citizenship. \_\_\_\_\_

15 Do you claim veterans' preference? NO [ ] YES [ ] ▶ Mark your claim of 5 or 10 points below.  
5 points [ ] ▶ Attach your DD 214 or other proof. 10 points [ ] ▶ Attach an Application for 10-Point Veterans' Preference (SF 15) and proof required.

16 Were you ever a Federal civilian employee? NO [ ] YES [ ] ▶ For highest civilian grade give:  
Series \_\_\_\_\_ Grade \_\_\_\_\_ From (MM/YY) \_\_\_\_\_ To (MM/YY) \_\_\_\_\_

17 Are you eligible for reinstatement based on career or career-conditional Federal status? NO [ ] YES [ ] ▶ If requested, attach SF 50 proof.

**APPLICANT CERTIFICATION**

18 I certify that, to the best of my knowledge and belief, all of the information on and attached to this application is true, correct, complete and made in good faith. I understand that false or fraudulent information on or attached to this application may be grounds for not hiring me or for firing me after I begin work, and may be punishable by fine or imprisonment. I understand that any information I give may be investigated.

SIGNATURE

DATE SIGNED

## INSTRUCTIONS

PLEASE READ ALL INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS FORM.

**Anti-Discrimination Notice.** It is illegal to discriminate against any individual (other than an alien not authorized to work in the U.S.) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

**Section 1 - Employee.** All employees, citizens noncitizens, hired after November 6, 1986, must complete Section 1 of this form at the time of hire, which is the actual beginning of employment. **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

**Preparer/Translator Certification.** The Preparer/Translator Certification must be completed if Section 1 is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete Section 1 on his/her own. However, the employee must still sign Section 1 personally.

**Section 2 - Employer.** For the purpose of completing this form, the term "employer" includes those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors.

Employers must complete Section 2 by examining evidence of identity and employment eligibility within three (3) business days of the date employment begins. If employees are authorized to work, but are unable to present the required document(s) within three business days, they must present a receipt for the application of the document(s) within three business days and the actual document(s) within ninety (90) days. However, if employers hire individuals for a duration of less than three business days, Section 2 must be completed at the time employment begins. **Employers must record:** 1) document title; 2) issuing authority; 3) document number, 4) expiration date, if any; and 5) the date employment begins. Employers must sign and date the certification. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. These photocopies may only be used for the verification process and must be retained with the I-9. **However, employers are still responsible for completing the I-9.**

**Section 3 - Updating and Reverification.** Employers must complete Section 3 when updating and/or reverifying the I-9. Employers must reverify employment eligibility of their employees on or before the expiration date recorded in Section 1. Employers **CANNOT** specify which document(s) they will accept from an employee.

- If an employee's name has changed at the time this form is being updated/ reverified, complete Block A.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee is still eligible to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.

- If an employee is rehired within three (3) years of the date this form was originally completed and the employee's work authorization has expired **or** if a current employee's work authorization is about to expire (reverification), complete Block B and:
  - examine any document that reflects that the employee is authorized to work in the U.S. (see List A **or** C),
  - record the document title, document number and expiration date (if any) in Block C, and
  - complete the signature block.

**Photocopying and Retaining Form I-9.** A blank I-9 may be reproduced provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed I-9s for three (3) years after the date of hire **or** one (1) year after the date employment ends, whichever is later.

**For more detailed information, you may refer to the INS Handbook for Employers, (Form M-274). You may obtain the handbook at your local INS office.**

**Privacy Act Notice.** The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 U.S.C. 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by officials of the U.S. Immigration and Naturalization Service, the Department of Labor, and the Office of Special Counsel for Immigration Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

**Reporting Burden.** We try to create forms and instructions that are accurate, can be easily understood, and which impose the least possible burden on you to provide us with information. Often this is difficult because some immigration laws are very complex. Accordingly, the reporting burden for this collection of information is computed as follows: 1) learning about this form, 5 minutes; 2) completing the form, 5 minutes; and 3) assembling and filing (recordkeeping) the form, 5 minutes, for an average of 15 minutes per response. If you have comments regarding the accuracy of this burden estimate, or suggestions for making this form simpler, you can write to both the Immigration and Naturalization Service, 425 I Street, N.W., Room 5304, Washington, D. C. 20536; and the Office of Management and Budget, Paperwork Reduction Project, OMB No. 1115-0136, Washington, D.C. 20503.

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. **ANTI-DISCRIMINATION NOTICE.** It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

**Section 1. Employee Information and Verification.** To be completed and signed by employee at the time employment begins

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #
I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.		I attest, under penalty of perjury, that I am (check one of the following): A citizen or national of the United States A Lawful Permanent Resident (Alien # A _____) An alien authorized to work until ___/___/___ (Alien # or Admission # _____)	
		Employee's Signature	

**Preparer and/or Translator Certification.** (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	
Date (month/day/year)	

**Section 2. Employer Review and Verification.** To be completed and signed by employer. **Examine one document from List A OR examine one document from List B and one from List C** as listed on the reverse of this form and record the title, number and expiration date, if any, of the document(s)

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): ___/___/___		___/___/___		___/___/___
Document #: _____		_____		_____
Expiration Date (if any): ___/___/___		_____		_____

**CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) \_\_\_/\_\_\_/\_\_\_ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment).**

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name	Address (Street Name and Number, City, State, Zip Code)	Date (month/day/year)

**Section 3. Updating and Reverification.** To be completed and signed by employer

A. New Name (if applicable)	B. Date of rehire (month/day/year) (if applicable)	
C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.		
Document Title: _____	Document #: _____	Expiration Date (if any): ___/___/___

**I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.**

Signature of Employer or Authorized Representative	Date (month/day/year)
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## LISTS OF ACCEPTABLE DOCUMENTS

### LIST A

#### Documents that Establish Both Identity and Employment Eligibility

1. U.S. Passport (unexpired or expired)
2. Certificate of U.S. Citizenship (*INS Form N-560 or N-561*)
3. Certificate of Naturalization (*INS Form N-550 or N-570*)
4. Unexpired foreign passport, with *I-551 stamp* or attached *INS Form I-94* indicating unexpired employment authorization
5. Alien Registration Receipt Card with photograph (*INS Form I-151 or I-551*)
6. Unexpired Temporary Resident Card (*INS Form I-688*)
7. Unexpired Employment Authorization Card (*INS Form I-688A*)
8. Unexpired Reentry Permit (*INS Form I-327*)
9. Unexpired Refugee Travel Document (*INS Form I-571*)
10. Unexpired Employment Authorization Document issued by the INS which contains a photograph (*INS Form I-688B*)

**OR**

### LIST B

#### Documents that Establish Identity

1. Driver's license or ID card issued by a state or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address
  2. ID card issued by federal, state, or local government agencies or entities provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address
  3. School ID card with a photograph
  4. Voter's registration card
  5. U.S. Military card or draft record
  6. Military dependent's ID card
  7. U.S. Coast Guard Merchant Mariner Card
  8. Native American tribal document
  9. Driver's license issued by a Canadian government authority
- For persons under age 18 who are unable to present a document listed above:**
10. School record or report card
  11. Clinic, doctor, or hospital record
  12. Day-care or nursery school record

**AND**

### LIST C

#### Documents that Establish Employment Eligibility

1. U.S. social security card issued by the Social Security Administration (*other than a card stating it is not valid for employment*)
2. Certification of Birth Abroad issued by the Department of State (*Form FS-545 or Form DS-1350*)
3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal
4. Native American tribal document
5. U.S. Citizen ID Card (*INS Form I-197*)
6. ID Card for use of Resident Citizen in the United States (*INS Form I-179*)
7. Unexpired employment authorization document issued by the INS (*other than those listed under List A*)

**Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)**

MALE APPLICANTS ONLY

**APPLICANT'S STATEMENT OF SELECTIVE SERVICE REGISTRATION STATUS**

If you are a male born after December 31, 1959, and are at least 18 years of age, civil service employment law (5 U.S.C. 3328) requires that you must be registered with the Selective Service System, unless you meet certain exemptions under Selective Service law. If you are required to register, but knowingly and willfully fail to do so, you are ineligible for appointment by executive agencies of the Federal Government.

CERTIFICATION OF REGISTRATION STATUS (Check one):

- I certify I am registered with the Selective Service System.
- I certify I have been determined by the Selective Service System to be exempt from the registration provisions of Selective Service law.
- I certify I have not registered with the Selective Service System.
- I certify I have not reached my 18th birthday and understand I am required by law to register at that time.

NON-REGISTRANTS UNDER AGE 26

If you are under age 26 and have not registered as required, you should register promptly at a United States Post Office or consular office if you are outside the United States.

NON-REGISTRANTS AGE 26 OR OVER

If you were born in 1960 or later, are 26 years of age or older, and were required to register but did not do so, you can no longer register under Selective Service law. Accordingly, you are not eligible for appointment to an executive agency unless you can prove to the Office of Personnel Management (OPM) that your failure to register was neither knowing nor willful. You may request an OPM decision through the agency that was considering you for employment by returning this statement with your written request for an OPM determination together with any explanation and documentation you wish to furnish to prove that your failure to register was neither knowing nor willful.

PRIVACY ACT STATEMENT

Because information on your registration status is essential for determining whether you are in compliance with 5 U.S.C. 3328, failure to provide the information requested by this statement will prevent any further consideration of your application for appointment. This information is subject to verification with the Selective Service System and may be furnished to other Federal agencies for law enforcement or other authorized use in implementing this law.

FALSE STATEMENT NOTIFICATION

A false statement may be ground for not hiring you, or for firing you if you have already begun work. Also, you may be punished by fine or imprisonment (Section 1001 or title 18, United States Code).

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Legal signature of individual (please use ink)

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Date signed (please use ink)

# Form W-4 (2000)

**Purpose.** Complete Form W-4 so your employer can withhold the correct Federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

**Exemption from withholding.** If you are exempt, complete only lines 1, 2, 3, 4, and 7, and sign the form to validate it. Your exemption for 2000 expires February 16, 2001.

**Note:** You cannot claim exemption from withholding if (1) your income exceeds \$700 and includes more than \$250 of unearned income (e.g., interest and dividends) and (2) another person can claim you as a dependent on their tax return.

**Basic instructions.** If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on itemized

deductions, adjustments to income, or two-earner/two-job situations. Complete all worksheets that apply. They will help you figure the number of withholding allowances you are entitled to claim. **However, you may claim fewer (or zero) allowances.**

**Child tax and higher education credits.** For details on adjusting withholding for these and other credits, see **Pub. 919, How Do I Adjust My Tax Withholding?**

**Head of household.** Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See line **E** below.

**Nonwage income.** If you have a large amount of nonwage income, such as interest or dividends, you should consider making estimated tax payments using **Form 1040-ES, Estimated Tax for Individuals.** Otherwise, you may owe additional tax.

**Two earners/two jobs.** If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 prepared for the highest paying job and zero allowances are claimed for the others.

**Check your withholding.** After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2000. Get Pub. 919 especially if you used the **Two-Earner/Two-Job Worksheet** on page 2 and your earnings exceed \$150,000 (Single) or \$200,000 (Married).

**Recent name change?** If your name on line 1 differs from that shown on your social security card, call 1-800-772-1213 for a new social security card.

## Personal Allowances Worksheet (Keep for your records.)

**A** Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . **A** \_\_\_\_\_

**B** Enter "1" if: } } **B** \_\_\_\_\_

- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are \$1,000 or less.

**C** Enter "1" for your **spouse**. But, you may choose to enter -0- if you are married and have either a working spouse or more than one job. (Entering -0- may help you avoid having too little tax withheld.) . . . . . **C** \_\_\_\_\_

**D** Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . . **D** \_\_\_\_\_

**E** Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . . . . . **E** \_\_\_\_\_

**F** Enter "1" if you have at least \$1,500 of **child or dependent care expenses** for which you plan to claim a credit . . . . . **F** \_\_\_\_\_

**G Child Tax Credit:**

- If your total income will be between \$18,000 and \$50,000 (\$23,000 and \$63,000 if married), enter "1" for each eligible child.
- If your total income will be between \$50,000 and \$80,000 (\$63,000 and \$115,000 if married), enter "1" if you have two eligible children, enter "2" if you have three or four eligible children, or enter "3" if you have five or more eligible children **G** \_\_\_\_\_

**H** Add lines A through G and enter total here. **Note:** This may be different from the number of exemptions you claim on your tax return. **H** \_\_\_\_\_

For accuracy, complete all worksheets that apply. } }

- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single**, have **more than one job** and your combined earnings from all jobs exceed \$34,000, OR if you are **married** and have a **working spouse or more than one job** and the combined earnings from all jobs exceed \$60,000, see the **Two-Earner/Two-Job Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

----- Cut here and give Form W-4 to your employer. Keep the top part for your records. -----

Form <b>W-4</b> Department of the Treasury Internal Revenue Service	<b>Employee's Withholding Allowance Certificate</b> <b>► For Privacy Act and Paperwork Reduction Act Notice, see page 2.</b>	OMB No. 1545-0010 <b>2000</b>
1 Type or print your first name and middle initial _____ Last name _____		2 Your social security number _____
Home address (number and street or rural route) _____		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <b>Note:</b> If married, but legally separated, or spouse is a nonresident alien, check the Single box.
City or town, state, and ZIP code _____		4 If your last name differs from that on your social security card, check here. <b>You must call 1-800-772-1213 for a new card</b> . . . . . <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above OR from the applicable worksheet on page 2)		5 _____
6 Additional amount, if any, you want withheld from each paycheck . . . . .		6 \$ _____
7 I claim exemption from withholding for 2000, and I certify that I meet <b>BOTH</b> of the following conditions for exemption: • Last year I had a right to a refund of <b>ALL</b> Federal income tax withheld because I had <b>NO</b> tax liability <b>AND</b> • This year I expect a refund of <b>ALL</b> Federal income tax withheld because I expect to have <b>NO</b> tax liability. If you meet both conditions, write "EXEMPT" here . . . . . <b>7</b> _____		
Under penalties of perjury, I certify that I am entitled to the number of withholding allowances claimed on this certificate, or I am entitled to claim exempt status.		
Employee's signature _____ (Form is not valid unless you sign it) <b>►</b>		Date <b>►</b> _____
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional) _____
		10 Employer identification number _____

**Deductions and Adjustments Worksheet**

**Note:** Use this worksheet only if you plan to itemize deductions or claim adjustments to income on your 2000 tax return.

1 Enter an estimate of your 2000 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2000, you may have to reduce your itemized deductions if your income is over \$128,950 (\$64,475 if married filing separately). See **Worksheet 3** in Pub. 919 for details.) . . . 1 \$ \_\_\_\_\_

2 Enter:  $\left\{ \begin{array}{l} \$7,350 \text{ if married filing jointly or qualifying widow(er)} \\ \$6,450 \text{ if head of household} \\ \$4,400 \text{ if single} \\ \$3,675 \text{ if married filing separately} \end{array} \right\}$  . . . . . 2 \$ \_\_\_\_\_

3 **Subtract** line 2 from line 1. If line 2 is greater than line 1, enter -0- . . . . . 3 \$ \_\_\_\_\_

4 Enter an estimate of your 2000 adjustments to income, including alimony, deductible IRA contributions, and student loan interest . . . . . 4 \$ \_\_\_\_\_

5 **Add** lines 3 and 4 and enter the total (Include any amount for credits from **Worksheet 7** in Pub. 919.) . . . . . 5 \$ \_\_\_\_\_

6 Enter an estimate of your 2000 nonwage income (such as dividends or interest) . . . . . 6 \$ \_\_\_\_\_

7 **Subtract** line 6 from line 5. Enter the result, but not less than -0- . . . . . 7 \$ \_\_\_\_\_

8 **Divide** the amount on line 7 by \$3,000 and enter the result here. Drop any fraction . . . . . 8 \_\_\_\_\_

9 Enter the number from the **Personal Allowances Worksheet**, line H, page 1 . . . . . 9 \_\_\_\_\_

10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earner/Two-Job Worksheet**, also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 . . . . . 10 \_\_\_\_\_

**Two-Earner/Two-Job Worksheet**

**Note:** Use this worksheet only if the instructions under line H on page 1 direct you here.

1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) . . . . . 1 \_\_\_\_\_

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here . . . . . 2 \_\_\_\_\_

3 If line 1 is **MORE THAN OR EQUAL TO** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter -0-) and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . . . 3 \_\_\_\_\_

**Note:** If line 1 is **LESS THAN** line 2, enter -0- on Form W-4, line 5, page 1. Complete lines 4-9 below to calculate the additional withholding amount necessary to avoid a year end tax bill.

4 Enter the number from line 2 of this worksheet . . . . . 4 \_\_\_\_\_

5 Enter the number from line 1 of this worksheet . . . . . 5 \_\_\_\_\_

6 **Subtract** line 5 from line 4 . . . . . 6 \_\_\_\_\_

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . . 7 \$ \_\_\_\_\_

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . . . 8 \$ \_\_\_\_\_

9 Divide line 8 by the number of pay periods remaining in 2000. For example, divide by 26 if you are paid every other week and you complete this form in December 1999. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . . 9 \$ \_\_\_\_\_

**Table 1: Two-Earner/Two-Job Worksheet**

Married Filing Jointly				All Others			
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above
\$0 - \$4,000 . . . . .	0	41,001 - 45,000 . . . . .	8	\$0 - \$5,000 . . . . .	0	65,001 - 80,000 . . . . .	8
4,001 - 7,000 . . . . .	1	45,001 - 55,000 . . . . .	9	5,001 - 11,000 . . . . .	1	80,001 - 100,000 . . . . .	9
7,001 - 13,000 . . . . .	2	55,001 - 63,000 . . . . .	10	11,001 - 17,000 . . . . .	2	100,001 and over . . . . .	10
13,001 - 19,000 . . . . .	3	63,001 - 70,000 . . . . .	11	17,001 - 22,000 . . . . .	3		
19,001 - 25,000 . . . . .	4	70,001 - 85,000 . . . . .	12	22,001 - 27,000 . . . . .	4		
25,001 - 31,000 . . . . .	5	85,001 - 100,000 . . . . .	13	27,001 - 40,000 . . . . .	5		
31,001 - 37,000 . . . . .	6	100,001 - 110,000 . . . . .	14	40,001 - 50,000 . . . . .	6		
37,001 - 41,000 . . . . .	7	110,001 and over . . . . .	15	50,001 - 65,000 . . . . .	7		

**Table 2: Two-Earner/Two-Job Worksheet**

Married Filing Jointly		All Others	
If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$50,000 . . . . .	\$420	\$0 - \$30,000 . . . . .	\$420
50,001 - 100,000 . . . . .	780	30,001 - 60,000 . . . . .	780
100,001 - 130,000 . . . . .	870	60,001 - 120,000 . . . . .	870
130,001 - 250,000 . . . . .	1,000	120,001 - 270,000 . . . . .	1,000
250,001 and over . . . . .	1,100	270,001 and over . . . . .	1,100

**Privacy Act and Paperwork Reduction Act Notice.** We ask for the information on this form to carry out the Internal Revenue laws of the United States. The Internal Revenue Code requires this information under sections 3402(f)(2)(A) and 6109 and their regulations. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; **providing fraudulent information may also subject you to penalties.** Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, to cities, states, and the District of Columbia for use in administering their tax laws, and for use in the National Directory of New Hires.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB

control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The time needed to complete this form will vary depending on individual circumstances. The estimated average time is: **Recordkeeping** 46 min., **Learning about the law or the form** 13 min., **Preparing the form** 59 min. If you have comments concerning the accuracy of these time estimates or suggestions for making this form simpler, we would be happy to hear from you. You can write to the Tax Forms Committee, Western Area Distribution Center, Rancho Cordova, CA 95743-0001. **DO NOT** send the tax form to this address. Instead, give it to your employer.





# National Disaster Medical System (NDMS) Member Information

Team:	Name (Last, First MI):	SSN:	<b>Male/Female</b> <i>circle one</i>
Home Phone #:	Home Phone #2:	Home Fax #:	
Work Phone #:	Work Extension:	Work Fax #:	
Pager #:	Pin #:	Pager Type (circle all applicable) <b>Numeric/Alpha-numeric/Voice</b>	If alpha-numeric, provide modem # to send electronic msg. or give name of service provider:
Cellular Phone #:	Other phone # and description:		Email Address:
Smoker or Non-Smoker (circle one) <i>For use in assigning hotel rooms.</i>		Place of Birth City and State:	
Do you have a passport?  Yes or No (circle one)	If yes, provide the following: Passport # <input style="width: 150px;" type="text"/> Expiration Date <input style="width: 100px;" type="text"/>		
#1 – Home commercial Airport choice:	Distance from your home to airport in miles and time:		
#2 – Home commercial Airport choice:	Distance from your home to airport in miles and time:		
Do you have one or more medical specialties? Yes or No (circle one) If yes, please list all specialties and indicate if you are <b>Board Certified, Board Eligible, or Neither.</b>			
Do you have Hazmat Training?  Yes or No (circle one)	If yes, check training level. <input type="checkbox"/> Awareness <input type="checkbox"/> Operations <input type="checkbox"/> Technician <input type="checkbox"/> Specialist <input type="checkbox"/> Incident Command		
Do you have a valid Drivers License?  If yes, please provide # <input style="width: 150px;" type="text"/> State <input style="width: 50px;" type="text"/> Expiration Date <input style="width: 100px;" type="text"/>	If you have a Commercial Drivers License, please list the following:  <b>Class</b> <input style="width: 150px;" type="text"/> <b>Endorsement Codes</b> <input style="width: 150px;" type="text"/>		
#1 – Emergency Contact Name:	Relationship:	Work Phone #:  Home Phone #:	
#2 – Emergency Contact Name:	Relationship:	Work Phone #:  Home Phone #:	
Blood Type:	Religion:		

**FAST START**



**INSTRUCTIONS FOR PROCESSING FEDERAL EMPLOYEE PAYMENTS**

Use: For processing Federal employee net salary, allotments, and other agency - approved payments associated with Federal employment (i.e. travel reimbursement, uniform allowance, etc). Employee must complete items 1,2,3 and 5. Complete item 4 only if you want to start, cancel or change the amount of a savings or discretionary allotment - see instructions on back of form.

**1. EMPLOYEE INFORMATION**

(SSN) EMPLOYEE PAYROLL IDENTIFICATION NUMBER

EMPLOYEE NAME   
(as on payroll records)  
(Last, First, Initials)

TELEPHONE NUMBER (WORK)  (HOME)

**2. TYPE OF ACCOUNT**

Checking  
 Savings

**3. DIRECT DEPOSIT ACCOUNT INFORMATION - NET PAY/TRAVEL/OTHER** (Use Sec. 4 for allotments)  
A voided personal check/sharedraft may be attached in lieu of completing this section.  
See instructions on back of this form.

ROUTING TRANSIT NUMBER   Check Digit

ACCOUNT NUMBER

ACCOUNT TITLE \_\_\_\_\_  
(Account Holder s Name)

FINANCIAL INSTITUTION NAME \_\_\_\_\_

**TYPE OF PAYMENT**

Net Pay  
 Travel  
 Other Federal employment related payments

**4. ALLOTMENT INFORMATION**  
Complete this section only if you want to start, cancel or change the amount of a savings or discretionary allotment - see instructions on back of form.

TYPE OF ALLOTMENT (Check One)	TYPE OF ACCOUNT (Check One)	ACTION (Check One)	AMOUNT (Check One)
<input type="checkbox"/> Savings (whole dollar amounts only)	<input type="checkbox"/> SAVINGS	<input type="checkbox"/> START	<input type="checkbox"/> INCREASE TO:
<input type="checkbox"/> Discretionary or Third Party	<input type="checkbox"/> CHECKING	<input type="checkbox"/> CANCEL	<input type="checkbox"/> DECREASE TO:
		<input type="checkbox"/> CHANGE	New Total \$ _____

ALLOTTEE NAME (person/company who will receive allotment)

ALLOTTEE S ROUTING NUMBER   Check Digit

ALLOTTEE S ACCOUNT NUMBER

ALLOTTEE S ACCOUNT TITLE (Account Holder s Name) \_\_\_\_\_

FINANCIAL INSTITUTION NAME \_\_\_\_\_

**5. AUTHORIZATION**

\* \_\_\_\_\_  
EMPLOYEE S SIGNATURE DATE

**6. AGENCY USE:**

PRIVACY ACT STATEMENT

The collection of the information you are requested to provide on this form is authorized under 31 CFR 209 and/or 210. The information is confidential and is needed to prove entitlement to payments. The information will be used to process payment data from the Federal agency to the financial institution and/or its agent.

INSTRUCTIONS FOR PROCESSING FASTSTART AUTHORIZATION

PURPOSE

You may use this form to provide instructions for processing your net salary. You may also use this for to provide instructions for processing allotments and other agency - approved payments associated with your Federal employment.

- 1. EMPLOYEE INFORMATION (always complete this section)
2. TYPE OF ACCOUNT/PAYMENT (Put an X in the appropriate space to indicate a checking or savings account and type of payment.)
3. DIRECT DEPOSIT ACCOUNT INFORMATION
ROUTING TRANSIT NUMBER (your financial institution s 9-digit routing transit number)
ACCOUNT NUMBER (your account number at your financial institution)
ACCOUNT TITLE (the depositor s name on the account to which payments are to be directed)
FINANCIAL INSTITUTION NAME (the name of the institution to which payments are to be directed)

The Routing Transit Number (RTN) can be obtained from the financial institution or found on the bottom of a check.

- 1. ROUTING TRANSIT NUMBER - Here you would put 021001082
2. ACCOUNT NUMBER - Here you would put 123-456-789 . Note the use of the dash symbol.
3. ACCOUNT TITLE (must include employee name)
4. FINANCIAL INSTITUTION NAME
5. If your check or sharedraft includes payable through under the bank name, contact the financial institution to help obtain the correct Routing Transit Number for Direct Deposit processing.

4. ALLOTMENT INFORMATION

ALLOTMENT TYPE

SAVINGS (If this option is checked, this will allow the specified allotment to be credited to an account owned by the payee.) Savings allotments are limited to two. Savings allotments must be in whole dollar amounts (no cents). The dollar amount of allotments may not exceed the pay due an employee per pay period.

DISCRETIONARY OR THIRD PARTY (If this option is checked, this will allow the specified allotment to be credited to an account not owned by the payee.) Certain restrictions may apply as to the kind of allotments your agency will allow. Check with your agency to determine what kinds of allotments it will allow. ANY CHANGES TO THE ALLOTMENT INFORMATION FURNISHED ON THIS REQUEST MUST BE MADE USING A NEW FASTSTART FORM.

- TYPE OF ACCOUNT (Put an X in the appropriate space to indicate a checking or savings account.)
ACTION (Put an X in the appropriate space to indicate start/cancel/change.)
AMOUNT (Put an X in the appropriate space to indicate if an allotment is an increase, decrease and always indicate \$ amount.)

ALLOTTEE S ROUTING NUMBER: Enter person s/company financial institution 9-digit routing transit number.
ALLOTTEE S ACCOUNT NUMBER: Enter the account number to which the allotment payment will be deposited.
ALLOTTEE S ACCOUNT NUMBER: Enter account holder s name on the account at the financial institution.
FINANCIAL INSTITUTION NAME: Enter the name of the financial institution to which the payment should be sent.

5. AUTHORIZATION

Sign and date the request form after you have carefully read the instructions and Privacy Act Statement.

6. AGENCY USE (This space is reserved for agency use.)

CHANGES AND CANCELLATIONS - Contact your agency for instructions.



# APPOINTMENT AFFIDAVITS

_____		_____
<i>(Position to which appointed)</i>		<i>(Date of appointment)</i>
_____	_____	_____
<i>(Department or agency)</i>	<i>(Bureau or Division)</i>	<i>(Place of employment)</i>

I, \_\_\_\_\_, do solemnly swear (or affirm) that—

## A. OATH OF OFFICE

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

## B. AFFIDAVIT AS TO STRIKING AGAINST THE FEDERAL GOVERNMENT

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

## C. AFFIDAVIT AS TO PURCHASE AND SALE OF OFFICE

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

\_\_\_\_\_  
*(Signature of appointee)*

Subscribed and sworn (or affirmed) before me this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_,

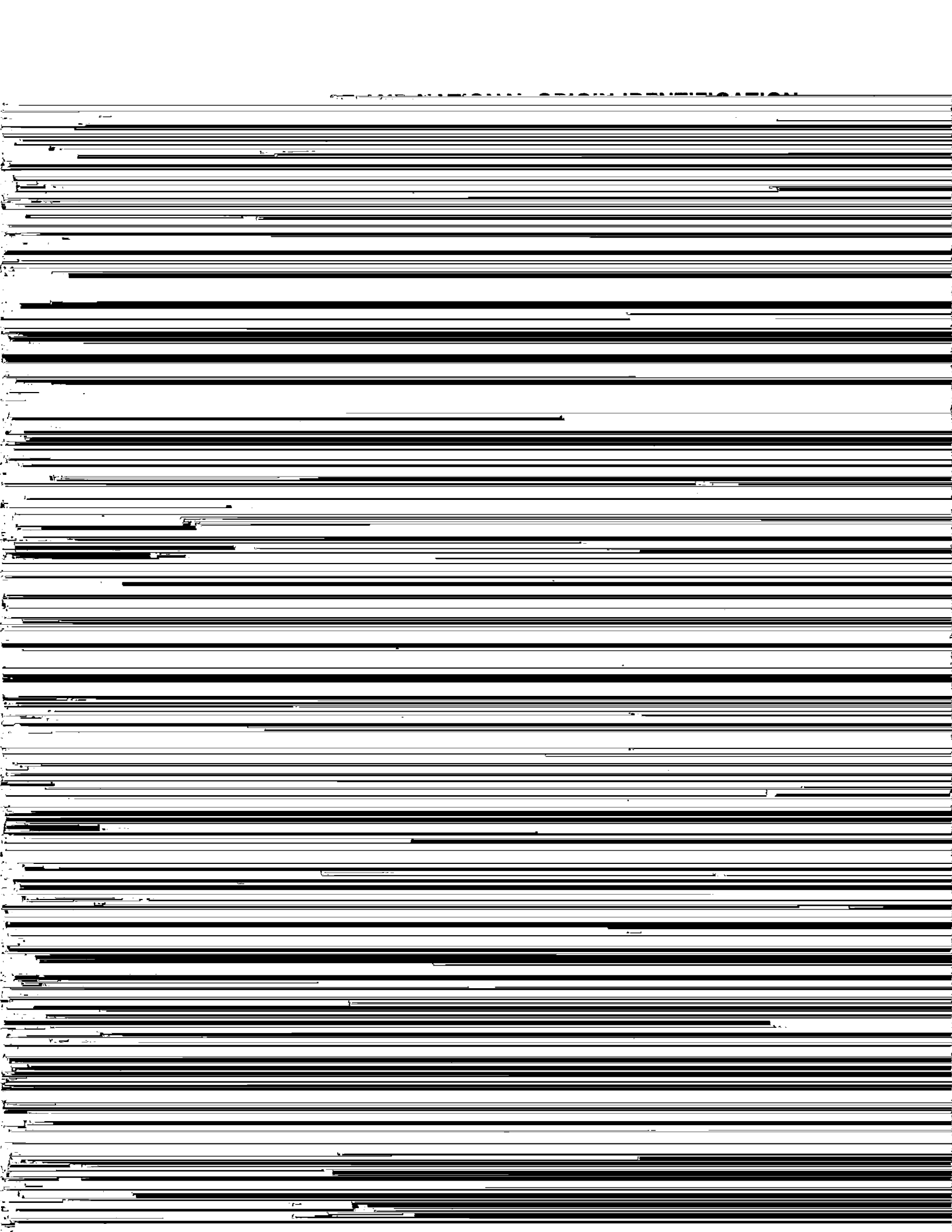
at \_\_\_\_\_  
*(City)* \_\_\_\_\_  
*(State)*

[SEAL]

\_\_\_\_\_  
*(Signature of officer)*

Commission expires \_\_\_\_\_  
*(If by a Notary Public, the date of expiration of his/her Commission should be shown)* \_\_\_\_\_  
*(Title)*

**NOTE.**—The oath of office must be administered by a person specified in 5 U.S.C. 2903. The words "So help me God" in the oath and the word "swear" wherever it appears above should be stricken out when the appointee elects to affirm rather than swear to the affidavits; only these words may be stricken and only when the appointee elects to affirm the affidavits.



# SELF-IDENTIFICATION OF HANDICAP



(See instructions and Privacy Act information on reverse)

Last Name, First Name, Middle Initial	Birth Date (Mo./Yr.)	Social Security Number	ENTER CODE HERE →
---------------------------------------	----------------------	------------------------	-------------------

**DEFINITION OF A HANDICAP:** A person is handicapped if he or she has a physical or mental impairment which substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such impairment. Those handicaps that

are to be reported are listed below (codes in bold numbers 13 through 94). In the case of multiple impairments, choose the code which describes the impairment that would result in the most substantial limitation.

**TO THE EMPLOYEE:** Self-identification of handicap status is essential for effective data collection and analysis. The information you provide will be used for statistical purposes only and will not in any way affect you individually. While self-identification is voluntary, your cooperation in providing accurate information is critical.

**01** I do not wish to identify my handicap status. (Please read the employee note above and the reverse side of this form before using this code.) (Note: Your personnel officer may use this code if, in his or her judgment, you used an incorrect code.)

**05** I do not have a handicap.

**06** I have a handicap but it is not listed below.

## SPEECH IMPAIRMENTS

**13** Severe speech malfunction or inability to speak; hearing is normal (Examples: defects of articulation [unclear language sounds]; stuttering; aphasia [impaired language function]; laryngectomy [removal of the "voice box"])

## HEARING IMPAIRMENTS

**15** Hard of hearing (Total deafness in one ear or inability to hear ordinary conversation, correctable with a hearing aid)

**16** Total deafness in both ears, with understandable speech

**17** Total deafness in both ears, and unable to speak clearly

## VISION IMPAIRMENTS

**22** Ability to read ordinary size print with glasses, but with loss of peripheral (side) vision (Restriction of the visual field to the extent that mobility is affected—"Tunnel vision")

**23** Inability to read ordinary size print, not correctable by glasses (Can read oversized print or use assisting devices such as glass or projector modifier)

**24** Blind in one eye

**25** Blind in both eyes (No usable vision, but may have some light perception)

## MISSING EXTREMITIES

**27** One hand

**28** One arm

**29** One foot

**32** One leg

**33** Both hands or arms

**34** Both feet or legs

**35** One hand or arm and one foot or leg

**36** One hand or arm and both feet or legs

**37** Both hands or arms and one foot or leg

**38** Both hands or arms and both feet or legs

## NONPARALYTIC ORTHOPEDIC IMPAIRMENTS

(Because of chronic pain, stiffness, or weakness in bones or joints, there is some loss of ability to move or use a part or parts of the body.)

**44** One or both hands

**47** One or both legs

**45** One or both feet

**48** Hip or pelvis

**46** One or both arms

**49** Back

**57** Any combination of two or more parts of the body

## PARTIAL PARALYSIS

(Because of a brain, nerve, or muscle problem, including palsy and cerebral palsy, there is some loss of ability to move or use a part of the body, including legs, arms, and/or trunk.)

**61** One hand

**67** One side of body, including one arm and one leg

**62** One arm, any part

**63** One leg, any part

**64** Both hands

**68** Three or more major parts of the body (arms and legs)

**65** Both legs, any part

**66** Both arms, any part

## COMPLETE PARALYSIS

(Because of a brain, nerve, or muscle problem, including palsy and cerebral palsy, there is a complete loss of ability to move or use a part of the body, including legs, arms, and/or trunk.)

**70** One hand

**76** Lower half of body, including legs

**71** Both hands

**77** One side of body, including one arm and one leg

**72** One arm

**73** Both arms

**74** One leg

**78** Three or more major parts of the body (arms and legs)

**75** Both legs

## OTHER IMPAIRMENTS

**80** Heart disease with no restriction or limitation of activity (History of heart problems with complete recovery)

**81** Heart disease with restriction or limitation of activity

**82** Convulsive disorder (e.g., epilepsy)

**83** Blood diseases (e.g., sickle cell anemia, leukemia, hemophilia)

**84** Diabetes

**86** Pulmonary or respiratory disorders (e.g., tuberculosis, emphysema, asthma)

**87** Kidney dysfunctioning (e.g., if dialysis [Use of an artificial kidney machine] is required)

**88** Cancer—a history of cancer with complete recovery

**89** Cancer—undergoing surgical and/or medical treatment

**90** Mental retardation (A chronic and lifelong condition involving a limited ability to learn, to be educated, and to be trained for useful productive employment as certified by a State Vocational Rehabilitation agency under section 213.3102(t) of Schedule A)

**91** Mental or emotional illness (A history of treatment for mental or emotional problems)

**92** Severe distortion of limbs and/or spine (e.g., dwarfism, kyphosis [severe distortion of back])

**93** Disfigurement of face, hands, or feet (e.g., distortion of features on skin, such as those caused by burns, gunshot injuries, and birth defects [gross facial birthmarks, club feet, etc.]

**94** Learning disability (A disorder in one or more of the processes involved in understanding, perceiving, or using language or concepts [spoken or written]; e.g., dyslexia)

The Rehabilitation Act of 1973 (P.L. 93-112) requires each agency in the Executive branch of the Federal Government to establish definite programs that will facilitate the hiring, placement, and advancement of handicapped individuals. The best means of determining agency progress in this respect is through the production of reports at certain intervals showing such things as the number of handicapped employees hired, promoted, trained, or reassigned over a given time period; the percentage of handicapped employees in the work force and in various grades and occupations; etc. Such reports bring to the attention of agency top management, the Office of Personnel Management (OPM), and the Congress deficiencies within specific agencies or the Federal Government as a whole in the hiring, placement, and advancement of handicapped individuals and, therefore, are the essential first step in improving these conditions and consequently meeting the requirements of the Rehabilitation Act.

The handicap data collected on employees will be used only in the production of reports such as those previously mentioned and not for any purpose that will affect them individually. The only exception to this rule is that the records may be used for selective placement purposes and selecting special populations for mailing of voluntary personnel research surveys. In addition, every precaution will be taken to ensure that the information provided by each employee is kept in the strictest confidence and is known only to the one or two individuals in the agency Personnel Office who obtain and record the information for entry into the agency's and OPM's personnel systems. You should also be aware that participation in the handicap reporting system is entirely voluntary, **with the exception of employees appointed under Schedule A, section 213.3102(t) (Mental Retardation); Schedule A, section 213.3102(u) (Severely Physically Handicapped); and Schedule B, section 213.3202(k) (Mentally Restored).** These employees will be requested to identify their handicap status and if they decline to do so, their correct handicap code will be obtained from medical documentation used to support their appointment. No other employees will be required to identify their handicap status if they feel for any reason it is not in their best interest to have this information officially recorded outside of medical records. We request only that anyone not wishing to have this information entered in the agency's and OPM's personnel systems indicate this to their Personnel Office, rather than intentionally miscoding themselves, since false responses will seriously damage the statistical value of the reporting system.

[In those instances where the employee is or was hired under Schedule A, section 213.3102(t) (Mental Retardation), the Personnel Director or his/her designee (a Vocational Rehabilitation Counselor may also be helpful) **will assist the individual in completing this form and ensure that the employee fully understands the meaning of the form and the options available to him/her, as noted above.**]

Employees will be given every opportunity to ensure that the handicap code carried in their agency's and OPM's personnel systems is accurate and is kept current. They may exercise this opportunity by asking their Personnel Officer to see a printout of the code and definition from their record, by notifying Personnel any time their handicap status changes, and by initiating action in either of these cases to have the necessary changes made to their records. The code carried on employees in their agency's system will be identical to that carried in OPM's system, and any change to the agency records will result in the same change being made to OPM's records.

Your cooperation and assistance in establishing and maintaining an accurate and up-to-date handicap report system is sincerely appreciated.

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### PRIVACY ACT STATEMENT

Collection of the requested information is authorized by the Rehabilitation Act of 1973 (P.L. 93-112). The information you furnish will be used for the purpose of producing statistical reports to show agency progress in hiring, placement, and advancement of handicapped individuals and to locate individuals for voluntary participation in surveys. The reports will be used to inform agency top management, the Office of Personnel Management (OPM), the Congress, and the public of the status of programs for employment of the handicapped. All such reports will be in the form of aggregate totals and will not identify you in any way as an individual.

Solicitation of your Social Security Number (SSN) is authorized by Executive Order 9397, which requires agencies to use the SSN as the means for identifying individuals in personnel information systems. Your SSN will only be used to ensure that your correct handicap code is recorded along with the other employee information that your agency and OPM maintain on you. Furnishing your SSN or any other of the requested data for this collection effort is voluntary and failure to do so will have no effect on you. It should be noted, however, that where individuals decline to furnish their SSN, the SSN will be obtained from other records in order to ensure accurate and complete data.

Employees appointed under Schedule A, section 213.3102(t) (Mental Retardation), Schedule A, section 213.3102(u) (Severely Physically Handicapped), or Schedule B, section 213.3202(k) (Mentally Restored) are requested to furnish an accurate handicap code, but failure to do so will have no effect on them. Where employees hired under one of these appointments fail to disclose their handicap, however, the appropriate code will be determined from the employee's existing records or medical documentation submitted to justify the appointment.

# Declaration for Federal Employment

## GENERAL INFORMATION

**1 FULL NAME**



**2 SOCIAL SECURITY NUMBER**



**3 PLACE OF BIRTH** (Include City and State or Country)



**4 DATE OF BIRTH** (MM/DD/YY)



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



**6 PHONE NUMBERS** (Include Area Codes)

DAY ▶

NIGHT ▶

## MILITARY SERVICE

**7** Have you served in the United States Military Service? *If your only active duty was training in the Reserves or National Guard, answer "NO".* . . . . .

Yes	No

If you answered "YES", list the branch, dates (MM/DD/YY), and type of discharge for all active duty military service.

BRANCH	FROM	TO	TYPE OF DISCHARGE

## BACKGROUND INFORMATION

**For all questions**, provide all additional requested information under item 15 or on attached sheets. The circumstances of each event you list will be considered. However, in most cases you can still be considered for Federal jobs.

**For questions 8, 9, and 10**, your answers should include convictions resulting from a plea of nolo contendere (*no contest*), but omit (1) traffic fines of \$300 or less, (2) any violation of law committed before your 16th birthday, (3) any violation of law committed before your 18th birthday if finally decided in juvenile court or under a Youth Offender law, (4) any conviction set aside under the Federal Youth Corrections Act or similar State law, and (5) any conviction whose record was expunged under Federal or State law.

**8** During the last 10 years, have you been convicted, been imprisoned, been on probation, or been on parole? (Includes felonies, firearms or explosives violations, misdemeanors, and all other offenses.) *If "Yes", use item 15 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved.* . . . . .

**9** Have you been convicted by a military court-martial in the past 10 years? (If no military service, answer "NO".) *If "Yes", use item 15 to provide the date, explanation of the violation, place of occurrence, and the name and address of the military authority or court involved.* . . . . .

**10** Are you now under charges for any violation of law? *If "Yes", use item 15 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved.* . . . . .

**11** During the last 5 years, were you fired from any job for any reason, did you quit after being told that you would be fired, did you leave any job by mutual agreement because of specific problems, or were you debarred from Federal employment by the Office of Personnel Management? *If "Yes", use item 15 to provide the date, an explanation of the problem and reason for leaving, and the employer's name and address.* . . . . .

**12** Are you delinquent on any Federal debt? (Includes delinquencies arising from Federal taxes, loans, overpayment of benefits, and other debts to the U.S. Government, plus defaults of Federally guaranteed or insured loans such as student and home mortgage loans.) *If "Yes", use item 15 to provide the type, length, and amount of the delinquency or default, and steps that you are taking to correct the error or repay the debt.* . . . . .

Yes	No

## ADDITIONAL QUESTIONS

**13** Do any of your relatives work for the agency or organization to which you are submitting this form? (Includes father, mother, husband, wife, son, daughter, brother, sister, uncle, aunt, first cousin, nephew, niece, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepfather, stepmother, stepson, stepdaughter, stepbrother, stepsister, half brother, and half sister.) *If "Yes", use item 15 to provide the name, relationship, and the Department, Agency, or Branch of the Armed Forces for which your relative works.*

**14** Do you receive, or have you ever applied for, retirement pay, pension, or other pay based on military, Federal civilian, or District of Columbia Government service? . . . . .

Yes	No



**CONTINUATION SPACE/AGENCY OPTIONAL QUESTIONS**

**15** Provide details requested in items 8 through 13 and 17c in the continuation space below or on attached sheets. Be sure to identify attached sheets with your name, Social Security Number, and item number, and to include ZIP Codes in all addresses. If any questions are printed below, please answer as instructed (these questions are specific to your position, and your agency is authorized to ask them).

**CERTIFICATIONS/ADDITIONAL QUESTION**

**APPLICANT: If you are applying for a position and have not yet been selected.** Carefully review your answers on this form and any attached sheets. When this form and all attached materials are accurate, complete item 16/16a.

**APPOINTEE: If you are being appointed.** Carefully review your answers on this form and any attached sheets, including any other application materials that your agency has attached to this form. If any information requires correction to be accurate as of the date you are signing, make changes on this form or the attachments and/or provide updated information on additional sheets, initialing and dating all changes and additions. When this form and all attached materials are accurate, complete item 16/16b and answer item 17.

**16** I certify that, to the best of my knowledge and belief, all of the information on and attached to this Declaration for Federal Employment, including any attached application materials, is true, correct, complete, and made in good faith. I understand that a false or fraudulent answer to any question on any part of this declaration or its attachments may be grounds for not hiring me, or for firing me after I begin work, and may be punishable by fine or imprisonment. I understand that any information I give may be investigated for purposes of determining eligibility for Federal employment as allowed by law or Presidential order. I consent to the release of information about my ability and fitness for Federal employment by employers, schools, law enforcement agencies, and other individuals and organizations to investigators, personnel specialists, and other authorized employees of the Federal Government. I understand that for financial or lending institutions, medical institutions, hospitals, health care professionals, and some other sources of information, a separate specific release may be needed, and I may be contacted for such a release at a later date.

**16a Applicant's Signature** ▶  
(Sign in ink)

**Date** ▶

**16b Appointee's Signature** ▶  
(Sign in ink)

**Date** ▶

APPOINTING OFFICER: Enter Date of Appointment or Conversion  
▶

**17 Appointee Only (Respond only if you have been employed by the Federal Government before):** Your elections of life insurance during previous Federal employment may affect your eligibility for life insurance during your new appointment. These questions are asked to help your personnel office make a correct determination.

**17a** When did you leave your last Federal job? . . . . .

**17b** When you worked for the Federal Government last time, did you waive Basic Life Insurance or any type of optional life insurance? . . . . .

**17c** If you answered "Yes" to item 17b, did you later cancel the waiver(s)? If your answer to item 17c is "No," use item 15 to identify the type(s) of insurance for which waivers were not cancelled. . . . .

Date (MM/DD/YY)		
Yes	No	Don't Know



12300 Twinbrook Parkway, Suite 360, Rockville, Maryland 20852

Tel (301) 443-1167 (800) 872-6367

FAX (301) 443-5146 (800) 872-5945

## NATIONAL DISASTER MEDICAL SYSTEM VOLUNTEER AGREEMENT

TEAM #

I, \_\_\_\_\_, offer to serve as a volunteer Federal employee to participate in the National Disaster Medical System (NDMS) within the Office of Public Health and Science (OPHS), Department of Health and Human Services (HHS), for response with an NDMS response team to provide emergency medical care as needed.

My services will be those of a \_\_\_\_\_.

In making this offer of my services, I agree and/or understand that I will:

1. Perform my volunteer services and activities under the general direction of NDMS sponsoring organization and approved or supervised by an appropriate Federal official.
2. Waive any claims for compensation from the Government of the United States for any services performed related to my volunteer assignment with NDMS.
3. Be subject to DHHS regulations concerning Standards of Conduct and Conflict of Interest. Copies of regulations are available from the NDMS response team leader.
4. Be eligible under the Federal Employees' Compensation Act, as amended (5 U.S.C. 8101 [1] [B]) to file for benefits for work-related injuries and/or illnesses that may arise and are directly related to the performance of my volunteer assignment.
5. Be eligible for coverage under the Federal Tort Claims Act, (28 U.S.C. 2671), for any damages or injuries that may arise from the performance of my volunteer assignment.
6. Be responsible for any cost or treatment of any illness or medical condition that is not directly related to the performance of my volunteer assignment.
7. Maintain a current health professional license, certification, or registration, as applicable.

I understand that my volunteer assignment may be terminated at any time by either party to this agreement.

\_\_\_\_\_  
(Signature of Volunteer)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
Division of Personnel Operations - Parklawn  
Human Resources Service, PSC

\_\_\_\_\_  
(Date)