Military Sealift Command

• Intro

• Requirements
  – Medical
    • Immunizations
    • Smallpox Vaccination
    • Anthrax
    • USCG Physical

• Timeline
  – Hard deadline on all paperwork – 2/27 Due
  – Shipping timeline
    • Summer Schedule

• Selection Process
  – Student Selection
  – Ship Selection
Military Sealift Command

• Immunizations
  – It is your responsibility to be completely current with all your vaccines.
  – CMA does not have your complete vaccine list.
  – If you do not have records you will pay to go and receive them again.
  – CMA will not pay for your vaccines.
Military Sealift Command

- Immunizations (cont.)
  - List of Vaccines
    - MMR
    - Polio (completion of basic series)
    - Tetanus
    - Varicella (or proof of immunity) (chicken pox)
    - Hepatitis A / B
    - Typhoid
    - Yellow Fever
    - Influenza (seasonal)
    - Smallpox (MSC will provide if required, but you will take)
    - Anthrax (MSC will provide if required, but you will take)
    - Tuberculin Skin Test
    - G6PD & Sickle Cell Test Results & CBC w/Differential
    - Blood Type & Cross
Military Sealift Command

- Question Answer Period
  - If you fill out this MSC packet you are locked to going with MSC unless you are medically disqualified.
  - This is your chance to make sure you understand the process before making the commitment.
Military Sealift Command

• PAPERWORK
  – We will go through this packet page by page.
  – Do **NOT** Skip Ahead.
  – Do **NOT** Fill anything out unless we are on that specific box.
  – If you make a mistake, mark the page to get a new form from the career center.
  – **MISTAKES WILL LEAD TO YOU NOT SHIPPING OUT ON TIME**
Military Sealift Command

- PAPERWORK
  - All of your paperwork is now in the packet before you.
  - This the order your packet will be turned back into us.
  - If it is not in this order we will not accept your packet.
FIRST PAGE

MILITARY SEALIFT COMMAND
ORDER OF PAPERWORK

CADET NAME: ____________________________  DECK / ENGINE ____________________

____ MSC Commercial Cruise Check-Off Sheet
____ Memo – Completed Packet For MSC
____ Cadet Personal Data Form
____ Academy Guide List For Cadets With Attached Voided Check
____ Anti-Terrorism Certificate
____ ISOPREP Security Registration Worksheets (2 pages)
____ 2 Digital Photos for ISOPREP Registration (taken by the Career Center) & ISOPREP Code
____ SERE 100 Level B Training Certificate of Completion (printed in Landscape Orientation)
____ Cadet Temporary Job Application And Medical Check-Off Lists
____ Appointment Affidavit
____ Employee Information Sheet
____ U.S. Passport (Copy)
____ Merchant Mariner Credential (Copy of Pages 2 & 3)
____ Basic Safety Training Certificate (CMA)
____ Transportation Worker Identification Credential (TWIC Card - Copy of Front & Back)
____ Optional Application For Federal Employment Form 612 – Page 3
____ Optional Application For Federal Employment Form 612 – Page 4
____ EFT & DTS Self-Registration Form
____ Direct Deposit Sign-Up Form
____ W-4 Form
____ Employment Eligibility Verification Form I-9
____ CIVMAR Address & Emergency POC Form (MSFSC Form 5300-1)
____ Designation Of Beneficiary Form
____ Second Seaman’s War Risk Insurance Form
____ Declaration For Federal Employment Form 306 – Page 1
____ Declaration For Federal Employment Form 306 – Page 2
____ Selective Service Number (print-out required for Male Cadets)
____ Copy of Military Discharge Papers DD-214 (only if you have prior military service)
____ Statement Of Prior Federal Employment
____ Ready Reserve Questionnaire
____ Ethnicity & Race Identification Form
____ Foreign Language Coding Sheet
____ Welfare To Work Program Form
____ Self-Identification Of Disability Form
____ Acknowledgement Of Temporary Appointment Form
____ Consent To Release Cadet Employment Information
____ Acknowledgement Of Receipt (Notice of Random Drug Testing Under the Dept of the Navy)
____ CMA Drug Free Letter
____ Consent For The Release Of Medical Information (2 pages)
____ Merchant Mariner Credential Medical Evaluation Report (3 Pages)
____ Report Of Medical History – Page 1
____ Report Of Medical History – Page 2
____ Report Of Medical History – Page 3
____ Smallpox Vaccination Initial Note – Page 1
____ Smallpox Vaccination Initial Note – Page 2
____ Smallpox Vaccination Program Contract – Page 1
____ Smallpox Vaccination Program Contract – Page 2
____ Smallpox Screening Form
____ Privacy Act Statement
____ Immunization Records
____ Blood Test Results (Blood Type & Cross, CBC with Differential, Sickle Cell Trait & G6PD)
____ 2 Passport Photos for Military ID Cards
PAGE 2 – MSC’s Sign Off Sheet

TO: MSC Commercial Cruise Cadets
FROM: Deborah Bauer
       Commercial Cruise Coordinator
DATE: ___/___/____ (Date of Completion)
SUBJECT: Completed Packet for MSC

ONLY DO THESE

- Print Name
- Circle Engine or Deck

COMPLETE

☐ The student named above has COMPLETED the required paperwork for Military Sealift Command.

1) MSC Packet
2) 2 Passport Photos (2" x 2")
3) Copy of Immunization Record
4) Identify Blood Type & Religion
5) Completed Medical Requirements
6) Attached Voided Check for Direct Deposit
7) Your Contact Info During the Summer
8) Anti-Terrorism Training Certificate
9) ISPREP Security Registration Worksheets
10) SERE Certificate of Completion

Cadet Name:
(Signature)
Cadet Personal Data Form

• FILL OUT TOP TO BOTTOM

• For HOME ADDRESS I want your address for this summer
### Academy Guidelist For Cadets

**MILITARY SEALIFT COMMAND**  
**ACADEMY GUIDELIST FOR CADETS**  
FAX: 757-443-2935

From:  DEBORAH BAUER – CALIFORNIA MARITIME ACADEMY  
To:  Cliff Schultz / Recruitment Branch / APMC  
Subj:  Cadet Shipping Program Fact Sheet  

Please fill out all information thoroughly to avoid delays in processing. Place check mark or fill in appropriate categories.

<table>
<thead>
<tr>
<th>Full Name:</th>
<th>SSN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>(Ensure home address and/or school address is properly listed on form)</td>
</tr>
<tr>
<td>Telephone Number:</td>
<td></td>
</tr>
</tbody>
</table>

Gender:  Male  |  Female  
Coming From:  Home  |  School  
US Citizen:  Yes  |  No  
Class Year:  Sophomore  |  Junior  |  Senior  
Training:  Firefighting  |  Damage Control  |  CPR  
Preferred Coast (no guarantee):  East  |  West  
Shipping dates available:  From April 25, 2015 to September 1, 2015  
Passport Number:  Expires:  
Cadet Type:  Deck  |  Engine  |  Ships Officer  
Type of Vessel:  Tanker  |  Dry Cargo  |  Other  
Length of stay on board:  60 – 100 days  
Immunizations:  PPD  |  Typhoid  |  Yellow Fever  |  Tetanus  

Next of Kin:

Blood Type & Cross:  
Religion:  

**Attach VOIED check for Direct Deposit.**

- **Fill Out Top to Bottom**
- **You are coming from Home.**
- **Shipping Dates – April 25 to September 1**
- **Length aboard – 60 to 90 days.**
- **You must know your BLOOD TYPE.**
- **You must list a religion.**
- **Attach VOIED CHECK to Bottom.**
THIS IS TO COMPLETED ON YOUR OWN AT HOME.

INSURE YOU PRINT THIS IN LANDSCAPE ORIENTATION

All cadets must complete the Department of Defense Anti-terrorism Level-One Training.

Go to the following website: https://atlevel1.dtic.mil/at

When you have completed the training, print out the certificate.

Please print the certificate in Landscape Orientation.

Bring your certificate to the Career Center. James Dalske must sign the certificate.
ISOPREP Registration
What is ISOPREP?

- **ISOPREP - ISOLATED PERSONNEL REPORT.** Information used to identify you in the unlikely event that you are captured, injured or killed

- **CIVMARS** are required to provide information specific to your life experiences
Requirements

• Complete the ISOPREP Worksheet
• Information is entered electronically in the ISOPREP system on a DD Form 1833
Requirement

Purpose of ISOPREP

• Essential to Personnel Recovery Efforts
• Assists in Identification: It contains personal information to ensure positive identification
• Facilitates medical treatment
• Assists in reintegration upon recovery
ISOPREP
AUTHENTICATION NUMBER

Four Digit Number Easy to Remember

- DO NOT USE LAST FOUR OF SSN
- DO NOT use the same number more than once ie., 7777
- DO NOT use numbers in sequence of three or more ie., 1234, 8762
- DO NOT use the digit 0 (zero) ie., 0179, 4609
- Good examples 8142, 6392, 9463

- On a piece of paper please write your name and secret number
ISOPREP Photos

• Required photos are taken without glasses (including sunglasses), hats, scarves, or any other items that may alter or distort the ability to readily identify the photographed individual.

• We take a picture of you face front and right cheek.
Worksheet Instructions

Print Your Answers
Write Legibly
Each Question MUST have an Answer

DO NOT LEAVE ANY QUESTIONS BLANK
• Enter today’s date
• Print last name, first name, middle initial
• If you have a hyphenated name, be sure to print it that way
• If you do not have a middle initial write NMI for No Middle Initial
Gender
   - Circle M or F

Social Security Number
   - Enter Full SSN

Date of Birth
   - YYYYMMDD 1967112 (November 20, 1967)

Blood Type
   - Circle Blood Type
# Height Total Inches

<table>
<thead>
<tr>
<th>Feet/Inches</th>
<th>Total Inches</th>
</tr>
</thead>
<tbody>
<tr>
<td>5’</td>
<td>60”</td>
</tr>
<tr>
<td>5’ 1”</td>
<td>61”</td>
</tr>
<tr>
<td>5’ 2”</td>
<td>62”</td>
</tr>
<tr>
<td>5’ 3”</td>
<td>63”</td>
</tr>
<tr>
<td>5’ 4”</td>
<td>64”</td>
</tr>
<tr>
<td>5’ 5”</td>
<td>65”</td>
</tr>
<tr>
<td>5’ 6”</td>
<td>66”</td>
</tr>
<tr>
<td>5’ 7”</td>
<td>67”</td>
</tr>
<tr>
<td>5’ 8”</td>
<td>68”</td>
</tr>
<tr>
<td>5’ 9”</td>
<td>69”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Feet/Inches</th>
<th>Total Inches</th>
</tr>
</thead>
<tbody>
<tr>
<td>5’ 10”</td>
<td>70”</td>
</tr>
<tr>
<td>5’ 11”</td>
<td>71”</td>
</tr>
<tr>
<td>6’</td>
<td>72”</td>
</tr>
<tr>
<td>6’ 1’</td>
<td>73”</td>
</tr>
<tr>
<td>6’ 2”</td>
<td>74”</td>
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<tr>
<td>6’ 3”</td>
<td>75”</td>
</tr>
<tr>
<td>6’ 4”</td>
<td>76”</td>
</tr>
<tr>
<td>6’ 5”</td>
<td>77”</td>
</tr>
<tr>
<td>6’ 6”</td>
<td>78”</td>
</tr>
<tr>
<td>6’ 7”</td>
<td>79”</td>
</tr>
</tbody>
</table>
Weight
Hair Color
Eye Color
Ethnic Group – African American, Caucasian, Citizenship – United States
Scars/Tattoos/Birthmarks
  – Anchor on left forearm
  – Vine on right calf
  – Tribal symbol on right upper arm
  – Large scar on right side of chin
  – Birthmark on upper left thigh
  – Write None if you do not have any distinguishing Scars/Tattoos/Birthmarks
Known Medical Conditions

- Hypertension
- Bee Sting Allergy
- Diabetes

Prescription Medications

- Name of Medication
- No Dosage
Clothing Size

- Answer these questions as it pertains to your body size today. For shirt size, pant size and hat size circle:

  XS  S  M  L  XL

- Boot size:  6  7  8  10 ½

- Boot type:  M - Mens   W - Womens

- Boot width:  M – Medium   W - Wide
# Standard Size Charts

## Hat Size

<table>
<thead>
<tr>
<th>Size</th>
<th>XS</th>
<th>S</th>
<th>M</th>
<th>L</th>
<th>XL</th>
<th>XXL</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>58</td>
<td>60</td>
<td>62</td>
<td>64</td>
<td>66</td>
<td>68</td>
</tr>
<tr>
<td>6</td>
<td>58</td>
<td>60</td>
<td>62</td>
<td>64</td>
<td>66</td>
<td>69</td>
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<tr>
<td>7</td>
<td>59</td>
<td>61</td>
<td>63</td>
<td>65</td>
<td>67</td>
<td>70</td>
</tr>
<tr>
<td>8</td>
<td>62</td>
<td>64</td>
<td>66</td>
<td>68</td>
<td>70</td>
<td>72</td>
</tr>
</tbody>
</table>

## Men's Pant Size

<table>
<thead>
<tr>
<th>Waist</th>
<th>XS</th>
<th>S</th>
<th>M</th>
<th>L</th>
<th>XL</th>
<th>XXL</th>
</tr>
</thead>
<tbody>
<tr>
<td>28-31</td>
<td>32</td>
<td>34</td>
<td>36</td>
<td>38</td>
<td>40</td>
<td>42</td>
</tr>
</tbody>
</table>

## Men's Shirt Size

<table>
<thead>
<tr>
<th>Chest (inches)</th>
<th>XS</th>
<th>S</th>
<th>M</th>
<th>L</th>
<th>XL</th>
<th>XXL</th>
</tr>
</thead>
<tbody>
<tr>
<td>38-40</td>
<td>42</td>
<td>44</td>
<td>46</td>
<td>48</td>
<td>50</td>
<td>52</td>
</tr>
</tbody>
</table>

## Women's Pant Size

<table>
<thead>
<tr>
<th>Waist</th>
<th>XS</th>
<th>S</th>
<th>M</th>
<th>L</th>
<th>XL</th>
<th>XXL</th>
</tr>
</thead>
<tbody>
<tr>
<td>22-24</td>
<td>24</td>
<td>26</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>34</td>
</tr>
</tbody>
</table>

## Women's Shirt Size

<table>
<thead>
<tr>
<th>Waist</th>
<th>XS</th>
<th>S</th>
<th>M</th>
<th>L</th>
<th>XL</th>
<th>XXL</th>
</tr>
</thead>
<tbody>
<tr>
<td>32-34</td>
<td>36</td>
<td>38</td>
<td>40</td>
<td>42</td>
<td>44</td>
<td>46</td>
</tr>
</tbody>
</table>

## Size Chart

### Men/Unisex Shirts

<table>
<thead>
<tr>
<th>Chest (inches)</th>
<th>XS</th>
<th>S</th>
<th>M</th>
<th>L</th>
<th>XL</th>
<th>XXL</th>
</tr>
</thead>
<tbody>
<tr>
<td>38-40</td>
<td>42</td>
<td>44</td>
<td>46</td>
<td>48</td>
<td>50</td>
<td>52</td>
</tr>
</tbody>
</table>

### Pants Size

<table>
<thead>
<tr>
<th>Waist (inches)</th>
<th>XS</th>
<th>S</th>
<th>M</th>
<th>L</th>
<th>XL</th>
<th>XXL</th>
</tr>
</thead>
<tbody>
<tr>
<td>32-34</td>
<td>36</td>
<td>38</td>
<td>40</td>
<td>42</td>
<td>44</td>
<td>46</td>
</tr>
</tbody>
</table>
Home of Record

- Use your official or permanent address
- Provide complete Street Address, City, State and Zip Code
- Phone Number with Area Code
**Primary Next of Kin**

- Person’s first and last name
  
  **CARSON JAMES**

- Person’s complete address

- Person’s area code and telephone number
PARENT NO 1

- First and Last Name
- Complete address, city, state, zip code
- Complete area code and telephone number
- If PARENT NO 1 is deceased, put a check mark in the DECEASED box
- If Parent name is unknown, put a check mark in the unknown box
DO NOT PUT ANY INFORMATION IN THESE BOXES
FLIP WORKSHEET OVER TO CONTINUE
<table>
<thead>
<tr>
<th>PARENT #2</th>
<th>IF DECEASED, CHECK BOX □</th>
<th>IF UNKNOWN, CHECK BOX □</th>
</tr>
</thead>
<tbody>
<tr>
<td>First, Last Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Street Address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City, State, Zip</td>
<td>Telephone (<em><strong>)</strong><strong>-</strong></em>_____</td>
<td></td>
</tr>
</tbody>
</table>

**PARENT NO 2**

- First and Last Name
- Complete address, city, state, zip code
- Complete area code and telephone number
- If PARENT NO 2 is deceased, put a check mark in the DECEASED box
- If Parent name is unknown, put a check mark in the unknown box
ISOPREP WORKSHEET

Background Questions

- Complete four of the five sections
- Each section must be completed entirely

DO NOT LEAVE ANY SPACES BLANK
First Pet

- Circle Male or Female
- Type: Dog, Cat, Hamster
- Pet’s Name
- Breed: German Shepherd
- Color
- How was Pet Obtained: Parents, Stray, Gift, Breeder, Shelter?
First Vehicle

− Make
− Model
− Year
− Coupe/Sedan/Hatchback
− Obtained How?
− City & State You Obtained?
High School
- Name
- City/State of High School
- School Mascot
- School Colors
- Year of Graduation or Last Year Attended
First Residence Away From Home

- Apartment/House/Condo/Mobile Home
- Number of Bedrooms
- Number of Bathrooms
- Rent/Own/Lease/Share
First Job

- Company Name
- Job Title
- City/State
- Indoors/Outdoors or Both
- How Long Did You Work There?
- What Year Did You Start?
Awareness Training
Come to Career Center to Complete training

CD training must be complete in career center (takes about 2 hours)
FILL OUT ALL IN YELLOW

CADET TEMPORARY JOB APPLICATION AND MEDICAL CHECK-OFF LISTS

CADET NAME: ___________________ LAST ______ FIRST ______ MIDDLE (Jr, Sr, etc.)

TYPE OF CADET: ___________ (DECK, ENGINE, etc.) JOB: ___________ SSN: ___________

SCHOOL NAME/ADDRESS: ________________ NAME ____________________________

________________________ ADDRESS __________ CITY __________ STATE __________ ZIP

E-MAIL ADDRESS: ________________ HOME TEL.: ________________ CELL TEL.: __________________

CADET TEMPORARY JOB APPLICATION FORMS:

____ APPOINTMENT AFFIDAVITS (SIGNED/DATED/FEDEXED TO COORDINATOR DATE OF TRAVEL)

____ PERSONAL INFO SHEET

____ MERCHANT MARINER CREDENTIAL (COPY PAGES 2 & 3)

____ PASSPORT BOOK (COPY)

____ OPTIONAL APPLICATION FOR FEDERAL EMPLOYMENT

____ DIRECT DEPOSIT SIGN-UP FORM

____ W-4 FORM

____ CHANGE OF ADDRESS FORM

____ DESIGNATION OF BENEFICIARY FORM

____ WAR RISK INSURANCE FORM

____ DECLARATION FOR FEDERAL EMPLOYMENT FORM

____ STATEMENT OF PRIOR FEDERAL EMPLOYMENT FORM

____ READY RESERVE QUESTIONNAIRE

____ RACE & NATIONAL ORIGIN L.D. FORM

____ FOREIGN LANGUAGE CODING SHEET

____ WELFARE TO WORK PROGRAM FORM

____ SELF-L.D. OF HANDICAP FORM

____ ACKNOWLEDGEMENT OF TEMP APPOINTMENT FORM

CADET MEDICAL CLEARANCE FORMS:

MUST BE FEDEXED TO: RN GLEN SCHAEFER, FORCE MEDICAL OFFICE, MSCLANT, 1959 MORRIS ST., SUITE 120, BLDG. Z-101, NAVSTA, NORFOLK, VA 23511-3429 TEL. (757)443-0698, FAX: (757)443-5765

____ USCG PHYSICAL EXAM FORM (WITHIN 1-YEAR) (WITH AUDIGRAM RESULTS)

____ MEDICAL HISTORY FORM (FROM LAST PHYSICAL TO PRESENT)

____ SMALLPOX QUESTIONNAIRE

____ IMMUNIZATION RECORDS
Deck / Engine Cadet

ONLY FILL OUT YELLOW PORTIONS

DO NOT DATE
DECK / ENGINECADET

ONLY FILL OUT YELLOW PORTIONS

NO DATE OF HIRE
Remove this page and insert inside copy of U.S. Passport
Remove this page and insert a copy of pages 2 & 3 of Merchant Mariner Credential.
Remove this page and insert front & back copy of Transportation Worker Identification Credential (TWIC™)
The California Maritime Academy

This is to certify that

Has successfully completed
Familiarization and Basic Safety-Training
CAMACP-363, CAMACP-313
in compliance with
46 CFR 15.1105
and
STCW Regulation A-VI/1-4

Completion Date: 29 August 2010

[Signatures]

STCW Coordinator

Dean, Academic Affairs

This document is printed for the purposes of participation in the California Maritime Academy Cadet Training Program

• We take care of this page
Optional Application for Federal Employment - Page #1

- This form is **NOT** optional.
- Fill out top to bottom
• This form is **NOT** optional.
• Fill out top to bottom
# EFT AND DTS SELF-REGISTRATION FORM

This form has been set to be completed electronically using your Tab key and Drop Downs or you can print and fill in the required fields.

### Privacy Act Statement

**Authority:** Used for reviewing, approving, accounting and disbursing for official travel. SSN is used to maintain a numerical identification system for individual claims. 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.

**Routine Uses:** To substantiate claims for reimbursement for official travel.

**Disclosure:** Voluntary, however, failure to furnish information requested may result in total or partial denial of amount claimed and may delay or prevent the receipt of payments through EFT/DDS programs.

### Your name:

### Your Full SSN: Date of Birth: MM/DD/YY

### Command / Unit: California Maritime Academy

### Mil Rank: Select from Drop Down GS Grade: Select from Drop Down Other:

### Mailing address:

### Phone:

- Work
- Cell
- Home

### For EFT/DDS payments, please provide the following information:

- **Gov Credit Card #**
- **Expiration date:**
- **ACCOUNT TYPE (checking or savings):** Select from Drop Down
- **ACCOUNT NUMBER:**
- **BANK ROUTING NUMBER (RTN):** Select from Drop Down
- **Other:**
Direct Deposit

- This is how you will get paid.
- Payroll ID is your Social Security #
PLEASE READ THIS CAREFULLY

All information on this form, including the individual claim number, is required under 31 USC 2022, 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. Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the Direct Deposit/Electronic Funds Transfer Program.

INFORMATION FOUND ON CHECKS
Most of the information needed to complete boxes A, C, and F in Section 11 is printed on your government check:

1. Be sure that the payer's name is written exactly as it appears on the check. Be sure current address is shown.
2. Claim numbers and suffixes are printed here on checks beneath the date for the type of payment shown here. Check the Green Book for the location of prefixes and suffixes for other types of payments.
3. Type of payment is printed to the left of the amount.

SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS
Joint account holders should immediately advise both the Government agency and the financial institution of the death of a beneficiary. Funds deposited after the date of death or ineligibility, except for salary payments, are to be returned to the Government agency. The Government agency will then make a determination regarding survivor rights, calculate survivor benefit payments, if any, and begin payments.

CANCELLATION
The agreement represented by this authorization remains in effect until canceled by the recipient by notice to the Federal agency or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so.

The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately advise the Federal agency if the authorization is cancelled by the financial institution. The financial institution cannot cancel the authorization by advice to the Government agency.

CHANGING RECEIVING FINANCIAL INSTITUTIONS
The payee's Direct Deposit will continue to be received by the selected financial institution until the Government agency is notified by the payee that the payee wishes to change the financial institution receiving the Direct Deposit. To effect this change, the payee will complete the new SF 1199A at the newly selected financial institution. It is recommended that the payee maintain accounts at both financial institutions until the transition is complete, i.e. after the new financial institution receives the payee's Direct Deposit payment.

FALSE STATEMENTS OR FRAUDULENT CLAIMS
Federal law provides a fine of not more than $10,000 or imprisonment for not more than five (5) years or both for presenting a false statement or making a fraudulent claim.
**W-4**

**Purpose:** Complete Form W-4 so that your employer can withhold the correct federal income taxes from your pay. Complete withholding a new Form W-4 each year and when your personal or financial circumstances change.

**Exemption from withholding:** If you are exempt, complete only lines 1, 2, 3, and 4. Do not sign the form to validate it. Your exemptions expire at the end of the calendar year in which you file the Form W-4. Your exemptions are not carried over to subsequent years. See Pub. 1551 for more information on how to claim your exemptions.

**Basic Instructions:** If you are not exempt, complete the Personal Allowances Worksheet below. The instructions on page 2 further instruct your withholding allowances based on exemptions, dependents, earned credits, adjustments to income, or two-earner/multiple jobs situation.

**Personal Allowances Worksheet (Keep for your records):**

| A | Enter "1" for yourself if no one else can claim you as a dependent. |
| B | Enter "1" if: |
| C | Enter "2" 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.) |
| D | Enter number of dependents (other than your spouse or yourself) you will claim on your tax return. |
| E | Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above). |
| F | Enter "1" if you have at least $1,000 or child care expenses for which you can claim a credit. |
| G | Child Tax Credit (including additional child tax credit). |
| 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.) |

**Employee’s Withholding Allowance Certificate:**

| 1 | Total number of allowances you are claiming (from line I below or from the applicable worksheet on page 2). |
| 2 | Additional amount, if any, you want withheld from each paycheck. |
| 3 | I claim exemption from withholding for 2013, and certify that I meet both of the following conditions for exemption: |
| 4 | In all cases, where tax is withheld, it will be handled as follows: |

**Employee’s signature:**

1. **Ask Parents if you need help.**
2. **Fill out all yellow.**
Employment Eligibility Verification

- Fill Out Yellow
# Lists of Acceptable Documents

All documents must be UNEXPIRED.

Employees may present one selection from List A or a combination of one selection from List B and one selection from List C.

## List A

<table>
<thead>
<tr>
<th>Documents that Establish Both Identity and Employment Authorization</th>
<th>OR</th>
<th>Documents that Establish Identity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. U.S. Passport or U.S. Passport Card</td>
<td>1. Driver's license or ID card issued by a State or unexpired passport of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address</td>
<td></td>
</tr>
<tr>
<td>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</td>
<td>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, gender, height, eye color, and address</td>
<td></td>
</tr>
<tr>
<td>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</td>
<td>3. Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</td>
<td></td>
</tr>
<tr>
<td>4. Employment Authorization Document that contains a photograph (Form I-766)</td>
<td>4. Certification of Birth Abroad issued by the Department of State (Form FS-545)</td>
<td></td>
</tr>
<tr>
<td>5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-64 or Form I-64A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.</td>
<td>5. Certification of Report of Birth issued by the Department of State (Form DS-1350)</td>
<td></td>
</tr>
<tr>
<td>6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association between the United States and the FSM or RMI</td>
<td>6. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal</td>
<td></td>
</tr>
</tbody>
</table>

## List B

<table>
<thead>
<tr>
<th>Documents that Establish Identity</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. School ID card with a photograph</td>
</tr>
<tr>
<td>4. Voter's registration card</td>
</tr>
<tr>
<td>5. U.S. Military card or draft record</td>
</tr>
<tr>
<td>6. Military dependent's ID card</td>
</tr>
<tr>
<td>7. U.S. Coast Guard Merchant Mariner Card</td>
</tr>
<tr>
<td>8. Native American tribal document</td>
</tr>
<tr>
<td>9. Driver's license issued by a Canadian government authority</td>
</tr>
</tbody>
</table>

## List C

<table>
<thead>
<tr>
<th>Documents that Establish Employment Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</td>
</tr>
<tr>
<td>2. Certification of Birth Abroad issued by the Department of State (Form FS-545)</td>
</tr>
<tr>
<td>3. Certification of Report of Birth issued by the Department of State (Form DS-1350)</td>
</tr>
<tr>
<td>4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal</td>
</tr>
<tr>
<td>6. Native American tribal document</td>
</tr>
<tr>
<td>7. Employment authorization document issued by the Department of Homeland Security</td>
</tr>
</tbody>
</table>

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

Refer to Section 2 of the Instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.
# Change of Address

## CIVMAR ADDRESS AND EMERGENCY POC FORM

**Employee Instructions:** Complete SECTION A of the form. The information will be used to update your information in all automated systems used by MSFSC. Please ensure that you sign and date the form. Form and supporting documentation can be submitted in one of four ways: 1) turned into MSFSC at the CIVMAR Support Unit East or West or at NEO; 2) email as an attachment to msfsc_hr_sys_support@navy.mil; 3) fax to 757-443-

### SECTION A

<table>
<thead>
<tr>
<th>Name</th>
<th>Birth Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Home Phone Number</th>
<th>Cell Phone Number</th>
<th>Email Address</th>
</tr>
</thead>
</table>

**Mailing Address (Street or PO Box) include apartment number**

- [ ] YES
- [ ] NO

- Used to distribute official correspondence such as LES, W-2, and letters.

<table>
<thead>
<tr>
<th>City/Town</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

**Overseas Address Only - Other Principal Subdivision (such as Province, State) and Postal Code**

**Note:** In some countries, the postal code may precede the city or town name.

<table>
<thead>
<tr>
<th>Residence Address</th>
<th>Same as Mailing Address</th>
<th>Change</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

- Used to muster employees in the event of an emergency or disaster, and also to validate eligibility for subsistence and quarters (S&Q). Proof of address is required and outlined on the back of this form.

<table>
<thead>
<tr>
<th>City/Town</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

**Overseas Address Only - Other Principal Subdivision (such as Province, State) and Postal Code**

<table>
<thead>
<tr>
<th>In the event of EMERGENCY OR DEATH-IN-SERVICE, I request notification be made to:</th>
<th>Emergency POC Name and Relationship</th>
</tr>
</thead>
</table>

**NOTE:** This is not a beneficiary form

| Address | |
|---------||

<table>
<thead>
<tr>
<th>Phone Number (include country code and/or area code)</th>
<th>Additional Phone Number (include country code and/or area)</th>
</tr>
</thead>
</table>

**Signature**

**Date**

**Perjury Statement:** Any submission may be investigated. Intentional false statements, willful concealments, or using documents you know are false, fictitious, or fraudulent may be subject to appropriate administrative and disciplinary actions, up to and including removal and/or criminal penalties to include fines or imprisonment. (U.S. Code Title 18, Section 1001)

**FOR OFFICIAL USE ONLY**

This document contains material covered by the Privacy Act of 1974 and should be viewed only by personnel having an official “NEED TO KNOW”. If you are not the intended recipient, be aware that
CIVMAR ADDRESS AND EMERGENCY POC FORM

SECTION B

Adequate proof of residence address:

The following are preferred verification and only one item is required. The item must be dated and no more than twelve months old.

- Lease or rental agreement
- Major utility bill (electric, gas, cable, water, sewer)
- Mortgage papers
- Deed
- Previous year’s tax return, with W2 attached
- Property tax statement
- Vehicle tax statement
- Monthly residence payment coupon

The following types of identification showing residence address can be used as alternative proof when none of the items above are provided. A current driver’s license along with two documents from the following list that were sent through the U.S. mail to the residence address within the past twelve months must be provided as proof.

- Bank check with printed name and address or Bank statement for checking or savings account
- Credit card bill
- Any Federal or State official correspondence
- Vehicle registration
- Home owner’s association documentation
- Current voter registration
- Annual Social Security statement for the current or preceding calendar year
- Current automobile or life insurance bills
- Current homeowners insurance policy or bill

NOTE: Documents can be original, copies of originals, or copies retrieved from Internet sites.

For MSC N1 Use Only

Proof of residence provided and is acceptable: √ YES ☐ NO
Change of Residence Address in HRMS is required: ☐ YES √ NO

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This document contains material covered by the Privacy Act of 1974 and should be viewed only by personnel having an official “NEED TO KNOW”. If you are not the intended recipient, be aware that any disclosure, copying, distribution or use of the content of this information is prohibited.

MSFSCFORM 5300/1 (Rev 11/11)
CIVMAR ADDRESS

- Fill Out Yellow
CIVMAR ADDRESS AND EMERGENCY POC FORM

SECTION B

Adequate proof of residence address:

The following are preferred verification and only one item is required. The item must be dated and no more than twelve months old.

- Lease or rental agreement
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- Previous year’s tax return, with W2 attached
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- Vehicle registration
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- Social Security statement for the current or preceding calendar year
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NOTE: Documents can be original, copies of originals, or copies retrieved from Internet sites.

For MSC N1 Use Only

Proof of residence provided and is acceptable: □ YES □ NO
Change of Residence Address in HRMS is required: □ YES □ NO

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MSFSCFORM 5300/1 (Rev 11/11)
Designation of Beneficiary

- Fill Out Top Line
- Fill out Beneficiary Info.
- Must total 100%
  - 50% Dad
  - 50% Sister
- Don’t Forget Bottom
**Second Seaman’s War Risk**

- Fill All Out
- Primary Vs. Secondary
• Leave Blank
Declaration for Federal Employment

Instructions

The information collected on this form is used to determine your acceptability for Federal and Federal contract employment and your enrollment status in the Government's Life Insurance program. You may be asked to complete this form at any time during the hiring process. Follow instructions that the agency provides. If you are selected, before you are appointed you will be asked to update your responses on this form and on other materials submitted during the application process and then to recertify that your answers are true.

All your answers must be truthful and complete. A false statement on any part of this declaration or attached forms or sheets may be grounds for not hiring you, or for firing you after you begin work. Also, you may be punished by a fine or imprisonment (U.S. Code, title 5, section 1001).

Either type your responses on this form or print clearly in dark ink. If you need additional space, attach letter-size sheets (8.5" X 11"). Include your name, Social Security Number, and item number on each sheet. We recommend that you keep a photocopy of your completed form for your records.

Privacy Act Statement

The Office of Personnel Management is authorized to request this information under sections 3302, 3303, 3304, 3328, and 8718 of title 5, U. S. Code. Section 1104 of title 5 allows the Office of Personnel Management to delegate personnel management functions to other Federal agencies. If necessary, and usually in conjunction with another form or forms, this form may be used in conducting an investigation to determine your suitability or your ability to hold a security clearance, and it may be disclosed to authorized officials making similar, subsequent determinations.

Your Social Security Number (SSN) is needed to keep our records accurate, because other people may have the same name and birth date. Public Law 104-134 (April 26, 1996) asks Federal agencies to use this number to help identify individuals in agency records. Giving us your SSN or any other information is voluntary. However, if you do not give us your SSN or any other information requested, we cannot process your application. Incomplete addresses and ZIP Codes may also slow processing.

Routine Uses: Any disclosure of this record or information in this record is in accordance with routine uses found in System Notice OPM/GOVT-1, General Personnel Records. This system allows disclosure of information to: training facilities; organizations deciding claims for retirement, insurance, unemployment, or health benefits; officials in litigation or administrative proceedings where the Government is a party; law enforcement agencies concerning a violation of law or regulation; Federal agencies for statistical reports and studies; officials of labor organizations represented by law in connection with representation of employees; Federal agencies or other sources requesting information for Federal agencies in connection with hiring or retaining, security clearance, security or suitability investigations, classifying jobs, contracting, or issuing licenses, grants, or other benefits; public and private organizations, including news media, which grant or publicize employee recognitions and awards; the Merit Systems Protection Board, the Office of Special Counsel, the Equal Employment Opportunity Commission, the Federal Labor Relations Authority, the National Archives and Records Administration, and Congressional offices in connection with official functions; prospective non-Federal employers concerning tenure of employment, civil service status, length of service, and the date and nature of action for separation as shown on the SF-50 (or authorized exception) of a specifically identified individual; requesting organizations or individuals concerning the home address and other relevant information on those who might have contracted an illness or been exposed to a health hazard; authorized Federal and non-Federal agencies for use in computer matching; spouses or dependent children asking whether the employee has changed from a self-and-family to a self-only health benefits enrollment; individuals working on a contract, service, grant, cooperative agreement, or job for the Federal government; non-agency members of an agency's performance or other panel and agency-appointed representatives of employees concerning information issued to the employees about illness-for-duty or agency-funded disability retirement procedures.

Public Burden Statement

Public burden reporting for this collection of information is estimated to vary from 5 to 30 minutes with an average of 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of the collection of information, including suggestions for reducing this burden, to the U.S. Office of Personnel Management, Reports and Forms Manager (3204-0142), Washington, DC 20415-7000. The OMB number, 3206-0182, is valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

• Leave Blank
• Fill out all yellow
• SIGN 17A & 17B
Male Cadets: Insert your printed page with your number.

https://www.sss.gov/RegVer/wfVerification.aspx

Required for Male Cadets born after January 1, 1960

Enter your Last Name, SSN, and DOB. Then click on the Submit button. Your Selective Service # will be listed on the following page.
CERTIFICATE OF RELEASE OR DISCHARGE FROM ACTIVE DUTY
(Form DD-214)

Insert this document here if you have prior military service.

• If Prior Military
  Insert DD-214
• If not – remove page.
Statement of Prior Federal Service

(please read the following information before completing this form)

Privacy Act Statement
Section 5523 of 5 U.S.C., "Annual Leave Accrual," authorizes collection of information to determine and record service that may be credited for accrual of annual leave. Part 351.503, 5 C.F.R., "Length of Service," authorizes collection of data to determine and record service that may be credited for reduction-in-force retention purposes.

Information about prior Federal civilian and military service is collected and maintained in your Official Personnel Folder (OPF). The information you furnish may be disclosed to other Federal agencies or Congressional or Judicial Offices in order to verify it or in connection with your application for a job, license, grant, or other benefit. It may also be disclosed to a rational, state, or local law enforcement agency where there is indication of a violation or potential violation of civil or criminal law or regulation, or to another Federal agency or court when the Government is party to a suit.

Furnishing this information is voluntary; however, failure to do so may result in your not receiving credit for prior Federal service.

I. What Is Needed to Verify Prior Service

In order for your employing agency to credit your prior Federal service for benefits, such as leave accrual and reduction-in-force retention, the dates of your active uniformed service and the type(s) of appointment, and dates of civilian service must be verified. Dates of active uniformed service are verified from the records issued by the branch of service in which you served. Dates and types of appointments to civilian positions are usually verified from Notification of Personnel Action (Standard Form 50 or CSG- or CPM-approved exceptions thereof), and payroll records (including records of deductions made under the Civil Service Retirement System—Standard Form 2800, or the Federal Employees Retirement System—Standard Form 3100). The information on the application or resume you submitted for the appointment you are receiving, along with the information on page 2 of this form, will be used by your agency to identify the Federalemployers and periods of employment for which records must be obtained to verify the prior service.

When Notification of Personnel Action or payroll records cannot be located to verify a period of service, and the service was covered by Social Security, a detailed statement of earnings information (showing periods of employment and the name of the employer) from the Social Security Administration will be accepted as proof of service.

If no personnel, payroll, or Social Security records can be located, then your agency can accept secondary evidence of civilian employment, as explained below.

II. Use of Secondary Evidence to Verify Federal Service

Secondary evidence may be considered as proof of Federal civilian service only when official Government records are lost, destroyed, or incomplete. Necessarily, the burden of proof is on the person claiming service that is not supported by official records in the custody of the U.S. Government. If you decide to claim credit for a period of service by submitting secondary evidence, it is important that you submit all documents in your possession that tend to prove you performed the service claimed, and that the service, if performed, was creditable for leave accrual and reduction-in-force purposes. No credit can be allowed for any service that is not substantiated by valid and conclusive secondary evidence. The following is applicable only if you are providing secondary evidence.

A. Documentary Evidence: Submit as many as possible of the documents listed in item 1 below. If your agency finds that these documents are insufficient to determine creditability, the documents listed in items 2 and 3 may be considered, but less weight will be given to such evidence.

1. Copies of official documents or letters about the service. These may be notices on appointment/separation; notices of changes in position/salary, organization, or headquarters; travel orders; payroll cards; IRS, etc.

2. Private records such as a diary, correspondence, copies of income tax returns, employment applications, credit applications, etc., that mention the Federal employer and the claimed service. Private records must have been made during or shortly after the period of service.

3. Any other documentary evidence tending to prove the service was actually performed and the starting and ending dates of the service.

B. Affidavit Evidence: If you are not able to supply copies of official documents (as described in item 1 above) that are sufficient for your agency to make a determination of creditability, you must submit affidavits from yourself and at least two other persons (preferably your supervisors) who know the facts. If you can obtain no documentary evidence (items 1, 2, and 3, above) to support your claim, you may submit these affidavits only; however, your claim is more likely to be rejected without supporting documents. The required affidavits are from:

   - The employee, stating as many of the details on the affidavit as can accurately be remembered.
   - At least two persons knowing the facts. Each person should show that he or she is in a position to know the facts sworn to, and give his or her age and mailing address.

Affidavits must be sworn to or affirmed before a notary public or other officer who is authorized by law to administer oaths.

C. Warning: Any submission may be investigated. Intentional false statements, willful concealments, or using documents you know are false, fictitious, or fraudulent is punishable by fine/imprisonment (18 U.S.C. 1001).
Statement of Prior Federal Service

- Fill out
  - #1
  - #2
  - #3
  - #4
  - #8
  - Sign
  - Date
Ready Reserve Questionnaire

- Fill Out Name
- IF you are SSOP fill out
- If you are not write a large N/A.
### Fill out all yellow

**ETHNICITY AND RACE IDENTIFICATION**

*Please initial the Racial Category and categories with which you most closely identify by clicking an "X" in the appropriate box. Check each box only.*

<table>
<thead>
<tr>
<th>Racial Category</th>
<th>Definition of Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian or Alaska Native</td>
<td>A person having origins in any of the original peoples of North and South America, including Central America, and who maintains a shared cultural tradition.</td>
</tr>
<tr>
<td>Asian</td>
<td>A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (excluding, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam)</td>
</tr>
<tr>
<td>Black or African American</td>
<td>A person having origins in any of the Black racial groups of Africa.</td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander</td>
<td>A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific islands.</td>
</tr>
<tr>
<td>White</td>
<td>A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.</td>
</tr>
</tbody>
</table>
**Do you speak a Foreign Language?**

**If so Fill out**

**If Not Write N/A**
**Welfare to Work Program**

(Please read the instructions and Privacy Act Statement before completing form)

<table>
<thead>
<tr>
<th>Agency Use Only</th>
<th>Name (Last, First, Middle Initial)</th>
<th>Social Security Number</th>
</tr>
</thead>
</table>

Specific Instructions:
The categories below are designed to identify whether or not you are receiving assistance under the Temporary Assistance to Needy Families Program. Place an “X” in the box next to the appropriate category.

<table>
<thead>
<tr>
<th>Category (Mark ONE only)</th>
<th>DEFINITION OF CATEGORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>I am an adult, or teen parent under age 19, receiving assistance under:</td>
</tr>
<tr>
<td></td>
<td>a) The Temporary Assistance for Needy Families (TANF) program administered by a State under the Federal block grant; <strong>OR</strong></td>
</tr>
<tr>
<td></td>
<td>b) Aid to Families with Dependent Children (AFDC); <strong>OR</strong></td>
</tr>
<tr>
<td></td>
<td>c) Tribal Temporary Assistance for Needy Families program administered by an eligible Indian tribe.</td>
</tr>
</tbody>
</table>

| B                          | I am not currently receiving this type of assistance. |

Privacy Act Statement

Furnishing this information is voluntary. Solicitation of this information is authorized by President Clinton’s Memorandum of March 8, 1997 entitled “Government Employment for Welfare Recipients.” This information will be used for workforce analysis and for monitoring agencies’ compliance with the President’s Memorandum. This information may also be used for statistical reports. It will not be used to make any personnel decisions about individuals.

Executive Order 9397 (November 22, 1943) authorizes use of your Social Security Number (SSN). That Order requires agencies to use the SSN for the orderly administration of personnel records. Your SSN will be used solely for that purpose. Your furnishing of your SSN is voluntary and failure to furnish it will have no effect on you.

U.S. Office of Personnel Management
AUTHORIZED FOR LOCAL REPRODUCTION

- Fill out all yellow
**Fill out all yellow**

---

**Table: Self Identification of Disability**

<table>
<thead>
<tr>
<th>Definition</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>An individual's disability, which may or may not be physical or mental, is a condition or trait that may enable an individual to live a full and productive life.</td>
<td>Self-identification of disability is essential for effective data collection and analysis. This information may be used for multiple purposes and across multiple agencies. By self-identifying, you are helping to ensure that disability information is accurate and up to date.</td>
</tr>
</tbody>
</table>

**Part I: Targeted/Severe Disabilities**

<table>
<thead>
<tr>
<th>Rating</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>Self-identification of disability is essential for effective data collection and analysis. This information may be used for multiple purposes and across multiple agencies. By self-identifying, you are helping to ensure that disability information is accurate and up to date.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-identification of disability is essential for effective data collection and analysis. This information may be used for multiple purposes and across multiple agencies. By self-identifying, you are helping to ensure that disability information is accurate and up to date.</td>
<td>Small</td>
</tr>
</tbody>
</table>

---

**Part II: Other Disabilities**

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-identification of disability is essential for effective data collection and analysis. This information may be used for multiple purposes and across multiple agencies. By self-identifying, you are helping to ensure that disability information is accurate and up to date.</td>
<td>Small</td>
</tr>
</tbody>
</table>

---

**Other Impairments**

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-identification of disability is essential for effective data collection and analysis. This information may be used for multiple purposes and across multiple agencies. By self-identifying, you are helping to ensure that disability information is accurate and up to date.</td>
<td>Small</td>
</tr>
</tbody>
</table>

---

**Special/Required Learning Conditions**

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-identification of disability is essential for effective data collection and analysis. This information may be used for multiple purposes and across multiple agencies. By self-identifying, you are helping to ensure that disability information is accurate and up to date.</td>
<td>Small</td>
</tr>
</tbody>
</table>

---

**Other Options**

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-identification of disability is essential for effective data collection and analysis. This information may be used for multiple purposes and across multiple agencies. By self-identifying, you are helping to ensure that disability information is accurate and up to date.</td>
<td>Small</td>
</tr>
</tbody>
</table>
Statement of Prior Federal Service

(Please read the following information before completing this form)

Privacy Act Statement
Section 5523 of 5 U.S.C., "Annual Leave Accrual," authorizes collection of information to determine and record service that may be creditable for accrual of annual leave. Part 351.500, 5 C.F.R., "Length of Service," authorizes collection of data to determine and record service that may be creditable for reduction-in-force retention purposes.

Information about prior Federal civilian and military service is collected and maintained in your Official Personnel Folder (OPF). The information you furnish may be disclosed to other Federal agencies or Congressional or Judicial Officers in order to verify it or in connection with your application for a job, license, grant, or other benefit. It may also be disclosed to a judicial, state, or local law enforcement agency where there is indication of a violation or potential violation of civil or criminal law or regulation, or to another Federal agency or court when the Government is party to a suit.

Furnishing this information is voluntary; however, failure to do so may result in your not receiving credit for prior Federal service.

I. What Is Needed to Verify Prior Service

In order for your employing agency to credit your prior Federal service for benefits, such as leave accrual and reduction-in-force retention, the dates of your active uniformed service and the type(s) of appointment(s) and dates of civilian service must be verified. Dates of active uniformed service are verified from the records issued by the branch of service in which you served. Dates and types of appointments to civilian positions are usually verified from Notifications of Personnel Action (Standard Form 50 or CSC- or OPM-approved exceptions thereto), and payroll records (including records of deductions made under the Civil Service Retirement System—Standard Form 2806, or the Federal Employees Retirement System—Standard Form 3100). The information on the application or resume you submit for the appointment you are receiving, along with the information on page 2 of this form, will be used by your agency to identify the Federal employers and periods of employment for which records must be obtained to verify the prior service.

When Notification of Personnel Action or payroll records cannot be located to verify a period of service, and the service was covered by Social Security, a detailed statement of earnings information (showing periods of employment and the name of the employer) from the Social Security Administration will be accepted as proof of service.

If no personnel, payroll, or Social Security records can be located, then your agency can accept secondary evidence of civilian employment, as explained below.

II. Use of Secondary Evidence to Verify Federal Service

Secondary evidence may be considered as proof of Federal civilian service only when official Government records are lost, destroyed, or incomplete. Necessarily, the burden of proof is on the person claiming service that is not supported by official records in the custody of the U.S. Government. If you decide to claim credit for a period of service by submitting secondary evidence, it is important that you submit all documents in your possession that tend to prove you performed the service claimed and that the service, if performed, was creditable for leave accrual and reduction-in-force purposes. No credit can be allowed for any service that is not substantiated by valid and conclusive secondary evidence. The following is applicable only if you are providing secondary evidence.

A. Documentary Evidence: Submit as many as possible of the documents listed in item 1 below. If your agency finds that these documents are insufficient to determine creditability, the documents listed in items 2 and 3 may be considered, but less weight will be given to such evidence.

1. Copies of official documents or letters about the service. These may be notices on appointment/separation; notices of changes in position/salary, organization, or headquarters; travel orders; payroll cards; ID cards, etc.
2. Private records such as a diary, correspondence, copies of income tax returns, employment applications, credit applications, etc., that mention the Federal employer and the claimed service. Private records must have been made during or shortly after period of service.
3. Any other documentary evidence tending to prove the service was actually performed and the starting and ending dates of the service.

B. Affidavit Evidence: If you are not able to supply copies of official documents (as described in item 1 above) that are sufficient for your agency to make a determination of creditability, you must submit affidavits from yourself and at least two other persons (preferably your supervisors) who know the facts. If you can obtain no documentary evidence (items 1, 2, and 3, above) to support your claim, you may submit these affidavits only; however, your claim is more likely to be rejected without supporting documents. The required affidavits are from:

   - The employee, stating as many of the details on the affidavit as can accurately be remembered.
   - At least two persons knowing the facts. Each person should show that he or she is in a position to know the facts sworn to, and give his or her age and mailing address.

Affidavits must be sworn to or affirmed before a notary public or other officer who is authorized by law to administer oaths.

C. Warning: Any submission may be investigated. Intentional false statements, willful concealments, or using documents you know are false, fictitious, or fraudulent is punishable by fine/imprisonment (18 U.S.C. 1001).
ACKNOWLEDGMENT OF TEMPORARY APPOINTMENT

I understand that I am being hired as a temporary employee and that as a temporary employee I am not eligible for any health insurance, health insurance or retirement benefits. I do understand that if and when I am converted to a permanent employee I will be eligible to elect or waive health and life insurance benefits and will be automatically covered under a retirement system. If I remain a temporary employee I understand that I will be eligible for health insurance only one year from original appointment date.

Name (Print)

Signature

Date

• Fill out all yellow
Military Sealift Command
Military Sealift Command, Norfolk
471 East “C” Street, Bldg SP-64
Norfolk, VA, 23511
Cadet Shipping Program

CONSENT TO RELEASE CADET EMPLOYMENT INFORMATION

I understand that my participation in the Military Sealift Command (MSC) Cadet Shipping Program is pursuant to the Cadet Shipping Agreement between MSC and The California Maritime Academy.

I further understand that upon MSC’s execution of the Notice of Personnel Action, Standard Form 50, I will be in a temporary employment status with MSC until the time of my termination upon completion of my training assignment.

I hereby authorize MSC to release to The California Maritime Academy all information with respect to any aspect of my employment that is in its possession or subject to its control. I understand that in addition to the Performance Appraisals required by the Cadet Shipping Agreement between MSC and my Academy, my employment information and/or personnel records include, but are not limited to, dates of employment, ship assignments, job duties, wages, conduct, discipline and/or adverse actions, work performance, training, and awards and/or items of recognition.

I further release and hold harmless both MSC and The California Maritime Academy from any and all liability that may potentially result from the release and/or use of information from my employment and/or personnel files.

I certify that my consent to release this information is voluntary.

______________________________
CADET SIGNATURE

______________________________
DATE
CONSENT TO RELEASE CADET EMPLOYMENT INFORMATION

I understand that my participation in the Military Sealift Command (MSC) Cadet Shipping Program is pursuant to the Cadet Shipping Agreement between MSC and The California Maritime Academy.

I further understand that upon MSC’s execution of the Notice of Personnel Action, Standard Form 50, I will be in a temporary employment status with MSC until the time of my termination upon completion of my training assignment.

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I further release and hold harmless both MSC and The California Maritime Academy from any and all liability that may potentially result from the release and/or use of information from my employment and/or personnel files.

I certify that my consent to release this information is voluntary.

CADET SIGNATURE

DATE
MEDICAL

RIGHT SIDE OF PACKET
Medical/Dental Screening Form for Cadets sailing on USNS Ships

Certain medical conditions are not compatible with the shipboard environment and may be beyond the capabilities of the ship's Medical Department. The information requested below will help us make a determination if any existing medical conditions are incompatible with embarkation aboard a USNS ship.

For safety reasons, those who require the use of crutches, canes or other assistive devices or have a condition that limits their ability to climb stairs or ladders without assistance will NOT be authorized to embark aboard USNS ships. Additionally, pregnant females are not eligible for embarkation in accordance with current Navy policy and directives.

Cadets are required to bring all of their prescription and over-the-counter (OTC) medications in sufficient quantities to cover your entire time aboard the ship. The ship's Medical Department may not be able to provide the same medications even in emergencies. Certain medications are also prohibited from being used aboard ship.

PRIVATE ACT STATEMENT

AUTHORITY: Department of Defense Regulations 6025.16-R and the Navy Regulations.
PRINCIPAL PURPOSE: Screen riders for health risks, active medical conditions, and any activity/ability limitations.
ROUTINE USE: Completion of this form is required to record medical data to be used to screen potential underway riders onboard USNS ships and to assist in providing appropriate medical response if medical services are needed.
NOTE: Records may be maintained in both electronic and/or paper form.
DISCLOSURE: Disclosure of this information is voluntary however, failure to provide the requested information may impede, delay, or prevent further processing of this request.

Cadet’s Name: ___________________________ Last: ___________________________ First: ___________________________ M.I.: ___________________________ Age: ______ Sex: Male / Female

Birth Date (MM/DD/YYYY): ___________ Your personal contact number: ___________________________

Email: ___________________________

Academy Medical Department Representative’s name and phone number: ___________________________

Check “Yes” to any of the below listed conditions you have ever experienced. Include dates of hospitalizations and surgeries. Submit additional information on a separate sheet of paper if necessary. Check “No” if the condition does not apply. It is important that you complete this form thoroughly. If it is incomplete or if it is not accurately filled out, the time spent in obtaining clarification might result in the Cadet not being cleared in a timely manner to sail. A letter from your physician describing your conditions is appreciated and may be attached.

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Cardiovascular Disease</th>
<th>Description of Hospitalization/Treatment/Dates</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Chest pain (Angina)</td>
<td></td>
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<td></td>
<td></td>
<td>Angioplasty</td>
<td></td>
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<td></td>
<td></td>
<td>Heart valve disease and/or surgery</td>
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<td></td>
<td></td>
<td>Stroke</td>
<td></td>
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<td></td>
<td>Elevated lipids</td>
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<td></td>
<td></td>
<td>Peripheral Vascular Disease</td>
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<td></td>
<td></td>
<td>Congestive Heart Failure</td>
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<td></td>
<td></td>
<td>High blood pressure</td>
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<td></td>
<td>Abnormal EKG</td>
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<td></td>
<td></td>
<td>Other (Pacemaker, etc)</td>
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<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Respiratory Disease</th>
<th>Description of Hospitalization/Treatment/Dates</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Asthma/Obstructive Airway Disease</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Sleep apnea</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Chronic Lung Disease/Emphysema</td>
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<td></td>
<td>Lung/Thoracic Surgery</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Shortness of Breath</td>
<td></td>
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<td></td>
<td></td>
<td>Other</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Gastrointestinal Disease</th>
<th>Description of Hospitalization/Treatment/Dates</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Reflux/Heartburn</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Ulcers</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Inflammatory Bowel Disease</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Other</td>
<td></td>
<td></td>
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</tbody>
</table>
Fill out entire form

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Endocrine Disease</th>
<th>Description of Hospitalization/Treatments/Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Diabetes</td>
<td>Comments:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Thyroid</td>
<td></td>
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<td></td>
<td>Other</td>
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</tbody>
</table>

<table>
<thead>
<tr>
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<th>Yes</th>
<th>Infectious Disease</th>
<th>Description of Hospitalization/Treatments/Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Hepatitis (A, B, or C)</td>
<td>Comments:</td>
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<tr>
<td></td>
<td></td>
<td>HIV</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Tuberculosis</td>
<td></td>
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<td></td>
<td></td>
<td>Other</td>
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</table>

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Blood Disorders</th>
<th>Description of Hospitalization/Treatments/Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Hemophilia</td>
<td>Comments:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Thalassemia</td>
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<tr>
<td></td>
<td></td>
<td>Sickle Cell Disease</td>
<td>Comments:</td>
</tr>
</tbody>
</table>
|    |     | Other (Bleeding Disorders) | Comments: |}

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Neuro/Musculoskeletal Disorders</th>
<th>Description of Hospitalization/Treatments/Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Arthritis (degenerative or rheumatoid)</td>
<td>Comments:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Limitations that restrict movement or full range of motion</td>
<td></td>
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<td></td>
<td></td>
<td>Joint Replacement Surgery</td>
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<td></td>
<td></td>
<td>Multiple Sclerosis</td>
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<td>Any physically limiting condition or the use of splints, crutches, or canes</td>
<td>Comments:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Leg cramps</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Any other conditions:</th>
<th>Description of Treatment/Hospitalizations/Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Epilepsy (If yes, date of last seizure)</td>
<td>Comments:</td>
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<tr>
<td></td>
<td></td>
<td>Renal/kidney disease</td>
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<td>Gallbladder Disease</td>
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<td>Liver Disease</td>
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<td></td>
<td></td>
<td>Migraine Headaches</td>
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<td></td>
<td></td>
<td>Take anti-coagulation medications</td>
<td>Comments:</td>
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<td></td>
<td></td>
<td>Motion sickness or claustrophobia</td>
<td>Comments:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Any psychiatric condition currently being treated with medication</td>
<td>Comments:</td>
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<tr>
<td></td>
<td></td>
<td>ADD/ADHD</td>
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<td></td>
<td></td>
<td>Claustrophobia</td>
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<td></td>
<td></td>
<td>Dental - Severe tooth or gum problems</td>
<td>Comments:</td>
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<td></td>
<td></td>
<td>Skin Disorder (eczema/psoriasis)</td>
<td>Comments:</td>
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<tr>
<td></td>
<td></td>
<td>If Female, any chance of being pregnant</td>
<td>Comments:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Any other medical condition not previously mentioned</td>
<td>Comments:</td>
</tr>
</tbody>
</table>

Allergies: List all of the allergies, including food, medications, or environmental. (If none, write NONE).

Allergy List:

Have you been hospitalized, had surgery or been seen in the emergency department in the prior three years for anything? (If it was discussed above, indicate such).

Hospitalizations/ER Visits:
**Medications:** List all medications you are currently taking, including over-the-counter, herbs, vitamins and supplements.

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage</th>
<th>Reason for Taking Medication</th>
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</thead>
<tbody>
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</table>
| I acknowledge that the above information provided is true.

Signature of the Cadet ____________________________ Date ____________

The following section is to be completed by the Academy Physician or Medical Department Representative:

(List dates completed) Hep A ________ IPV/Fasio ________ MMR ________

Tdap ________ Typhoid ________ Yellow Fever ________ Influenza ________

G6PD result ________ Blood Type ________ Sickle Cell screen result ________

Tuberculin skin test: POS or NEG and date ________ CXR (date and result if applicable) ________

INH or other LTBI treatment started (if applicable) ________ Current St ______ Wt ______ BMI ______

**Physical requirements verification:**

Yes ☐ No ☐

- Vision correctable to 20/40 or better in each eye
- Color vision normal
- Hearing within USCG NVIC standards
- No restrictions on wearing SCBA or Respirator
- BMI > 40
- Physical ability sufficient to: physically fit to respond to and operate ship's emergency equipment, including pulling a 1.5 inch uncharged fire hose 50 feet, lifting a charged fire hose, being able to wear Self-Contained Breathing Apparatus, and having the agility and strength to don flotation devices and exposure suits without assistance. Minimum physical standards also include the ability to lift and carry at least 40 pounds, the ability to crouch and crawl, climb vertical ladders, step over a door sill of 24 inches, fit through a restricted opening of 24x24 inches, and stand for periods up to 4 hours.

Comments:

**Academy Physician or Medical Department Representative**

Printed or stamped name and signature: ____________________________ Date ____________

Contact number: __________________________________________________

**For NSC Medical Department Use Only**

Medical screener comments: __________________________________________

Cadet is medically cleared: YES: _____ NO: _____

Signature/stamp of the NSC Medical Screener _________________________ Date ____________

Revised: 21 NOV 2013
Career Center will secure this form
I authorize release from:
(Name of disclosing party):

[Box checked]: California Maritime Academy

Address:

200 Maritime Academy Drive
Vallejo

City: CA   Zip: 94590

To release to:
(Name of receiving party):

James Dalske, Deborah Bauer, Tess Luna

Address:

200 Maritime Academy Drive
Vallejo

City: CA   Zip: 94590

Specific Dates (if applicable):

Please check box(es) below for specific information to be released:

☐ General Medical Records
☐ Psychiatric Records
☐ Drug/Alcohol Treatment
☐ HIV Test Results
☐ Other: USCG Physical

Signature Date

☐ Please mail the records.
☐ Please fax the records.
☐ I will pick up the records.

Purpose of this release is for:
☐ Continuity of care
☐ Other: Commercial Cruise

Signature Date

My consent may be revoked at any time. Unless previously revoked, this consent will terminate six months after the date of my signing this consent. Each disclosure requires an additional signed authorization. Only original signed requests are valid.

Signature of Patient Date
(Parent/Guardian if patient is under 18)

Relationship to Patient
(If signed by other than patient)

ID Verified by: ____________________________ Record Release Approved by: ____________________________
Fee Due: ____________________________ Collected: ____________________________ processed by: ____________________________
For Office Use Only: Sign and Date
CAL MARITIME

Student Health & Wellness Center
California State University, Maritime
200 Maritime Academy Drive
Vallejo, CA 94590
Phone: 707-654-1170
Fax: 707-654-1171

Patient Name:
Address:
City: State: Zip:
Phone: DOB: SID:

Authorize release from:
(Name of disclosing party):
James Dalske, Debbie Bauer, Tess Luna

To release to:
(Name of receiving party):
Military Sealift Command

Name
Address
City
State Zip
Phone: Fax:

Specific Dates (if applicable):
Please check box(es) below for specific information to be released:

☐ General Medical Records
☐ Psychiatric Records
☐ Drug/Alcohol Treatment
☐ HIV Test Results
☐ Other

Signature Date

Please mail the records.
☐ Please fax the records.
☐ I will pick up the records.

Purpose of this release is for:
☐ Continuity of care
☐ Other: Commercial Cruise

My consent may be revoked at any time. Unless previously revoked, this consent will terminate six months after the date of my signing this consent. Each disclosure requires an additional signed authorization. Only original signed requests are valid.

Signature of Patient Date
(Parent/Guardian if patient is under 18)

Relationship to Patient
(If signed by other than patient)

Record Release Approved by:
Processed by:

For Office Use Only: Sign and Date
ID Verified by: Fee Due: Collected:

• Your USCG Physical should already be done. (9 pages)

• IF NOT Take this Form to the Health Center and Schedule an appointment.

• Come into Career Center to get your Physical to include in your packet
You must take this page to the Health Center

You must have this form filled out prior to your physical appointment.
You must have this form filled out prior to your physical appointment.
20. 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.)

- COMMENTS

- You must have this form filled out prior to your physical appointment.
You Must Fill This Form Out Top to Bottom
**Smallpox Vaccination Initial Note Page #2**

<table>
<thead>
<tr>
<th>CHRONOLOGICAL RECORD OF MEDICAL CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smallpox Vaccination Initial Note Page 2 of 2</td>
</tr>
<tr>
<td>This page may be completed by a healthcare provider</td>
</tr>
</tbody>
</table>

1. **Provider Assessment Date (MM/DD/YYYY)**: [ ] / [ ] / [ ]
   - If Provider Assessment Date or Action Taken Immunization Date is blank, default is “Today’s date” on page 1.

2. **Reason for Vaccination (Indicate One):**
   - [ ] Pre-outbreak: disease prevention
   - [ ] Post-outbreak: not exposed to virus
   - [ ] Post-outbreak: exposed to virus
   - [ ] Other reason: (Describe)

3. **Vaccine Risk Factors based on page 1 review and interview**
   - [ ] Sex: Female
   - [ ] Close Contact
   - [ ] Pregnancy
   - [ ] Immune Exposure
   - [ ] Skin condition
   - [ ] Relevant allergy
   - [ ] Heart condition
   - [ ] Unsure
   - [ ] 3HPO
   - [ ] (Describe)

4. **Provider comment on any concerns about contraindications, need to defer, need to consult, and/or relevant diagnosis**

<table>
<thead>
<tr>
<th>VACCINE ADMINISTRATION</th>
</tr>
</thead>
</table>
| Vaccination Date (MM/DD/YYYY): [ ] / [ ] / [ ]

5. **Provider Decision and Plan (Check all that apply):**
   - [ ] Vaccine: Primary (e.g., birth year > 1972, military entry > 1984)
   - [ ] Vaccine: Revaccination
   - [ ] Medically immune: vaccinated within appropriate interval (MI)
   - [ ] Vaccination deferred: Pending consult or lab test
   - [ ] Vaccination deferred: Temporary contraindication (MT)
   - [ ] Vaccination contraindicated unless exposed (MF)
   - [ ] Vaccine not given: Other reason (specify below)

6. **IF NOT IMMUNIZED, Check all that apply:**
   - [ ] Reason for non-immunization explained
   - [ ] Lab test requested
   - [ ] Consult request written
   - [ ] Follow-up appointment planned
   - [ ] Other reason (specify below):

   | List labs or consults requested, and length of time deferred:
   | [ ] [ ] [ ] [ ] [ ]

7. **VACCINE ADMINISTRATION**
   - [ ] Location: Left Arm
   - [ ] Right Arm
   - [ ] Other Location (describe)
   - [ ] Number of Jabs: [ ] [ ] [ ] [ ] [ ]
   - [ ] Lot #: [ ] [ ] [ ] [ ] [ ]
   - [ ] For QA: local visit serial # [ ] [ ] [ ]

8. **IF IMMUNIZED, Check all that apply:**
   - [ ] Information sheet given to recipient
   - [ ] Recipient advised about post-vaccination reaction and site care
   - [ ] Reasons for follow-up clinic visit described
   - [ ] Patient understands information given
   - [ ] Bandages provided if needed

   Please assure that all actions taken and deferreds are updated into your service's electronic Immunization Tracking System (ITS) as soon as possible.

---

**Provider Signature and Printed Name/Stamp:**

**Vaccine administered by: (Signature and Printed Name/Stamp):**

---

**Patient’s identification (May use for mechanical imprint):**

<table>
<thead>
<tr>
<th>Last Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] [ ] [ ] [ ] [ ] [ ]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>First Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] [ ] [ ] [ ] [ ] [ ]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] [ ] [ ] [ ] [ ] [ ]</td>
</tr>
</tbody>
</table>

---

**Records maintained at:**

[Blank]
Smallpox Vaccination Form #1

You Must Fill This Out

Initial Every Box

Sign on Bottom
Smallpox Vaccination Form #2

- You Must Fill This Out
- Initial Box to Right
- Sign on Bottom
<table>
<thead>
<tr>
<th>ITEM NUMBER</th>
<th>SCREENING ELEMENTS</th>
<th>INITIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Privacy Act Signed</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>A. What You Need to Know About Smallpox Vaccine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B. Small Vaccine &quot;What You Need to Know&quot;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C. Caring For the Smallpox Vaccination Site</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D. DoD Individual Briefing: Smallpox</td>
<td></td>
</tr>
<tr>
<td></td>
<td>E. Symptom Diary; After Smallpox Vaccination Form</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Are you allergic to DIHYDROSTREPTOMYCIN or Phenol?</td>
<td>Yes or No</td>
</tr>
<tr>
<td>4</td>
<td>Do you have any contraindications, as listed in the &quot;Exemptions to Vaccination&quot; portion of the DoD Individuals Briefing, not previously mentioned?</td>
<td></td>
</tr>
<tr>
<td>4a</td>
<td>List Contraindications:</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>If in a CHILD BEARING AGE, I understand that I should AVOID becoming pregnant for at least FOUR (4) WEEKS after Smallpox Vaccination.</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>I am aware that blood donations should be DEFERRED for 21 days after vaccination or until after the vaccination scab separates normally, whichever is later.</td>
<td></td>
</tr>
</tbody>
</table>

**I HAVE READ AND ANSWERED ALL OF THE QUESTIONS TO THE BEST OF MY KNOWLEDGE AND ABILITY.**

**SIGNATURE OF VACCINEE**

<table>
<thead>
<tr>
<th>HEALTHCARE PROVIDER / VACCINATOR</th>
<th>INITIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Referral required for further evaluation?</td>
</tr>
<tr>
<td>2</td>
<td>Smallpox Vaccination Initial Noted Completed (2-page format)</td>
</tr>
<tr>
<td>3</td>
<td>Smallpox Vaccination administered this date:</td>
</tr>
<tr>
<td>4</td>
<td>PHS 731 entry completed</td>
</tr>
<tr>
<td>5</td>
<td>SF-601 and NAVMED 6230/4 entry completed</td>
</tr>
<tr>
<td>6</td>
<td>Database entry completed</td>
</tr>
<tr>
<td>7</td>
<td>Patient to return to verify response to vaccine 5 - 8 days after vaccination</td>
</tr>
</tbody>
</table>

**INITIAL ON YELLOW**

**#3 is yes or NO**

**SIGN ON VACCINEE**
**PRIVACY ACT STATEMENT - HEALTH CARE RECORDS**

**THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.**

1. **AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN)**

Sections 133, 1071-87, 3012, 5031 and 8012, title 10, United States Code and Executive Order 9397.

2. **PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED**

This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) of member or sponsor is required to identify and retrieve health care records.

3. **ROUTINE USES**

The primary use of this information is to provide, plan and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: Aid in preventive health and communicable disease control programs and report medical conditions required by law to federal, state and local agencies; compile statistical data; conduct research; teach; determine suitability of persons for service or assignments; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state, or local government upon request in the pursuit of their official duties.

4. **WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION**

In the case of military personnel, the requested information is mandatory because of the need to document all active duty medical incidents in view of future rights and benefits. In the case of all other personnel/beneficiaries, the requested information is voluntary. If the requested information is not furnished, comprehensive health care may not be possible, but CARE WILL NOT BE DENIED.

This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

<table>
<thead>
<tr>
<th>SIGNATURE OF PATIENT OR SPONSOR</th>
<th>SSN OF MEMBER OR SPONSOR</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DD FORM 2005, FEB 76

PREVIOUS EDITION IS OBSOLETE. Adobe Professional 7.0
ALASKA IMMUNIZATION RECORD
OFFICIAL DOCUMENT

State law requires that your child meet Alaska’s Immunization requirements to be enrolled in school or licensed day care.
RETAIN THIS DOCUMENT AS PROOF OF IMMUNIZATION.

Name

Birthdate

SSN

Allergies

Vaccine Reactions

PRESENT THIS RECORD AT EACH MEDICAL VISIT

Remove this page and insert a copy of your immunization records.
Required Immunizations & Blood Tests for Military Sealift Command

Show proof of current immunizations for:

- Hepatitis B (or proof of immunity)
- MMR
- Polio (completion of basic series)
- Tetanus
- Varicella (or proof of immunity)
- Hepatitis A
- Typhoid
- Yellow Fever
- Influenza
- Smallpox (given on ship, only if deploying to designated High Threat Area)
- Anthrax (given on ship, only if deploying to designated High Threat Area)
- Tuberculin Skin Test
- G6PD & Sickle Cell Test Results
- Blood Type & Cross
- CBC with Differential
THIS ENTIRE PACKET IS DUE: February 27

QUESTIONS