OMB Control No. 2900-0205
Estimated Burden: 30 Minutes
Expiration Date: 05/31/2026

Department of Veterans Affairs

HEALTH PROFESSIONS TRAINEE DATA COLLECTION FORM

SEE LAST PAGE FOR PAPERWORK REDUCTION ACT, PRIVACY ACT, AND INFORMATION ABOUT DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER

INSTRUCTIONS: Please submit this data collection form, furnishing all information in sufficient detail to enable the Department of Veterans Affairs (VA) to determine your eligibility for appointment. Type or print in ink. If additional space is needed, please attach a separate sheet and refer to items being answered by number. Clinical training programs may require additional information from trainees. All information required by the training program to which you have applied, as well as information requested on all data collection forms, must be included.

SECTION I - APPLICANT INFORMATION

1A. NAME *(Last, First, Middle)*:	1B. OTHER NAMES USED:
2. PRESENT ADDRESS *(Include ZIP Code)*:	3A. PRIMARY PHONE NUMBER *(Include Area Code)*: 3B. ALTERNATE PHONE NUMBER *(Include Area Code)*:

4. SOCIAL SECURITY NUMBER:	5A. PRIMARY EMAIL ADDRESS:	5B. ALTERNATE EMAIL ADDRESS:	6. DATE OF BIRTH *(MM/DD/YYYY)*:

7A. VA TRAINING FACILITY *(City, State)*:	7B. VA TRAINING START DATE *(MM/DD/YYYY)*:	7C. VA TRAINING END DATE *(MM/DD/YYYY)*:

SECTION II - U.S. MILITARY DUTY STATUS

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

SECTION III - CITIZENSHIP

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

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

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

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

11A. THE TRAINEE HAS MET ALL OF THE CRITERIA OF THE TRAINEE QUALIFICATIONS & CREDENTIALS VERIFICATION LETTER (TQCVL). ☐ YES ☐ NO

11B. INCOMPLETE ITEMS ON THE TQCVL HAVE BEEN ADDRESSED AND RESOLVED. ☐ YES ☐ NO

11C. SPECIAL ATTENTION HAS BEEN GIVEN TO THE FOLLOWING ITEMS FROM THE APPLICATION FORMS:

11D. COMMENTS:

11E. THIS TRAINEE HAS BEEN APPROVED FOR APPOINTMENT. ☐ YES ☐ NO

11F. COMMENTS:

12A. SIGNATURE OF FACILITY DESIGNATED EDUCATION OFFICER OR DESIGNEE:	12B. TITLE:	12C. DATE *(MM/DD/YYYY)*:

NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

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

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

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

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

15. YOUR NATIONAL PROVIDER IDENTIFIER *(NPI)*:

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

16. DO YOU HAVE PENDING, OR HAVE YOU EVER HAD ANY LICENSE, CERTIFICATION, OR REGISTRATION TO PRACTICE (INCLUDING DEA CERTIFICATE) REVOKED, SUSPENDED, DENIED, RESTRICTED, OR PLACED ON A PROBATIONARY STATUS, OR HAVE YOU EVER VOLUNTARILY RELINQUISHED A LICENSE, CERTIFICATION, OR REGISTRATION IN LIEU OF FORMAL ACTION?

☐ YES *(Explain in Section XI)* ☐ NO

17. DO YOU HAVE PENDING, OR HAVE YOU EVER HAD CLINICAL PRIVILEGES AT ANY HEALTH CARE INSTITUTION OR AGENCY REVOKED, SUSPENDED, DENIED, RESTRICTED, LIMITED, OR PLACED ON A PROBATIONARY STATUS, OR HAVE YOU EVER VOLUNTARILY RELINQUISHED CLINICAL PRIVILEGES IN LIEU OF FORMAL ACTION?

☐ YES *(Explain in Section XI)* ☐ NO

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

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

SECTION VIII - GRADUATES OF AN INTERNATIONAL MEDICAL SCHOOL

19A. ARE YOU A GRADUATE OF AN INTERNATIONAL MEDICAL SCHOOL? ☐ YES ☐ NO	19B. EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES *(EDFMG)* CERTIFICATE NUMBER:	19C. ECFMG CERTIFICATE DATE *(MM/DD/YYYY)*:

NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

SECTION IX - INTERNSHIP, RESIDENCY, AND FELLOWSHIP TRAINING

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

SECTION X - ADDITIONAL QUESTIONS

ITEM NO.	CHECK THE APPROPRIATE BOX. IF "YES," EXPLAIN DETAILS IN SECTION XI	
21	AS A PARTICIPANT IN THE MEDICARE AND MEDICAID PROGRAMS, HAVE YOU EVER BEEN CONVICTED OF OR INVESTIGATED FOR MAKING FALSE, FICTITIOUS, OR FRAUDULENT STATEMENTS, REPRESENTATIONS, WRITINGS, OR DOCUMENTS REGARDING THE DELIVERY OF OR PAYMENT FOR HEALTH CARE BENEFITS, ITEMS OR SERVICES THAT WOULD BE IN VIOLATION OF THE CRIMINAL FALSE CLAIMS ACT?	☐ YES ☐ NO
22	ARE YOU NOW, OR HAVE YOU EVER BEEN, INVOLVED IN ADMINISTRATIVE, PROFESSIONAL, OR JUDICIAL PROCEEDINGS IN WHICH MALPRACTICE ON YOUR PART WAS ALLEGED? *(If "YES," give details in Section XI, including name of action or proceedings, date filed, court or reviewing agency, and the status or outcome of the case concerning those allegations. Please also provide your explanation of what occurred).* *As a provider of health care services, the VA has an obligation to exercise reasonable care in determining that applicants are properly qualified. It is recognized that many allegations of professional malpractice are proven groundless. Any conclusion concerning your answer as it relates to professional qualifications will be made only after a full evaluation of the circumstances involved.*	☐ YES ☐ NO

SECTION XI - REMARKS

ITEM NO.	INCLUDE ADDITIONAL INFORMATION REQUESTED IN ITEMS ABOVE. BE SURE TO INDICATE ITEM NUMBER ON FORM TO WHICH THE COMMENT REFERS.

NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

SECTION XII - CERTIFICATION

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL OF MY STATEMENTS ARE TRUE, CORRECT, COMPLETE, AND MADE IN GOOD FAITH.

NOTE: A false statement on any part of your application may be grounds for not hiring you, or for terminating you after you begin work. Also, you may be punished by fine or imprisonment (U.S. Code, Title 18, Section 1001).

23A. SIGNATURE OF TRAINEE	23B. DATE *(MM/DD/YYYY)*:

AUTHORIZATION FOR RELEASE OF INFORMATION

In order for the Department of Veterans Affairs (VA) to assess and verify my educational background, professional qualifications and suitability for employment, and consistent with the requirements of the Rehabilitation Act (29 U.S.C. § 701, et seq.), Americans with Disabilities Act of 1990 (ADA) (42 U.S.C. § 12101, et seq.) and Title II of the Genetic Information Nondiscrimination Act of 2008 (GINA) (42 U.S.C. § 2000ff, et seq.), I:

☐ Authorize VA to make lawful inquiries about me to current and previous employers, educational institutions, state licensing boards, professional liability insurance carriers, other professional organizations or persons, agencies, organizations, or institutions listed by me as references, and to any other sources which VA may deem appropriate or be referred by those contacted;

☐ Authorize lawful release of such information and copies of related records and documents to VA officials;

☐ Release from liability all those who provide information to VA in good faith and without malice in response to such inquiries;

☐ Authorize VA to lawfully disclose to such persons, employers, institutions, boards, or agencies identifying and other information about me to enable VA to make such inquiries; and

☐ Authorize VA to lawfully share any information about me with the affiliated institution or training program official.

SIGNATURE OF TRAINEE	DATE *(MM/DD/YYYY)*:

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE

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

AUTHORITY: The information requested on this form and Authorization for Release of Information is solicited under Title 38, United States Code, Chapters 73 and 74.

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

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

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

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

Disclosure of your Social Security Number (SSN) is mandatory to obtain the employment and benefits that you are seeking. Solicitation of the SSN is authorized under provisions of Executive Order 9397 dated November 22, 1943. The SSN is used as an identifier throughout your Federal career. It will be used primarily to identify your records. The SSN also will be used by Federal agencies in connection with lawful requests for information about you from former employers, educational institutions, and financial or other organizations. The information gathered through the use of the number will be used only as necessary in personnel administration processes carried out in accordance with established regulations and published notices of systems of records, 'Applicants for Employment' under Title 38, U.S.C.-VA (02VA135), in the 2003 Compilation of Privacy Act Issuances. The SSN will also be used for the selection of persons to be included in statistical studies of personnel management matters. The use of the SSN is necessary because of the large number of Federal employees and applicants with identical names and birth dates whose identities can only be distinguished by the SSN.