



DEPARTMENT OF VETERANS AFFAIRS NEW YORK HARBOR HEALTH CARE SYSTEM

April 2013

Dear Incoming Resident:

Welcome to the Department of Veterans Affairs (VA) New York Harbor Health Care System! To process your appointment at the VA NY Harbor-Brooklyn Campus, you will need to complete a VA application packet and return it to the Program Specialist in the Employee Education Office at the Brooklyn VA. To facilitate processing your appointment, please go to the following website, download and complete all the documents in the PDF (list of documents is shown below). <http://www.nyharbor.va.gov/neores.asp>

In addition, all residents must complete the web-based mandatory training for trainees. When you are on the website please follow the link to the TMS On-Line Training website and click on *Create New User*. You can also access the training site directly using the following link: <http://www.tms.va.gov>.

Included in this packet are instructions for completing the training online. Completion of the training is a requirement of appointment, so please make certain you print the certificate of completion and submit it with your completed application.

The VA application packet includes:

1. Application Instructions and Checklist
2. List of VA Representatives, listed by service
3. Resident Appointment Letter
4. Application for Residents (SF-2850D)
5. Appointment Affidavit (SF-61)
6. Declaration for Federal Employment (OF-106 REV 10/2011)
7. Fingerprint Prep Sheet
8. English Proficiency Form
9. Form I-9
10. Employee's Confidentiality Statement
11. HIPDB/NPDB Form
12. List of Personal Identity Verification Documentation Criteria
13. Request for Personal Identity Verification Card (VA Form 0711)
14. National Provider Identification (NPI) Number Instructions
15. Instructions for Web-Based VHA Mandatory Training for Trainees
16. New Person Registration Worksheet

Your individual VA Service Representative will answer any questions you might have about the application process. After completing all forms, **please compile them IN ORDER** and mail the complete packet to:

Dept. of Veterans Affairs
Makesha White-Reed, Program Specialist
423 East 23rd Street, Room 7027West
New York, NY 10010
Makesha.White-Reed@va.gov

All residents rotating at the VA NY Harbor Health Care System must be fingerprinted and issued a VA ID badge before receiving access to the Medical Center's electronic medical record system. As soon as you have completed the packet, please contact your VA Service Representative to schedule fingerprinting. I encourage you to schedule this as early as possible. Before fingerprinting, you must provide proof of identification (PIV Identity Documentation Criteria for acceptable documents) and, if you are not a U.S. citizen, a copy of your VISA.

Thank you for your prompt attention in completing and returning these forms timely.

Please be sure to return the completed packet by MAY 1, 2013.

Sincerely,

Andrew J. Adler, MD
Designated Learning Officer

VA NY HARBOR APPLICATION INSTRUCTIONS & CHECKLIST

Below is a checklist and overview of the instructions for all the required documents in the VA application. Remember to answer everything to the best of your knowledge. If something does not pertain to you, please enter "n/a". Remember to print clearly and legibly as others will be working on your paperwork. You can use this checklist to keep track of your progress in completing the VA application.

1. VA Service Representatives List

For your records. Please keep this information handy.

2. Resident Appointment Letter

Print your name, sign and mark either resident or fellow status.

3. Application for Health Professions Trainees (SF 10-2850D)

Complete all questions and sign pages 3 & 4.

4. Appointment Affidavit (SF 61)

Print your name and sign. It is **NOT** necessary to notarize this form.

5. Declaration for Federal Employment (OF 306 REV 10/2011)

Complete all questions and sign.

6. Fingerprint Prep Sheet

Complete all questions.

7. English Proficiency Form

Complete all questions and sign.

8. Form I-9

Read all pages; complete and sign page 7.

9. Employee Confidentiality Statement

Complete all questions and sign.

10. HIPDB/NPDB Form

Complete all questions.

11. List of PIV Identity Documentation Criteria

Attach copies of two non-expired picture IDs from the list of acceptable documents.

12. Request for Personal Identity Verification Card (VA Form 0711)

Complete Section I and sign page 3. Remember to attach copies of two non-expired picture IDs. A list of acceptable documents is included in a separate attachment.

13. National Provider Identification Number

Follow instructions on obtaining NPI number; remember to forward the NPPES e-mail to the VA Compliance Officer, Ms. Johanna Rubin (Johanna.Rubin@va.gov).

14. Instructions for Web-based VHA Mandatory Training for Trainees

Follow attached instructions and print completion certificate for inclusion in application.

15. New Person Registration Worksheet

Complete all sections and sign.

UNITED STATES DEPARTMENT OF VETERANS AFFAIRS
 VA NEW YORK HARBOR HEALTHCARE SYSTEM – BROOKLYN CAMPUS
 800 POLY PLACE
 BROOKLYN, NEW YORK 11209

Dr. Andrew Adler, Designated Learning Officer

Andrew.Adler@va.gov

Please call your SERVICE REPRESENTATIVE for all questions you may have. If unable to phone, feel free to email them.

VA SERVICE REPRESENTATIVES

<p><u>Dermatology</u> Chief: Dr. Usha Alapati Representative: Cindy Farley (718) 836-6600 Ext.: 3725 / Fax (718) 630-2881 Cindy.Farley@va.gov</p>	<p><u>Mental Health</u> Program Director: Dr. Ian Buckingham Representative: Regina Pierce (718) 836-6600 Ext.: 3733, 4120 / Fax: 718-630-2951 Regina.Pierce@va.gov</p>
<p><u>Medical Service</u> (includes all medical fellowships) Chief: Dr. David Blumenthal Representative: Dawn Matera Alternate: Clelia Sarrapere (718) 836-6600 Ext.: 6504, 4865 / Fax (718) 630-3761 Dawn.Matera@va.gov</p>	<p><u>Radiology</u> Chief: Dr. Patrick Malloy Representative: Cecil Stapleton Representative: Maria Cruz Representative: Stacia Sansone (718) 836-6600 Ext.: 3915 (Maria), 3689 (Stacia) / Fax 718-630-2966 Cecil.Stapleton@va.gov Maria.Cruz@va.gov Stacia.Sansone@va.gov</p>
<p><u>Pathology & Laboratory Medicine</u> Chief: Dr. Matthew Pincus Representative: Vera Kol (718) 836-6600 Ext.: 4822 / Fax: (718) 630-3688 Vera.Kol@va.gov</p>	<p><u>Radiation Oncology</u> Chief: Dr. David Schwartz Representative: Loohy Phildor (718) 836-6600 Ext.: 6557 Loohy.Phildor@va.gov</p>
<p><u>Surgery</u> (includes all surgical specialties) Chief: Dr. Thomas K. Weber Representative: Martin Kaufman Alternate: Surgery Secretary (718) 836-6600 Ext.: 3706, 6829 / Fax (718) 630-3707 Martin.Kaufman@va.gov</p>	



**DEPARTMENT OF VETERANS AFFAIRS
NEW YORK HARBOR HEALTH CARE SYSTEM**

Medical Centers

Brooklyn Campus
800 Poly Place
Brooklyn, NY 11209
(718) 836-6600

New York Campus
423 E. 23rd Street
New York, NY 10010
(212) 686-7500

April 2013

RESIDENT APPOINTMENT LETTER

Welcome to the Department of Veterans Affairs (VA) New York Harbor Healthcare System. You have been appointed on an intermittent basis at our facility as a medical resident or fellow beginning 7/1/2013 until you complete your training at our affiliated medical school, under the authority of Title 38 United States Code 7406. During your appointment with our facility, you will be paid indirectly by the VA using a disbursement agreement with your medical school and will be authorized to perform services as directed by your Service Chief.

Unless you have had prior service as a federal employee, acceptance of this letter, as signified by your signature below and completion of the attached SF 61 (Appointment Affidavits) prior to the start of your training, will serve as your appointment authorization for this period. If you have had prior federal service, you are requested to report to the Human Resources Management office as soon as possible for additional appointment information and/or processing. Please bring this letter with you, as well as any documents you may have relating to your prior service.

Sincerely,

Andrew J. Adler, MD
Designated Learning Officer

Enclosure: Standard Form 61

I AGREE TO SERVE IN THE ABOVE CAPACITY UNDER THE CONDITIONS INDICATED.

PRINT NAME: _____

SIGNATURE: _____

- MEDICAL RESIDENT
- DENTAL RESIDENT
- FELLOW



APPLICATION FOR HEALTH PROFESSIONS TRAINEES

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

INSTRUCTIONS: Please submit this application furnishing all information in sufficient detail to enable the Department of Veterans Affairs (VA) to determine your eligibility for appointment in Veterans Health Administration. Type, or print in ink. If additional space is required, please attach a separate sheet and refer to items being answered by number. Residency, fellowship and internship announcements for clinical training programs may require additional information. All applications must include the information required by the training program to which you are applying as well as information requested on all application forms.

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

1A. NAME (Last, First, Middle)		1B. OTHER NAMES USED (For example: maiden name, nickname, etc.)	
2. PRESENT ADDRESS (Include ZIP Code)		3A. DAY TELEPHONE (include area code)	
		3B. EVENING TELEPHONE (include area code)	
4. SOCIAL SECURITY NUMBER	5. PREFERRED EMAIL ADDRESS	6. DATE OF BIRTH (mm/dd/yyyy)	7. PLACE OF BIRTH (City, State, and Country (if not U.S.A.))
8A. PROGRAM/DISCIPLINE OF STUDY		8F. CURRENT COLLEGE/UNIVERSITY/SCHOOL: INCLUDE CITY AND STATE (Do not abbreviate)	
8B. ARE YOU APPLYING FOR A VA ADVANCED FELLOWSHIP PROGRAM FOR PHYSICIAN RESIDENTS? <input type="checkbox"/> YES <input type="checkbox"/> NO		8C. ENTER YOUR NATIONAL PROVIDER IDENTIFIER (NPI)	
8D. START DATE OF YOUR DEGREE PROGRAM OF STUDY (mm/yyyy)		8E. EXPECTED END DATE OF YOUR DEGREE PROGRAM OF STUDY (mm/yyyy)	
		8G. TARGET DEGREE LEVEL OF YOUR CURRENT TRAINING PROGRAM <input type="checkbox"/> Certificate/Diploma <input type="checkbox"/> Master's <input type="checkbox"/> Post-doctoral (other than residents) <input type="checkbox"/> Associate <input type="checkbox"/> Post-master's fellowship <input type="checkbox"/> Baccalaureate <input type="checkbox"/> Doctoral <input type="checkbox"/> Residency/Fellowship	
9A. VA TRAINING FACILITY (City, State)		10. CHECK APPROPRIATE BOXES IF YOU ARE ENROLLED IN A COLLEGE/UNIVERSITY THAT IS CLASSIFIED AS: <input type="checkbox"/> Tribal College or University (TCU) <input type="checkbox"/> Historical Black College and University (HBCU) <input type="checkbox"/> Hispanic Serving Institution (HSI)	
9B. VA TRAINING START DATE (mm/yyyy) <input type="checkbox"/> UNKNOWN	9C. VA TRAINING END DATE (mm/yyyy) <input type="checkbox"/> UNKNOWN		

II - FOR APPLICANTS CURRENTLY ON ACTIVE DUTY IN U.S. MILITARY DUTY

11A. ARE YOU NOW IN U.S. MILITARY? <input type="checkbox"/> YES (If YES, complete 11b, 11c) <input type="checkbox"/> NO	11B. SERIAL OR SERVICE NO.	11C. BRANCH OF SERVICE
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III - CITIZENSHIP

12A. CITIZENSHIP <input type="checkbox"/> U.S. CITIZEN BY BIRTH <input type="checkbox"/> NATURALIZED U.S. CITIZEN <input type="checkbox"/> NOT A U.S. CITIZEN (Complete item 12B) NOTE: Complete items 13A, 13B, 13C, or 13D ONLY if you are not a U.S. citizen.	12B. COUNTRY OF CITIZENSHIP
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13A. IMMIGRANT	13B. EXCHANGE VISITOR		13C. OTHER NON-IMMIGRANT		13D. FORM DS2019
"A" NUMBER	VISA TYPE	VISA NUMBER	VISA TYPE	VISA NUMBER	DO YOU HAVE A VALID DS2019? <input type="checkbox"/> YES <input type="checkbox"/> NO
DATE	ISSUE DATE	EXPIRATION DATE	ISSUE DATE	EXPIRATION DATE	DATE OF LAST VALIDATION (mm/dd/yyyy)

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

14A. The trainee has met all of the criteria of the Trainee Qualifications & Credentials Verification Letter (TQCVL).	<input type="checkbox"/> YES <input type="checkbox"/> NO
14B. Incomplete items on the TQCVL have been addressed and resolved.	<input type="checkbox"/> YES <input type="checkbox"/> NO
14C. Special attention has been given to the following items from the application forms.	
14D. Comments:	
14E. This applicant has been approved for appointment.	<input type="checkbox"/> YES <input type="checkbox"/> NO
14F. Comments:	
15A. SIGNATURE OF FACILITY DESIGNATED EDUCATION OFFICER OR DESIGNEE	15B. TITLE
15C. DATE	

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER
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V- LICENSE, CERTIFICATION, OR REGISTRATION IN CURRENT CLINICAL PROFESSION

16A. 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.	16B. LICENSE, CERTIFICATION OR REGISTRATION BODY	16C. STATE ISSUING LICENSE	16D. LICENSE, CERTIFICATION OR REGISTRATION NUMBER	16E. IS THE LICENSE, REGISTRATION, OR CERTIFICATION CURRENT? IF NO, EXPLAIN IN PART XI.	16F. EXPIRATION DATE
				<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT REQUIRED	
				<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT REQUIRED	
				<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT REQUIRED	
				<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT REQUIRED	

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

17A. LIST ALL LICENSES, CERTIFICATIONS, AND REGISTRATIONS, INCLUDING DEA, THAT YOU HAVE EVER HAD AS A HEALTH PROFESSIONAL, I.E. MEDICAL, NURSING, PHARMACY, ETC.	17B. LICENSE, CERTIFICATION OR REGISTRATION BODY	17C. STATE ISSUING LICENSE	17D. LICENSE, CERTIFICATION OR REGISTRATION NUMBER	17E. IS THE LICENSE, REGISTRATION, OR CERTIFICATION CURRENT? IF NO, EXPLAIN IN PART XI.	17F. EXPIRATION DATE
				<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT REQUIRED	
				<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT REQUIRED	
				<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT REQUIRED	
				<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT REQUIRED	

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

18. DO YOU HAVE PENDING OR HAVE YOU EVER HAD ANY LICENSE, CERTIFICATION, OR REGISTRATION TO PRACTICE (including DEA Certificate) REVOKED, SUSPENDED, DENIED, RESTRICTED, LIMITED, OR ISSUED/PLACED ON A PROBATIONAL STATUS OR VOLUNTARILY RELINQUISHED? YES - EXPLAIN IN PART XI NO

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

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

20A. NAME OF SCHOOL	20B. ADDRESS (City, State, and Zip Code)	20C. START DATE (mm/yy)	20D. DATE COMPLETED (mm/yy)	20E. DIPLOMA/DEGREE/ CERTIFICATE OR QUALIFICATIONS RECEIVED	20F. MAJOR FIELD OF STUDY

VIII - GRADUATES OF AN INTERNATIONAL MEDICAL SCHOOL

21A. ARE YOU A GRADUATE OF AN INTERNATIONAL MEDICAL SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO	21B. EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG) CERTIFICATE NUMBER	21C. ECFMG CERTIFICATE DATE
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IX- INTERNSHIP, RESIDENCY AND FELLOWSHIP TRAINING

22A. NAME OF HOSPITAL OR INSTITUTION	22B. ADDRESS (City, State and ZIP Code)	22C. SPECIALTY	22D. COMPLETED (mm/yy)	22E. AMOUNT OF TIME APPROVED BY SPECIALTY BOARD

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER
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AUTHORIZATION FOR RELEASE OF INFORMATION

In order for the Department of Veterans Affairs (VA) to assess and verify my educational background, professional qualifications and suitability for employment, I:

- Authorize the VA to make inquiries concerning such information about me to my previous employer(s), current employer, educational institutions, State licensing boards, professional liability insurance carriers, other professional organizations and/or persons, agencies, organizations or institutions listed by me as references, and to any other appropriate sources to whom the VA may be referred by those contacted or deemed appropriate;
- Authorize release of such information and copies of related records and/or documents to VA officials;
- Release from liability all those who provide information to the VA in good faith and without malice in response to such inquiries; and
- Authorize the VA to disclose to such persons, employers, institutions, boards or agencies identifying and other information about me to enable the VA to make such inquiries.
- Authorize VA to share any information about me with the affiliated institution and /or training program official.

SIGNATURE OF APPLICANT	DATE
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PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering data and 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 the attached application 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 primarily to determine your qualifications and suitability for appointment to a residency, advanced fellowship, fellowship, internship or other type of clinical training appointment. If you are appointed by the VA, the information will be used to make pay and benefit determinations and, as necessary, in personnel administration processes carried out in accordance with established regulations and published notices of systems of records.

ROUTINE USES: Information on the form or the form itself 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 Exclusions is maintained by Health and Human Services (HHS) Office of Inspector General (OIG) on the List of Excluded Individuals and Entities (LEIE), to State licensing boards, and/or appropriate professional organizations or agencies to assist the VA in determining your suitability for a clinical training appointment. This information may also be used to periodically verify, evaluate and update your clinical privileges, credentials and licensure status, to report apparent or potential violations of law, to provide statistical data upon proper request, 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. The information you supply 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 at any time. The information from this form may also be used to survey you regarding employment opportunities in VA and solicit you perceptions regarding your clinical training experience at VA and non-VA facilities.

EFFECTS OF NON-DISCLOSURE: See statement below concerning disclosure of your social security number. Your obligation to respond is mandatory and failure to provide this information may delay or make impossible the proper application of Civil Service rules and regulations and VA personnel policies and thus may prevent you from obtaining employment, employees benefits, or other entitlements.

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

Disclosure of your SSN (social security number) is mandatory to obtain the employment and related benefits that you are seeking. Solicitation of the SSN is authorized under the provisions of Executive Order 9397, dated November 22, 1943. The SSN is used as an identifier throughout your Federal career from the time of application through retirement. 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 your 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 made necessary because of the large number of present and former Federal employees and applicants who have identical names and birth dates, and whose identities can only be distinguished by the SSN.

APPOINTMENT AFFIDAVITS

(Position to which appointed)

(Date of appointment)

DVA-NYHHS
(Department or agency)

VHA
(Bureau or Division)

VA NYHHS, BK Campus
(Place of employment)

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

A. OATH OF OFFICE

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

B. AFFIDAVIT AS TO STRIKING AGAINST THE FEDERAL GOVERNMENT

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

C. AFFIDAVIT AS TO PURCHASE AND SALE OF OFFICE

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

PLEASE SIGN BELOW

(Signature of appointee)

Subscribed and sworn (or affirmed) before me this _____ day of _____, 2013

At _____
(City)

NEW YORK
(State)

[SEAL]

(Signature of officer)

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

(Title)

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

FINGERPRINT RECORD PREP SHEET

PLEASE PRINT CLEARLY

NAME (LAST, FIRST, MIDDLE)	
SSN	
DOB	YEAR: MONTH: DAY:
ALIAS	
SEX	
RACE	
EYE COLOR	
HAIR COLOR	
HEIGHT (FT/IN)	FEET: INCHES:
WEIGHT (LBS)	LBS
PLACE OF BIRTH (COUNTRY/STATE)	COUNTRY: STATE:
CITIZENSHIP	
SERVICE	
POSITION / DUTY STATION	630
ADDRESS	STREET:
	CITY: STATE: ZIP:
TELEPHONE	() EXT.

TO BE COMPLETED BY HUMAN RESOURCES:

STAFFER: _____

DATE PRINTED: _____

PRINTED BY: _____

CREDENTIALING CHECKLIST FOR PERSONNEL

APPLICATION FOR EMPLOYMENT PROFESSIONAL

SUPPLEMENTAL INFORMATION ABOUT ENGLISH PROFICIENCY

Please complete the following by providing the necessary information relative to your Primary, Secondary and Post Secondary Education.

Indicate each school attended the dates of attendance, the location of each school and the principal language in which the curriculum was conducted. This information is requested in order that the Department of Veterans Affairs, New York Harbor Healthcare System may comply with Public Law 95-201 which requires that all *employees involved in direct patient care be proficient in written and spoken English.*

Name of School Attended	Dates of Attendance (month & year)	Location of school	Language in which curriculum was taught

I certify that the above information is true and complete to the best of my knowledge and belief.

Signature

Date

I have reviewed the above information and find that it does (not) satisfy the requirements of Public Law 95-201

Human Resource Specialist

Date



**DEPARTMENT OF VETERANS AFFAIRS
NEW YORK HARBOR HEALTH CARE SYSTEM**

Medical Centers

Brooklyn Campus
800 Poly Place
Brooklyn, NY 11209
(718) 836-6600

New York Campus
423 E. 23rd Street
New York, NY 10010
(212) 686-7500

In Reply Refer To:

EMPLOYEE'S CONFIDENTIALITY STATEMENT

In accordance with the requirements of Title 38 CFR 17.500-17.540, the Veterans Administration Medical Quality Assurance Program, this Employee Confidentiality Statement is signed acknowledging an understanding of the Public Law and confirming my commitment to comply with the intent of this law under penalty of fine (not more than \$5,000.00 for the first offense, not more than \$20,000 for subsequent offenses) and/or other appropriate disciplinary action.

I future acknowledge understanding that all records or documents related to the following Quality Assurance activities are considered confidential and privileged and will only be divulged on a need to know basis to other Department of Veterans Affairs employees, pursuant to 38 CFR 17.533 or to other non-DVA agencies or organizations pursuant to the disclosure provisions of 38 CFR 17.534

1. Continuous monitoring functions
2. Patient injury control investigation
3. Utilization review
4. Problem focused health care evaluations
5. Regional program review
6. VAPRO
7. Tort claim management information system
8. Occurrence screening

PRINT NAME: _____

SIGNATURE: _____

DATE SIGNED: _____

SERVICE: _____

HIPDB / NPDB

**(Health Integrity & Protection Data Bank/
National Practitioner Data Bank)**

MALE: _____ **FEMALE:** _____

LAST NAME: _____

FIRST NAME: _____

BIRTH DATE: _____

HOME ADDRESS: _____

SOCIAL SECURITY #: _____

SCHOOL(S) ATTENDED: _____

YEAR OF GRADUATION: _____

STATE OF LICENSURE: _____

STATE LICENSE NUMBER #: _____

SPECIALTY: _____

OCCUPATION: _____

PIV IDENTITY DOCUMENTATION CRITERIA

The following criteria must be met by all VA employees, contractors, and affiliates prior to being issued a PIV card, or Non-PIV Card.

FIPS 201-1, Section 2.2 states the applicant shall be required to provide two original forms of identity source documents. The identity source documents must come from the list of acceptable documents included in *Form I-9, OMB No. 1115-0136, Employment Eligibility Verification*. At least one document shall be a valid State or Federal government-issued picture identification (ID).

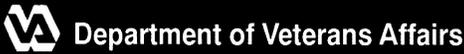
**Table of Accepted Identification (From Form I-9)
Last Update: January 7, 2008**

Picture ID From Federal or State Government	Non-Picture ID or Acceptable Picture ID not issued by Federal or State Government
<ul style="list-style-type: none"> • State-Issued Drivers License • State DMV-Issued ID Card • U.S. Passport (unexpired or expired) • Military ID Card • Military Dependent's card • US Coast Guard Merchant Mariner card • Foreign Passport with appropriate stamps • Permanent Resident Card or Alien Registration Card with a photograph (INS Form I-151 or I-551) • ID Card issued by federal or state government agencies provided it includes a photograph. 	<ul style="list-style-type: none"> • Social Security Card • Certified Birth Certificate • State Voter Registration Card • Native American Tribal Document • Certificate of U.S. Citizenship (INS Form N-560 or N-561) • Certificate of Naturalization (INS Form N-550 or N-570) • Certification of Birth Abroad Issued by the Department of State (Form FS-545 or Form DS-1350) • Permanent or Temporary resident card. • ID Card issued by local government agencies provided it includes a photograph or includes the following information: name, date of birth, gender, height, eye color, and address • Non-photo ID Card issued by federal or state government agencies provided it includes the following information: name, date of birth, gender, height, eye color, and address • School ID with photograph • Canadian Drivers License • US Citizen ID Card (Form I-179)

PIV IDENTITY DOCUMENTATION CRITERIA

1. Two forms of identification are required from the above list of acceptable documents. Either of the following is accepted:
 - a. Two forms of identification from the left column (Federal or State Government issued picture ID).
 - b. One form of identification from the left column (Federal or State Government issued picture ID) and one form from the right column (Non-Picture ID or Acceptable Picture ID not issued by Federal or State Government).

2. The following rules apply for form identification:
 - a. Any form of identification used for ID proofing may not be expired (except U.S. Passport)
 - b. Department of Veterans Affairs site/facility badges are not accepted as a valid form of identification.
 - c. VA PIV Cards are federally issued ID cards and can be used as a valid form of identification.
 - d. Handwritten or photocopied documents are not accepted.
 - e. An ID issued before a legal name change (e.g. birth certificate or driver's license) can be presented as one form of ID if a legal document (e.g. marriage certificate/license or a court order) is also presented linking the previous name to the current legal name. The linking document has to display both the former and current legal names. Both documents must be valid and not expired (except U.S Passport). For example, a married woman may use both a certified copy of her birth certificate displaying her maiden name and a driver's license displaying her married name as the 2 forms of ID compliant with PIV Guidelines, as long as she provides a marriage license displaying both her maiden name and married name.
 - f. The Applicant's name listed on the VA PIV Registration Portal, Request for One-VA Identification Card, must match the name on one of the IDs presented by the Applicant.



REQUEST FOR PERSONAL IDENTITY VERIFICATION CARD

PRIVACY ACT STATEMENT: VA is authorized to ask for the information requested on this form by Homeland Security Presidential Directive (HSPD)-12, and 31 USC 7701. The information and biometrics collected, collected as part of the Federal identity-proofing program under HSPD-12 are used to verify the personal identity of VA applicants for employment, employees, contractors, and affiliates (such as students, WOC employees, and others) prior to issuing a Department identification credential. The credentials themselves are to be used to authenticate electronic access requests from VA employees, contractors, and affiliates issued a Department identification credential to gain access to VA facilities and networks (where available) through digital access control systems, as well as to other federal government agency facilities and systems where permitted by law. The information collected on this form is protected by the Privacy Act, 5 USC Section 552(a) and maintained under the authority of 38 USC Section 501 and 38 USC Sections 901-905 in VA system of records "Police and Security Records-VA (103VA07B)". VA may make a "routine use" disclosure of the information in this system of records for the routine uses listed in this system of records, including: civil or criminal law enforcement, constituent congressional communications initiated at your request, litigation or administrative proceedings in which the United States is a party or has an interest, the administration of VA programs, verification of identity and status, and personnel administration by Federal agencies. Failure to provide all of the requested information may result in VA being unable to process your request for a Personal Identity Verification Card, or denial of issuance of a Personal Identity Verification Card. If you do not have a Personal Identity Verification Card, you may not be granted access to VA facilities or networks, which could have an adverse impact on your application to become, or status as, a VA employee, contractor or affiliate where such access is required to perform your assigned duties or responsibilities.

PAPERWORK REDUCTION ACT NOTICE: The public reporting burden is approximately 5 minutes including time to review instruction, find the information, and complete this form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the VA Clearance Officer (005E3), 810 Vermont Avenue, Washington, DC 20420.

SECTION I - APPLICANT INFORMATION

APPLICANT INFORMATION *(Completed by Applicant)*

1. LEGAL NAME OF APPLICANT <i>(Insert last, first, middle and suffix name)</i>		2. NICKNAME TO BE USED FOR APPLICANT <i>(Insert last name and first name, if applicable)</i>	
3. DATE OF BIRTH <i>(MM/DD/YYYY)</i>	4. SOCIAL SECURITY NO.	5. HOME PHONE NUMBER <i>(Include Area Code) (Optional)</i>	
6. HOME E-MAIL ADDRESS <i>(Optional)</i>		7. HOME ADDRESS	
8. SIGNATURE OF APPLICANT			9. DATE SIGNED

SECTION II - SPONSOR VERIFICATION *(Completed by Sponsor)*

PART A - APPLICANT EMPLOYMENT INFORMATION *(Completed by Sponsor)*

1. NAME AND ADDRESS OF FACILITY OR ASSIGNED DUTY STATION		2. NAME OF SPONSORING DEPARTMENT, SERVICE, OR SECTION, AND MAIL ROUTING SYMBOL	
		3. CREDENTIALS/ORGANIZATIONAL TITLE <i>(AKA Position/Job Title)</i>	4. COST CTR.
		5. WORK PHONE NUMBER <i>(If applicable)</i>	6. WORK E-MAIL ADDRESS

PART B - TYPE OF REQUEST AND EMPLOYMENT STATUS *(Completed by Sponsor)*

1. TYPE OF REQUEST			
NEW ID	RENEWAL	REPLACEMENT ID <i>(Damaged/Lost)</i>	CHANGE LEVEL OF ACCESS
2. TYPE OF CARD		3. TYPE OF ACCESS	
PERSONAL IDENTITY VERIFICATION (PIV)	VA (NON-PIV)	LOGICAL ACCESS _____ <i>(Domain)</i>	PHYSICAL ACCESS <i>(Complete Part D)</i>
4. EMPLOYMENT STATUS			
VA EMPLOYEE	CONTRACTOR	AFFILIATE <i>(Specify)</i>	TEMPORARY VA EMPLOYMENT

PART C - PHYSICAL SECURITY ACCESS DATA *(Completed by Sponsor)*

1. SPECIAL SECURITY ACCESS REQUIRED	2. SPECIFY LOCATION OF SPECIAL SECURITY <i>(i.e. tower, bldg. no., etc.)</i>	3. IS APPLICANT A KEY EMERGENCY RESPONDER, CRITICAL EMPLOYEE, OR NEITHER?
YES <i>(If "YES," Specify in Item 2)</i>	NO	EMERGENCY RESPONDER
		CRITICAL EMPLOYEE NEITHER

PART D - TYPE OF BACKGROUND INVESTIGATION FOR POSITION *(Completed by Sponsor)*

TYPE OF BACKGROUND INVESTIGATION FOR POSITION				
SAC	NACI	SECRET	TOP SECRET	OTHER <i>(Specify)</i>

PART E - CONTRACTORS, AFFILIATES, AND TEMPORARY EMPLOYMENT INFORMATION *(Completed by Sponsor)*

1. EMPLOYMENT EXPIRATION DATE /CONTRACT END DATE <i>(MM/DD/YYYY)(For Contractors, Affiliates, and Temporary Employment)</i>	2. NAME OF FIRM OR COMPANY <i>(If applicable)</i>	
	4. NAME OF RESPONSIBLE VA ORGANIZATION	5. MAIL ROUTING SYM.
3. NAME OF CONTRACTING OFFICER TECH. REPR. <i>(If applicable)</i>		

PART F - SPONSOR AUTHORIZATION AND CERTIFICATION (Completed by Sponsor)**CERTIFICATION:** I Certify under penalty of perjury that the information in Section II is true and correct.

1. NAME OF SPONSOR		2. SPONSOR CREDENTIALS/ORGANIZATIONAL TITLE	
3. CERTIFICATE NUMBER (Issued by PCI Manager or Registrar)		4. SIGNATURE OF SPONSOR	5. DATE SIGNED (MM/DD/YYYY)
6. WORK ADDRESS		7. NAME OF SPONSOR'S DEPARTMENT, SERVICE, OR SECTION	
		8. WORK PHONE NUMBER (Include Area Code)	
		9. WORK E-MAIL ADDRESS	

SECTION III - APPLICANT IDENTITY VERIFICATION (Completed by Registrar)**INSTRUCTIONS:** To be completed and signed by Registrar at the time of proofing. Review Section I - Applicant Information, and Section II - Sponsor Verification, assuring that information has been filled out correctly and signed accordingly. The identification must follow these guidelines:

- Applicant must present two (2) forms of identification from the Accepted Identification Documentation List.
- The names on the identification must match exactly (If one ID has a full middle name, and the other has a middle initial, then the initial must match).
- One State or Federal ID must contain a photograph. ● Both IDs must be original documents. ● Both IDs must be currently valid, not expired.
- Verify that the applicant has background information on file. If no evidence of a SAC exists, then capture fingerprint data and process accordingly.

PART A - BACKGROUND CHECK**1. TYPE OF BACKGROUND CHECK**

		SAC (Fingerprint Check)		NACI			OTHER (Specify)	
1A. DATE INITIATED BACKGROUND CHECK (MM/DD/YYYY)								
1B. DATE ADJUDICATED BACKGROUND CHECK (MM/DD/YYYY)								
2. FINGERPRINTS CAPTURE REQUIRED? YES NO (If "NO," proceed to Part B)		3. SEX	4. RACE	5. HEIGHT	6. WEIGHT	7. EYES	8. HAIR	9. PLACE OF BIRTH
10. NOTICABLE SCARS AND TATTOOS								

PART B - PHOTOGRAPHIC IDENTIFICATION NUMBER 1

1. EXACT NAME LISTED ON PHOTO ID		2. DOCUMENT IDENTIFICATION NUMBER		3. EXPIRATION DATE (MM/DD/YYYY)	
4. DOCUMENT TYPE		5. ISSUANCE DATE (MM/DD/YYYY)		6. ISSUING AUTHORITY	

PART C - IDENTIFICATION NUMBER 2

1. EXACT NAME LISTED ON ID		2. DOCUMENT IDENTIFICATION NUMBER		3. EXPIRATION DATE (MM/DD/YYYY)	
4. DOCUMENT TYPE		5. ISSUANCE DATE (MM/DD/YYYY)		6. ISSUING AUTHORITY	

PART D - REGISTRAR INFORMATION AND SIGNATURE

1. WORK ADDRESS		2. PRINTED NAME OF REGISTRAR	
		3. NAME OF DEPARTMENT, SERVICE, OR SECTION	
		4. WORK PHONE NUMBER (Include Area Code)	5. WORK E-MAIL ADDRESS
6. DATE APPLICANT INITIATED BACKGROUND INVESTIGATION		7. APPLICANT'S REQUEST FOR PERSONAL IDENTITY VERIFICATION CARD ACTION TAKEN: APPROVED DENIED	

CERTIFICATION: I certify that under penalty of perjury that I have examined the documents presented by the above named person, and that the above listed documents appear to be genuine and to relate to the person named.

8. SIGNATURE OF REGISTRAR		9. DATE SIGNED (MM/DD/YYYY)	
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SECTION IV - PERSONAL IDENTITY VERIFICATION CARD ACCEPTANCE**PART A - CARD INFORMATION(Completed by Issuer)**

1. NEW PIV CREDENTIAL SERIAL NUMBER	2. OLD ACCESS ID CARD NUMBER	3. EXPIRATION DATE (MM/DD/YYYY)
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PART B - PERSONAL IDENTITY VERIFICATION CARD ACCEPTANCE (Completed by Applicant)**ACKNOWLEDGEMENT:** I acknowledge receiving my identity credential and will comply with the following obligations:

- I have been provided training on the responsibilities associated with receipt of this Personal Identity Verification Card.
- I will use my Personal Identity Verification card in accordance with the training I have been provided.

CERTIFICATION: I certify that I have read and agree to the above statements and that I have received my card.

1. PRINTED NAME OF APPLICANT	2. APPLICANT SIGNATURE OF ACCEPTANCE	3. DATE SIGNED (MM/DD/YYYY)
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PART C - PUBLIC KEY INFORMATION (PKI) CERTIFICATE ACCEPTANCE (Completed by Applicant)**AUTHORIZATION STATEMENT**

You have been authorized to receive one or more private and public key pairs and associated certificates. A private key enables you to digitally sign documents and messages and identify yourself to gain access to information systems and facilities. You may have another private key to decrypt data such as encrypted messages. People and electronic systems inside and outside VA will use public keys associated with your private keys to verify your digital signature, or to verify your identity when you attempt to authenticate to systems, or to encrypt data sent to you. The certificates and private keys will be issued on a token, for example your Personal Identity Verification Card. The token and the certificates and private keys on your token are government property. Users are authorized to use the certificates within VA, as well as while conducting business with other Federal, state, and Local Government agencies.

ACKNOWLEDGEMENT OF RESPONSIBILITIES

- I represent and warrant that the information provided in application for this certificate is accurate, current, and complete. If this information changes, I will notify my Registrar of the changes;
- I will use my certificate(s) and private key(s) for official purposes only;
- I will comply with the Certificate Practices Statement for selecting a Personal Identification Number (PIN) or other required method for controlling access to my private keys and will not disclose same to anyone, leave it where it might be observed, nor write it on the token itself;
- I understand that digital signatures applied using my digital certificates carry the same legal obligation as my physically signing the document;
- I understand that if I receive key management (encryption/decryption) key pairs on my token, copies of the private decryption keys have been provided to the key recovery database in case they need to be recovered; and
- I will report any compromise (e.g., loss, suspected or known unauthorized use, misplacement, etc.) of my PIN or token to my supervisor, security officer, Certification Authority (CA), or a Registrar, immediately.

LIABILITY

I will have no claim against VA arising from use of the PKI certificates, the key recovery process, or a Certification Authority's (CA) determination to terminate or revoke a certificate. VA is not liable for any losses, including direct or indirect, incidental, consequential, special, or punitive damages, arising out of or relating to any certificate issued by a VA CA.

GOVERNMENT LAW

VA Public Key Certificates shall be governed by the laws of the United States of America.

CERTIFICATION: I certify that I have read and agree to the above statements and that I have received my PKI certificate(s).

1. FULL LEGAL NAME OF APPLICANT	2. SIGNATURE OF ACCEPTANCE	3. DATE SIGNED (MM/DD/YYYY)
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SECTION V - ISSUER (Completed by Issuer)

1. WORK ADDRESS	2. PRINTED NAME OF ISSUER	
	3. NAME OF DEPARTMENT, SERVICE, OR SECTION	
	4. WORK PHONE NUMBER (Include Area Code)	5. WORK E-MAIL ADDRESS

CERTIFICATION: I certify under penalty of perjury, that I have monitored the identity verification of the person above in accordance with applicable identity proofing processes and have witnessed that person sign this form.

6. SIGNATURE OF ISSUER	7. DATE SIGNED (MM/DD/YYYY)
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.VA Form 0711 Completion Instructions

IMPORTANT: *Carefully follow instructions for each section , especially with respect to who completes the section.*

Section I- Applicant Information

Applicant Information - Completed by Applicant

- Item 1 - Enter Applicant's full legal name. (Should match IDs)
- Item 2 - Enter any Nickname to be used for Applicant. (NOTE: Applies only to **new Applicant** that does not have an E-mail account)
- Item 3 - Enter Applicant's date of birth.
- Item 4 - Enter Social Security Number.
- Item 5 - Enter Applicant's home phone number, including area code.
- Item 6 - Enter Applicant's personal home e-mail address.
- Item 7 - Enter Applicant's home mailing address.
- Item 8 - Applicant Signature.
- Item 9 - Date Signed.

Section II - Sponsor Verification - Completed by Sponsor

Part A - Applicant Employment Information - Completed by Sponsor

- Item 1 - Enter the facility or duty station, name and address, that applicant is assigned too.
- Item 2 - Enter name of Sponsoring Department, Service, Section and Mail Routing Symbol.
- Item 3 - Enter applicant's position job title
- Item 4 - Enter cost center.
- Item 5 - Enter Applicant's work phone number (As applicable).
- Item 6 - Enter work E-mail address.

Part B - Type of Request and Employment Status - Completed by Sponsor

- Item 1 - Check applicable box.
- Item 2 - Check applicable box based on type of appointment.
- Item 3 - Check applicable box. If Logical box is checked, enter Domain name.
- Item 4 - Check applicable box.

Part C - Physical Security Access Data - Completed by Sponsor

- Item 1 - Check applicable box.
- Item 2 - Enter location where access is needed.
- Item 3 - Emergency Responder is a person who has completed forty to sixty hours of Department of Transportation approved training in providing care for medical emergencies (otherwise known as a First Responder); Critical Employee is a Designated VA official/employee who requires access to a VA facility during emergency situations.

Part D - Type of Background Investigation for Position

- Item 1 - Check applicable box.

Part E - Contractors, Affiliates, and Temporary Employment Information - Completed by Sponsor

- Item 1 - Enter employment expiration date for contractors, affiliates, and temporary employment.
- Item 2 - Self Explanatory (As applicable).
- Item 3 - Enter full legal name of Contracting Officer's Technical Representative (COTR) (As applicable).
- Item 4 - Enter Name of Responsible VA Organization.
- Item 5 - Enter Mail Routing Symbol.

Part F - Sponsor Authorization and Certification - Completed by Sponsor

- Item 1 - Enter name of sponsor.
- Item 2 - Enter Sponsor Credentials and Organizational Title.
- Item 3 - Enter Certificate Number which is issued by the Registrar. Contact your Registrar if you do not know the number.
- Items 4-9 - Self explanatory.

Section III- Applicant Identity Verification - Completed by Registrar

Picture ID From Federal or State Government

State-Issued Drivers License
State DMV-Issued ID Card
U.S. Passport
Military ID Card
U.S. Coast Guard Merchant Mariner card
Foreign Passport with appropriate stamps
Permanent Resident Card or Alien Registration
Card with a photograph (INS Form I-151/I-551)
ID Card issued by federal or state government agencies

Non-Picture ID or Acceptable Picture ID not issued by Fed. or State Gov't

Social Security Card
Certified Birth Certificate
State Voter Registration Card
Native American Tribal Document
Certificate of U.S. Citizenship (INS Form N-560 or N-561)
Certificate or Naturalization (INS Form N-550 or N-570)
Certification of Birth Abroad Issued by the Department of State
(Form FS-545 or Form DS-1350)
Permanent or Temporary resident card
ID Card issued by local government agencies provided it includes
the following information: name, date of birth, gender, height,
eye color, and address
Non-photo ID Card issued by federal or state government agencies
provided it includes the following information: name, date of birth,
gender, height, eye color, and address
School ID with photograph
Canadian Drivers License
U.S. Citizen ID Card (Form I-179)

Part A - Background Check - Completed by Registrar

Item 1A - Enter date initiated background check for SAC, NACI, or Other (specify)
Item 1B - Enter date adjudicated background check for SAC, NACI, or Other (specify)
Item 2 - Check applicable box.
Item 3-9 - Self explanatory
Item 10 - Enter all noticable scars and tattoos and other distinguishable features.

Part B - Photographic identification number 1 - Completed by Registrar

Item 1 - Enter the full exact name as seen on the Applicant's ID.
Item 2 - Enter IDs number. (i.e. license number, passport number)
Item 3 - Enter date that ID number 1 expires.
Item 4 - Enter the type of ID presented. (i.e. Virginia state issued drivers license)
Item 5 - Enter date that the ID was issued to the Applicant.
Item 6 - Enter name issuing ID. (i.e. Department of State, State of Maryland)

Part C - Identification number 2 - Completed by Registrar

Item 1-6 - Same as Part A, only with a second form of an acceptable ID

Part D - Registrar information and signature - Completed by the Registrar

Item 1-5 - Self Explanatory
Item 6 - Enter Date applicant initiated background check.
Item 7 - Check appropriate box.
Item 8-9 - Self Explanatory

Section IV- Personal Verification Identity Card Acceptance

Part A - Card Information - Completed by Issuer

Item 1 - Enter new PIV card serial number.

Item 2 - Enter old PIV card serial number (As applicable)

Item 3 - Enter expiration date of new PIV card

Part B - Personal Verification Identity Card - Completed by Applicant

Item 1- 3 - Self Explanatory

Part C - Public key information (PKI) certificate acceptance - Completed by Applicant

Item 1 - Enter full legal name of Applicant.

Item 2-3 - Self Explanatory

Section V - Issuer

Item 1-7 - Self Explanatory

NATIONAL PROVIDER IDENTIFICATION NUMBER

To all Residents and Fellows,

Provisions of the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* mandate the adoption of a standard unique identifier for health care providers. The National Plan and Provider Enumeration System (NPPES) will collect identifying information from health care providers and issues a unique National Provider Identifier (NPI).

The Veterans Administration requires that all resident and fellow physicians who rotate at the VA obtain their National Provider Identification (NPI) number before training/working in a VA facility – whether currently working at the VA, continuing in future rotations, or incoming for a new academic year.

If you do not currently have an NPI number, you must apply for your NPI number and provide this to your VA contact person, listed by service below, as well as to Ms. Johanna Rubin, Compliance Officer. You should do this as soon as possible, but preferably within two weeks of your receipt of this packet.

Estimated time to complete the NPI application form is 15 minutes. NOTE: Be sure to use the 'Next' & 'Previous' keys located at the bottom of the page, do not use the Internet Server's 'Back' & 'Forward' keys.

Instructions for those who already have an NPI:

1. If you have previously obtained an NPI number, please go back into the NPPES application and update the application using this link:
<https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart>
 - Go to NPPES login- enter in your NPI ID and password. If you have forgotten this information, please call 1-800-465-3203. Ask for the NPI specialist. They will provide you with the information.
 - Select five 'Secret Question'(s) (these will assist you in resetting your password).
 - Clicking “Next” will direct you to the application
 - Please identify personal information as it is recognized in your legal documents (e.g. passport, visas, etc.).
 - Note, unless you have a private practice as your primary practice location, you are **NOT** a 'Sole Proprietor' **Answer to this question is NO**
 - "Domestic Mailing Address Information"- **Note:** The address you provide is viewable by the public. You may elect to use the SUNY Downstate program mailing address:

Department SUNY Downstate Medical Center
450 Clarkson Avenue Box 1262
Brooklyn, New York 11203
(718) 270-8867

- Domestic Practice Location Information: Please indicate your SUNY Downstate program address:

Department SUNY Downstate Medical Center
450 Clarkson Avenue Box 1262
Brooklyn, New York 11203
(718) 270-8867

- Contact information: Make sure you are the contact person with your personal e-mail address (the contact information is not viewable by the public). Remember you are the sole owner of the NPI application and number. This number will be asked for and used many times during your career and will need to be updated accordingly.
- If you have an additional taxonomy number other than 390200000X you can keep that number also however, **you must use the 390200000X as primary.**
- *FOREIGN NATIONALS: YOU MUST OBTAIN AN NPI NUMBER AFTER YOUR ARRIVAL TO THE US AND HAVE OBTAINED A SOCIAL SECURITY NUMBER.*

You must also include your NPI number on line 8C on the official application for 'Health Professions Trainees' (VA Form 10-2850D, which is included in the front of the resident application packet).

Please see the following directions for the step-by-step instructions for applying for your NPI number. Once you have received your NPI number, **please copy the NPPES e-mail message that lists** your NPI number and e-mail or deliver it in hard copy to the appropriate contact listed below.

INSTRUCTIONS for those who are applying for the first time:

Estimated time to complete the NPI application form is 20 minutes. NOTE: Be sure to use the "Next" & "Previous" keys located at the bottom of the page, do not use the Internet Server's "Back" & "Forward" keys.

- ✓ Make sure you have the following information available **BEFORE** you begin the application process:
 - Provider Name (your name as it appears in legal documents)
 - SSN- Social Security Number
 - Provider Date of Birth
 - Country of Birth
 - State of Birth (*if Country of Birth is U.S.*)
 - Provider Gender
 - Mailing Address of your school/program and phone number
 - Practice Location Address and Phone Number (school/program)

When asked to select a taxonomy, go to Allopathic/Osteopathic, scroll down to 39 and select

 - Taxonomy (Provider Type)
 - * Student in an Organized Healthcare Education/Training Program 390200000X
 - State License Information if applicable

-Contact Person Name - that is YOU

-Contact Person Phone Number and E-mail - That is YOU

2. Access the National Provider Identifier website through the following link:
<https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart>
3. Click on the highlighted link "Apply Online for an NPI"
4. Read through the instructions and click on Step 3. 'Begin Application Form'
5. You will be routed to the 'NPI Application Form - Create NPI User ID and Password' page
 - a. Respond to everything on this page
 - b. Choose an NPI User ID (make this something that you would remember, as you will be using the ID a password throughout your career) - Personal information, such as a Social Security Number, should not be used as the User ID. The User ID can contain a maximum of four digits.
 - c. Choose an NPI Password (Password must be 8-12 characters long, contain at least one letter, one number, no special characters, and not be the same as the User ID.)
 - d. Select five 'Secret Question'(s) (these will assist you in resetting your password).
 - e. Clicking 'Next' will direct you to the application
6. Please identify personal information as it is recognized in your legal documents (e.g. passport, visas, etc.).
7. Note, unless you have a private practice as your primary practice location, you are **NOT** a 'Sole Proprietor'
8. 'Domestic Mailing Address Information'- Note: The address you provide is viewable by the public. You may elect to use the mailing address of the SUNY Downstate Medical Center program address.
9. 'Domestic Practice Location Information': Please indicate your UMDNJ program address.
10. 'Add Identifier' If you have knowledge of any legacy/identifiers (such as HFS Provider Number or UPIN) please include these. Generally, this will not apply and you can leave this blank.
11. 'Add Taxonomy': As an intern, resident or fellow, you must identify yourself as **390200000X: Student in an Organized Health Care/ Education/ Training Program**
12. 'Contact Person Name': You are the contact person,
13. **IMPORTANT:** The "Contact Person Email" is the email address where you will receive your NPI confirmation letter and NPI Number. **Please make sure that it is a working address (e.g. not your medical school address, which may expire shortly after graduation).** Make sure to keep a hardcopy of this email for future reference.
14. You are finished! Make sure to mark the **[X]** on the Certification Statement and Submit.
15. You will be given a Tracking Number and should receive a confirmation email from NPPES with your NPI. If you do not receive this confirmation email within 15 days, call NPPES @ 1-800-465-3203. An NPI Specialist will be able to assist you. Generally, we have found that NPI confirmation letters arrive within 10 to 15 minutes of your successful application submission.

First time applying:

DIRECTIONS FOR A RESIDENT PHYSICIAN TO OBTAIN A NATIONAL PROVIDER IDENTIFICATION NUMBER (NPI NUMBER)

The National Provider Identification (NPI) number is a unique 10-digit numeric identifier mandated by the Health Insurance Portability and Accountability Act (HIPAA) for all clinicians for billing and for ordering patient care services (e.g., nursing home care, visiting nurse, etc.). Although a NPI number is generally not required of a resident physician, **at the VA NY Harbor all resident pharmaceutical orders are required by law to be billed (when appropriate) to third-party carriers and the resident's NPI number must accompany this bill.** To satisfy this statutory regulation the VA NY Harbor requires all resident physicians to obtain NPI numbers before their rotation at the Medical Center. The NPI number application process is web-based, free-of-charge and yields a lifetime NPI number assignment. You must securely maintain your NPI number and, as you advance in your career, must update the required personal data as necessary. These directions will assist in the application for your NPI number.

Tips before you start: (a) the NPI number application must be completed in one sitting (will take approximately 15 minutes); (b) if you are licensed, have this information ready (N.B., medical licensure is not required to obtain a NPI number); (c) move smartly though the application or risk a "time-out" that will require you to start over with a new ID and password (data is not saved with a premature termination of the application process); (d) use only the "BACK" and "FORWARD" buttons on the bottom of the page; (e) you must create a USER ID and PASSWORD that must be saved to log-on in the future should you need to change any information; (f) the mailing address of your practice is:

Department SUNY Downstate Medical Center
450 Clarkson Avenue Box 1262
Brooklyn, New York 11203
(718) 270-8867

DIRECTIONS: (Please print copies of each screen and save in a folder for future use)

1.	Google 'NATIONAL PROVIDER IDENTIFIER ENUMERATION SYSTEM' (National Plan and Provider Enumeration System)
2.	NPPES website: Click on 'NATIONAL PROVIDER IDENTIFIER (NPI)'
3.	Click on 'APPLY ONLINE FOR AN NPI'
4.	Please read 'INFORMATION REQUIRED FOR INDIVIDUAL PROVIDERS'; scroll down and click 'BEGIN APPLICATION FORM'
5.	Create a USER ID and PASSWORD (SAVE – required for future log-on to change data)
6.	Select the secret question (ex.: mother's maiden name)
7.	Select radio button → TYPE 1
8.	Provider Profile Question 'Is Provider a Sole Proprietor'? → NO
9.	Domestic Address: Applicant's home address : 10. SUNY Downstate Medical Center 11. 450 Clarkson Avenue, Box 1262 12. Brooklyn, NY 11203 13. (718) 270-8867

14.	Address Standardization: Select → Accept Standardized Address box
15.	Domestic Practice Location: Use address : 16. SUNY Downstate Medical Center 17. 450 Clarkson Avenue, Box 1262 18. Brooklyn, NY 11203 19. (718) 270-8867
20.	Phone Number: (718) 270-8867
21.	Other Identifiers: Skip & select → NEXT
22.	Other Identifiers: Select → CANCEL
23.	Taxonomy: Select → ADD TAXONOMY select 39 (Student Health Care)
24.	Taxonomy (cont'd): select → 390200000X (Student Health Care*) * this is the <u>only</u> selection to be used for all residents and fellows
25.	If you do not have a license number select → SAVE (Print & keep with your records)
26.	Contact Person: Select → SAME AS PROVIDER
27.	Certification: Check & submit
28.	<u>Save tracking number</u> (needed if an error is made or NPI number hasn't e-mailed in timely manner)

TRACKING NUMBER: _____

IMPORTANT:

After receiving your NPI number, please e-mail a copy of the NPPES email to your VA Contact Person as directed in the accompanying letter. Also, KEEP A COPY FOR YOUR RECORDS.

If you have any problems please contact your VA Contact Person at the extension listed or e-mail address provided to you.

OR

**Contact Johanna Rubin, Compliance Officer, 917-364-5176.
You can leave a voice mail with name and phone number.**

PLEASE KEEP A COPY OF THE NPPES E-MAIL FOR FUTURE USE.

Thank you very much for your attention to this request.

VA Brooklyn Campus telephone number is (718) 836-6600

Dermatology

Representative: Ms. Cindy Farley Ext.3725 / Fax: 718-630-2881
Representative's email: Cindy.Farley@va.gov

Medical Service

(Includes all medical fellowships)
Representative: Ms. Dawn Matera Ext.6504 / Fax: 718-630-3761
Representative's email: Dawn.Matera@va.gov

Pathology & Laboratory Medicine

Representative: Ms. Vera Kol Ext.4822 / Fax: 718-630-3688

Representative's email: Vera.Kol@va.gov

Mental Health

Representative: Ms. Regina Pierce Ext.3733, 4120 / Fax: 718-630-2951

Representative's email: Regina.Pierce@va.gov

Radiology

Representative: Ms. Maria Cruz Ext.3689 / Fax: 718-630-2966

Representative's email: Maria.Cruz@va.gov

Radiation Oncology

Representative: Mr. Loohvy Phildor Ext.6557 / Fax: 718-630-2857

Representative's email: Loohvy.Phildor@va.gov

Surgery

(Includes all surgical specialties)

Representative: Mr. Martin Kaufman Ext. 3706, 6829/ Fax: 718-630-3707

Representative's email: Martin.Kaufman@va.gov



MANDATORY TRAINING

All residents must complete mandatory training before being granted access to the VA computer system. Self-enrollment Talent Management System (TMS) process requires trainees to enter the following information that is specific to your facility. If the self-enrollee is missing any of this required information, they will not be able to self-enroll in TMS.

After completing the online training, please print out a certificate and include it with your application.

When registering, use your SUNY Downstate address.

Trainees will self-enroll in TMS at <http://www.tms.va.gov> and click on *Create New User*. Please refer to the user job aid (attached) for step-by-step instructions for creating a new non-VA user record

***Please note: For step 5, you must use your VA Service Representative's first name, last name, and e-mail address.**



User Job Aid: Create New non-VA User Record

Purpose

The purpose of this job aid is to guide users through the step-by-step process of creating the Create New User tool in the VA TMS. In this job aid you will learn how to:

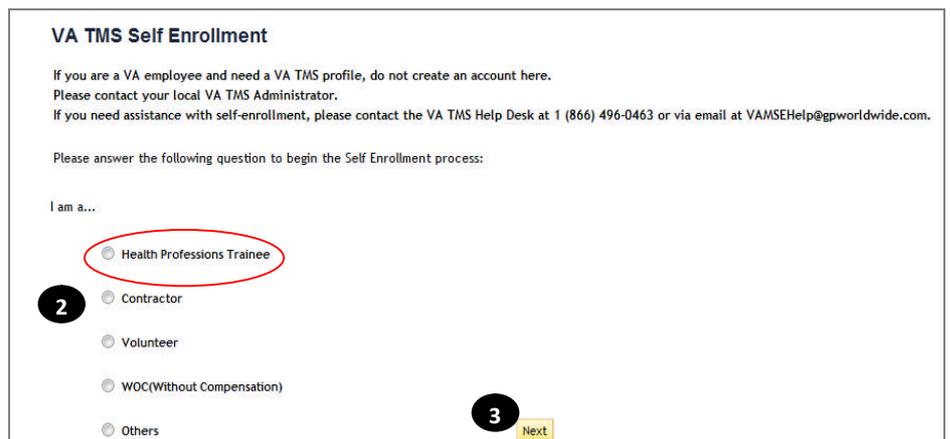
- A. Create New User Record 9 Steps
- B. Complete Required Training 6 Steps

Task A. Create New User Record

1 Step 1
From the Login page, in the **brown** navigation bar click the **Create New User** link.



2 Step 2
In the **VA TMS Self Enrollment** page, select **Health Professions Trainee** radio button.



3 Step 3
Click **Next**.



4 Step 4
In **My Account Information** section, fill in all required fields as noted by the red asterisk, taking care to type accurately when entering your Social Security Number, e-mail address, and legal name; proceed to **Step 5**.

4a Step 4a
If you are a foreign national, click the **click here** link.

4b Step 4b
If there is a security pop-up click **Allow**.

4c Step 4c
In the email pop-up add any additional information to assist the Admin, such as your name and contact information, then click **Send**.

Note: Fields marked with * are required

My Account Information

- The length of the password must be between 8 and 12 characters.
- The password must contain the following types of characters:
 - English lowercase letters.
 - English uppercase letters.
 - Arabic numerals(0,1,2,...9).
 - Non alphanumeric special characters (!@#5%^&*()-_+=[]{}<>?/";:|)
- Characters cannot be repeated more than twice in a row.
- The password cannot contain user name(login ID).
- The password cannot contain users first name and last name.
- The password cannot be the same as any of the previous 3 passwords.
- The password cannot contain 6 or more characters in a row from the previous password.
- Password cannot be same as the E-Signature PIN.

* Password :

* Re-enter Password :

* Security Question :

* Security Answer :

* Re-enter Security Answer :

* SSN : - -

(If you are foreign national and do not have an SSN please [click here](#))

* Re-enter SSN : - -

* DOB (MM/DD/YYYY) :

* Legal First Name :

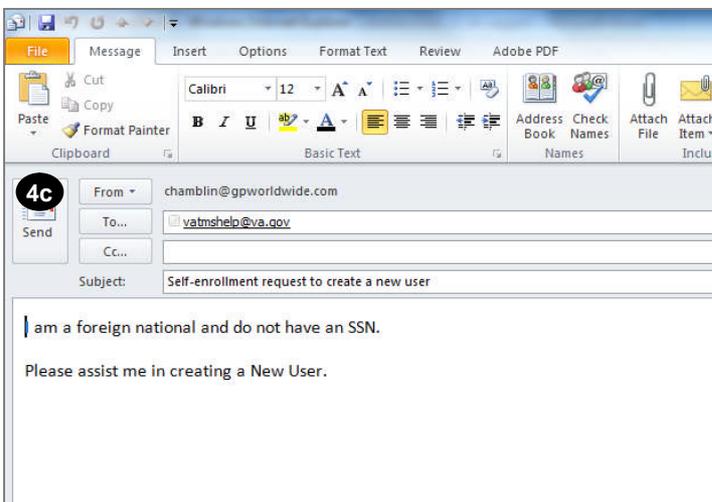
* Legal Last Name :

Middle Name(Optional) :

* Email Address :

* Re-enter Email Address :

Phone Number (do not include hyphens i.e 1112223333) :





5 Step 5
 In **My Job Information** section, fill in all required fields as noted by the red asterisk, entering the data provided by your VA point of contact where appropriate. VA location code is NYN

6 Step 6
 You are required to take training on the Health Insurance Portability and Accountability Act (HIPAA). Click the box.

7 Step 7
 Click **Submit**.

8 Step 8
 From the congratulations page, note your VA TMS USER ID for future use.

9 Step 9
 Click **Continue**.

My Job Information

VA City :

VA State :

* VA Location Code : **5**
 (Supplied by your VA Contract)

* VA Point of Contact First Name :

* VA Point of Contact Last Name :

* VA Point of Contact Email Address :

Point of Contact Phone Number (do not include hyphens i.e. 1112223333) :

HIPAA Training Required : **6**

7

VA TMS Self Enrollment

Congratulations! You have successfully created a profile in the VA TMS. Please copy down the User ID indicated below. You will need it if you ever need to log in to the VA TMS in the future.

Your VA TMS User ID is sample.john1105 **8**

To access your mandatory training content, click on the Continue button.

9



Task B. Complete Required Training

1 Step 1
From the Home page, hover over item in your To Do List to display the pop-up menu.

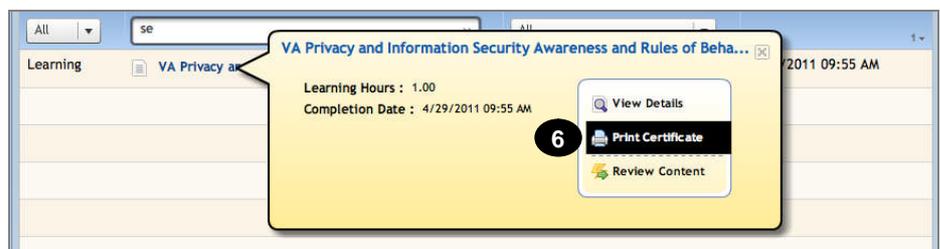
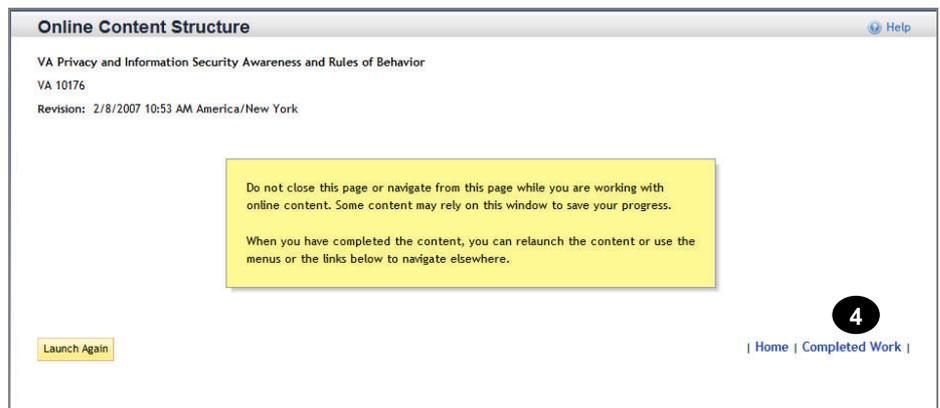
2 Step 2
Click Go to Content.

3 Step 3
Complete training per instructions.

4 Step 4
On the Online Content Structure page, click the Completed Work link.

5 Step 5
From the Completed Work page, hover over the title of the completed training to display the pop-up menu.

6 Step 6
Click Print Certificate.



UNITED STATES DEPARTMENT OF VETERANS AFFAIRS
NEW YORK HARBOR HEALTHCARE SYSTEM - Brooklyn Campus

NEW PERSON REGISTRATION WORKSHEET

PLEASE COMPLETE CLEARLY AND LEGIBLY

LAST NAME	FIRST NAME	MIDDLE INITIAL
SOCIAL SECURITY NUMBER	Date of Birth (MM/DD/YYYY)	SEX (circle one)
		MALE FEMALE
INDICATE PRIMARY DEGREE	INDICATE TRAINING LEVEL	ACADEMIC AFFILIATION
MD(144) DO (145)	Resident Fellow	SUNY Downstate Medical Center
INDICATE IF RESIDENT OR STUDENT	VHA TRAINING FACILITY	
Resident Student	NYHHS - Brooklyn Campus	
STARTING DATE OF TRAINING	LAST TRAINING MONTH & YEAR (when training is complete)	
July 1, 2013		
NEW YORK AREA Home Street Address (ONLY NY address)		
City	State	Zip Code
E-Mail Address (use SUNY Downstate e-mail address)		
Circle the correct response: Do you currently have a VISA?		
Yes	Not Applicable	No, but I will before I arrive to the U.S.
Circle the correct response: If you currently have a VISA, have you attached a copy of the VISA to this worksheet?		
Yes	No	Not Applicable

DO NOT FORGET TO ANSWER ALL QUESTIONS. THIS IS USED TO ENTER YOUR INFORMATION INTO THE VA COMPUTER SYSTEM.

Date Completed

Signature