CLEAR APP INFO

APPLICANT PROCESSING PACKET

CLEAR UNIT INFO

APPLICANT INFORMATION

LAST, FIRST MIDDLE	
LAST, FIRST MI.	
FIRST NAME, MI	
LAST NAME	
SSN	
LAST 4	
DOB YYYYMMDD	MMDDYYYY
POB CITY	
POB STATE	
POB COUNTY POB	
COUNTRY	
AGE	
HT IN INCHES	
WT	
RANK	
PAY GRADE	
CURRENT ADDRESS	
CURRENT CITY	
CURRENT STATE	
CURRENT ZIP	
CURRENT CELL	
EDUCATION LEVEL	
MARRIED (MARK X)	
SINGLE (MARK X)	
MALE (MARK X)	X
FEMALE (MARK X)	
TODAYS DATE	

SGLV INFORMATION

LIFE INS PRIM FIRST MI. LAST	
PRIMARY ADDRESS	
PRIMARY CITY	
PRIMARY ST	
PRIMARY ZIP	
PRIMARY RELATIONSHIP	
LIFE INS SEC FIRST MI. LAST	
SECONDARY ADDRESS	
SECONDARY CITY	
SECONDARY STATE	
SECONDARY ZIP	
SECONDARY RELATION	

UNIT INFORMATION

RSP ADDRESS	Richmond, Ky. 40475
UNIT NAME	B Co. Det 1 (RSP)
UNIT ADDRESS	233 Battlefield Memorial Hwy
UNIT CITY	Richmond,
UNIT STATE	KY
UNIT ZIP	40475
UIC	W90UB1
PRN	811

RECRUITER INFORMATION

REC LAST, FIRST MI	Horn, Tony B.
RANK	SFC
GRADE	E-7
PHONE	(859) 329-9574
TITLE	RRNCO
RR ORGANIZATION	B CO DET 1 KY R&R BN
ADDRESS	1812 Irvine Road
CITY	Richmond,
STATE	KY
ZIP	40475
EMAIL	TONY.B.HORN2.MIL@MAIL.MIL
RSID	KYKG

EDIT DA 3865

EDIT HS LETTER

EDIT TATTOO FORM

EDIT PARENTAL CONSENT

Armed Forces Bank

PRINT HS LETTER

PRINT PC AND HS LETTER

PRINT PC

United States Military Entrance Processing Command Prescreen Cover Sheet (v20180601)

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, DoD Instruction 6130.03, and E.O. 9397, as amended (SSN).
PRINCIPAL PURPOSE(S): The primary collection of this information is from individuals seeking to join the Armed Forces. The information collected on this form is used to assist DoD physicians in making determinations as to acceptability of applicants for military service and verifies disqualifying medical condition(s) noted on the prescreening form (DD 2807-2). An additional collection of information using this form occurs when a Medical Evaluation Board is convened to determine the medical fitness of a current member and if separation is warranted. Completed forms are covered by recruiting, medical evaluation board, and official military personnel file SORNs maintained by each of the Services.

ROUTINE USE(S): The Blanket Routine Uses found at http://dpcld.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx apply to the use of this data.

DISCLOSURE: Voluntary. However, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. An applicant's SSN is used during the recruitment process to keep all records together and when requesting civilian medical records. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status. The SSN of an Armed Forces member is to ensure the collected information is filed in the proper individual's record.

1. Service Liaison-To be completed by Liaison: Initial Submission ☐ 1st Resubmission ☐ 2nd Resubmission ☐ 3rd Resubmission

Applicant Name:_____SSN:_____SPF:_____

Date received from Recruiter:_____Date & Time of Submission to Files Room:_____# of Pages:_____

Maximum # of Business Days:_____ Calculated Date of Completion:_____Submitting Liaison's Name:_____

2. Service Liaison DOUBLE CHECK the following on the Prescreen Packet

1. Is the 2807-2 dated within 90 days?	Yes ☐	No ☐	
2. Do the SSN & Name match?	Yes ☐	No ☐	
3. Are DOB, height & weight filled and valid?	Yes ☐	No ☐	
4. Are birth sex and preferred gender annotated on Section 3 of DD Form 2807-2?	Yes ☐	No ☐	
5. Are all "YES" answers explained on Section 3 of DD Form 2807-2?	Yes ☐	No ☐	
6. Are applicant, recruiter & parent (if minor) signatures present?	Yes ☐	No ☐	
7. Is a DD Form 1966/5 attached (if applicant is under 18 years old)?	Yes ☐	No ☐	N/A ☐
8. Are DD 214 / NGB 22 / DD 368 / MFR and/or REDD report attached? (if Prior Service)	Yes ☐	No ☐	N/A ☐
9. Is a braces letter attached? (if applicable)	Yes ☐	No ☐	N/A ☐
10. Are all medical documents submitted IAW USMEPCOM guidance?	Yes ☐	No ☐	
11. Have you reviewed documents to ensure they are not duplicates or previously submitted documents?	Yes ☐	No ☐	
12. Are **all required/requested** medical documents for every medical condition submitted?	Yes ☐	No ☐	

3. Files Room – To be completed by Files Room personnel only

Date & Time Received from Liaison_____ Received by:_____

4. Medical Department – To be completed by Medial Provider and/or Technician only

Date & Time Received From Files Room: _____ Received by: _____

4a. Medical prescreen records have been reviewed by a Medical Technician:

☐ Prescreen Meets Criteria for Medical Provider Review

☐ Prescreen Incomplete:_____

_____

Date & Time Reviewed:_____ Technician Reviewing the Prescreen:_____

Applicant Name:_____SSN:_____

4b. Medical prescreen records meets criteria for Medical Provider review

Date & Time Given to CMO/ACMO:_____ Received by:_____

Date & Time Given to Reviewing Provider:_____Provider Reviewing the Prescreen:_____

4c. Medical information has been reviewed by a MEPS provider and is **complete**:

☐ Processing Authorized (PA) ☐ Processing Hold (PHJ) ☐ Other:_____

☐ Processing Not Justified (PNJ) ☐ Processing Requested by SMWRA (PRW)

4d. Medical information has been reviewed by a MEPS provider and **is not complete** and require(s) (METR):

☐ Pre-operative / operative note / post-operative note: _____

☐ Last follow up visit: _____

☐ All medical documents for the past_____

☐ Pathology report for:_____

☐ Pharmacy records for:_____

☐ All medical documents from military treatment facility related to reason for discharge.

☐ Current Ortho-Surgical evaluation with documentation of release from care without limitations.

☐ PCP / Specialist evaluation regarding _____with diagnosis, prognosis, treatment plan, and functional limitations, including documentation of release from care without limitations.

☐ Other:_____

_____

4e. MEPS Medical Personnel Only

Same information requested: 1st Time Date: _____ 2nd Time Date: _____ 3rd Time & "N" status date: _____

New non-disclosed medical information discovered upon review: Yes ☐ No ☐

Calculated Date of Completion MET: Yes ☐ No ☐

Date & Time Completed: _____Reviewing Provider:_____

Date & Time Returned to Files Room: _____Returned by:_____

Received by:_____

Additional Notes:

_____

_____

_____

_____

_____

United States Military Entrance Processing Command Prescreen Continuation Sheet (v20180601)

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, DoD Instruction 6130.03, and E.O. 9397, as amended (SSN).
PRINCIPAL PURPOSE(S): The primary collection of this information is from individuals seeking to join the Armed Forces. The information collected on this form is used to assist DoD physicians in making determinations as to acceptability of applicants for military service and verifies disqualifying medical condition(s) noted on the prescreening form (DD 2807-2). An additional collection of information using this form occurs when a Medical Evaluation Board is convened to determine the medical fitness of a current member and if separation is warranted. Completed forms are covered by recruiting, medical evaluation board, and official military personnel file SORNs maintained by each of the Services.

ROUTINE USE(S): The Blanket Routine Uses found at http://dpcld.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx apply to the use of this data.

DISCLOSURE: Voluntary. However, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. An applicant's SSN is used during the recruitment process to keep all records together and when requesting civilian medical records. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status. The SSN of an Armed Forces member is to ensure the collected information is filed in the proper individual's record.

Applicant Data

Applicant Name: _____ SSN: _____ SPF: _____

Additional Notes and/or Corrections

PRINT NASHVILLE

Nashville MEPS Applicant Processing Request Form (Jan2016)

Note: Areas that are highlighted in yellow are drop down menus.

	PS
	NPS/GNPS/PS

Applicant Last Name **First Name** **Middle Name** **Suffix**

Applicant's PRID **Gender** FEMALE **Age** **Education Level**

THE FOLLOWING IS BEING REQUESTED FOR THE APPLICANT

1. **Processing Date** **Enlisting Same Date** YES **Hotel** YES

2. **Projection Type** PHYSICAL ONLY

3. **High School Pull needed?** YES **High School** **City/State**

Date of Test

4. **Does your applicant need Testing?** YES **Select Testing Type** PHYSICAL ONLY

5. **Does your applicant need Special Testing?** YES **Select Type** NO SELECTION NEEDED

6. **Does your applicant need Medical Processing?** YES **Select Medical Type** NO SELECTION NEEDED

7. **Does your applicant require special Medical Processing? If so, select option:** NO SELECTION NEEDED

8. **If your applicant requires a consult, please select type.** NO SELECTION NEEDED

8. **Has your applicant processed with another service?** YES **Select Branch** NO SELECTION NEEDED

9. **Do you require additional services?** YES **Select Type** NO SELECTION NEEDED

SFC Horn, Tony B.	KYKG	(859) 329-9574
Type/Print RRNCO Name	**RSID**	**Contact Phone Number**

Email add: TONY.B.HORN2.MIL@MAIL.MIL

REMARKS:

This form MUST be faxed/emailed in with your Applicant signed and initialed USMEPCOM 680-3-AE and DD Form 2807-2. If your applicant is GPS or PS, you will need to include the LONG form DD 214 or NGB form 22 for the last period of service. If your applicant requires an RE-Code waiver, you must provide approved administrative waiver with the above mentioned documents (per USMEPCOM Reg 40-1, para 5-15a). In addition, Parental consent must accompany this request for applicants 17 years of age. The RRNCO should have all processing documents sent to the MIRS clerk NLT 10:30, 72hrs in advance so packets can be processed and turned into Operations by 1100.

*****EMAIL IS PREFERABLE*****

david.a.hiatt2.mil@mail.mil;carl.e.chellman.civ@mail.mil; megan.i.christopher.mil@mail.mil;jesus.j.merino.mil@mail.mil; danielle.n.sanchez4.mil@mail.mil

MEPS: Phone: (615) 741-5006 **FAX:** (615) 831-1815 **Maxwell House Hotel:** (615) 259-4343

Packet Check Sheet

SSN: **DOB:**

Phone: **ADDRESS:** KY

	2807	**PASSPORT**	
	680	**MARRIAGE LICENSE**	
	1199	**CHILD BIRTH CERTS (If more than two you will need waiver)**	
	AOC / SUBMITTED DATE:	**WIFE BIRTH CERT/DL/SSN**	
	SF86	**FINGER PRINTED DATE**	
	PRENTAL CONSENT	**(PRIOR TO TRANSMISSION OF FINGERPRINTS SEE NOTE 1 AND 2) FINGER PRINTS TRANSMISSION DATE:**	
	BIRTH CERT	**UNIT**	
	DL- CURRENT ADD/ EXPIRATION	**MOS**	
	SSN- ENSURE THAT IT IS SIGNED	**VCN REQUESTED DATE**	
	HS JR-HS LETTER AND TRANS	**VCN RECIEVED**	
	HS SR-HS LETTER AND TRANS	**WAIVER DOCS**	
	HS DIPLOMA	**PRIOR TO RZ PROJECTION SEE NOTE 5**	
	GED (MUST HAVE HS TRANS)	**EMAILED PROJECTION**	
	COLLEGE TRANS FOR PROMO	**TEMP RESERVATION PULLED**	
	SIGNED 369	**ALL DOCS SCANNED INTO RZ**	

PROCESSING FINGURE PRINTS

1-ENSURE ALL CHARGES ARE DOCUMENTED IN MORAL SECTION OF RZ
2-YOU MUST SCAN IN LIVE SCAN SHEET (EBC RELEASE) AND 369 (EBC RELEASE 369) IN RZ BEFORE PROJECTION
3-PROJECT AS- ADMINISTRATIVE ONLY/ SVC PROCESSING
4-TRANSMIT FINGURE PRINTS IN TRANSMISSION MANAGER **(DON'T TRANSMITT UNTIL YOU HAVE AOC)**
5-PRIOR TO PROJECTION CHECK RZ /ELECTRONIC PACKET/ WAIVER DOC'S FOR EBC RESULTS.

SUBJECT LINE WILL READ: REQUEST FOR LIVE SCAN RESULTS

RZ CHECKLIST

Questionnaires	Status	NOTES	Questionnaires	Status	NOTES
Recruiter:					
680-3A-E			Parental Consent		
Foreign Languages			Test Scores		
Beneficiaries			Remarks Review		
Name Preference			Source Documents		
Recruiter/Applicant Input:					
Instructions			Employment / Military Service History		
Person			Military Service Schools		
Physical Screening Criteria			Foreign History		
Personal Screening Criteria			Background/Investigation		
Moral Screening Criteria			Education		
Technology Information			Financial History		
Group/Member Associations			Family & Associates		
Contact Method			Citizenship		
Aliases			Character References		
Residences			Optional Comments		

-Ensured that applicant has Driver's license not instructional permit for MOS that requires DL _____

MOS that require DL: 88M 12M 12N 31B 88M 89D 92F 12C 31E 56M

ORDER OF DOCUMENTS FOR ENLISTMENT PACKETS (PRIOR TO SENDING TO CONTROL DESK) NASHVILLE MEPS ID B29

DOCUMENT	NOTES	SIGNED	SCANNED	LOADED
AOC	SCAN UNDER 369 KY STATE			
369	SIGNED 369 ,COURT DOCS AND 369's CURRENT AND PREVIOUS RESIDENCE IF NOT SAME COUNTY			
SEX OFFENDER	ENSURE NAME DATE AND SS# OF APPLICANT AND NAME OF RECRUITER ARE PRINTED ON FORM			
ANY COURT DOCUMENTS/TICKETS	ENSURE THAT COURT DOCUMENTS HAVE FINES PAID IF NOT GET RECIEPT			
SF 1199A (DATED DOE)	1199-3865 save as LASTfirst SF1199			
WAIVER COVER SHEET	IF APPLICABLE			
APP BIRTH CERTIFICATE	ENSURE THAT NAMES MATCH ON BC AND SSN CARD			
APP SSN CARD	ENSURE THAT CARD IS SIGNED			
APP DRIVERS LICENSE AND/OR STATE ID	VERIFY THAT DL/ID IS NOT EXPIRED. ID AND PERMIT WILL SCAN UNDER (VALID STATE ID OR PERMIT			
APP PASSPORT	IF APPLICABLE AND CURRENT			
EDUCATION DOCUMENTS	HS LETTER W/ TRANSCRIPTS, HS DIPLOMA, COLLEGE TRANSCRIPTS (IF NOT SHIPPING WITHIN 120 DAYS MUST HAVE COLLEGE ENROLLMENT LETTER), COLLEGE DEGREE			
MARRIAGE CERTIFCATE				
DEPENDANTS SSN CARDS	SCAN EACH ON SEPARATE PAGE IN ONE PDF FILE			
DEPENDENTS BIRTH CERTIFICATES	SCAN EACH INDIVIDUALLY			
SPOUSE DL				
STUDENT LOANS	IF APPLICABLE			
DD 2058 (Dated DOE)	SCAN UNDER DD2058			
STATE SPECIFIC FORMS (Dated DOE)	SF 312, **DD2760**			
STATE INCENTIVE FORMS (Dated DOE)	TUITION AWARD LETTER			
SGLV 8286, SGLV 8286A (Dated DOE)	IF APPLICABLE			
VCN	SCAN AS UNIT VACANCY STATEMENT			
IRS W-4 (Dated DOE)				
DD 2983 (Dated Date Meet)				
TATTOO FORM (Dated DOE)	SCAN UNDER USAREC FM 1241 ENLIST			
PARENTAL CONSENT	1966 PAGE 5			

The signatures dates on the 680AE's and Prescreens cannot be over 60 calendar days old (when they come to MEPS to process or when we turn them in). Also they cannot be postdated, for instance if an applicant is processing on the 22nd and the pre-screen is turned in on the 16th, it has to be dated the 16th or before.

PRINT LOUISVILLE

Order of enlistment forms in the enlistment packet

☐ Projected in RZ

☐ Parental Consent (if applies)
☐ Original 680-A-E
☐ Original 2807-2
☐ DD 2983
☐ SGLV 8286
☐ DD 214/NGB22/REDD

SOURCE DOCUMENTS

☐ Birth Certificate / DD 372
☐ Social Security Card
☐ Drivers License/State ID
☐ HS Diploma / GED
☐ HS Letter (if applies)
☐ Certified HS Transcipts (if applies)
☐ Child's Birth Certificate (if applies)
☐ College Transcripts (if applies)
☐ Student Loan Information (if applies)
☐ Marriage Certificate (if applies)
☐ Divorce Decree (if applies)
☐ Child Custody Papers (if applies)

FINGER PRINTS COMPLETED

☐ SUBMITTED AFTER AOC /369 /AND EBC RELEASE is SIGNED AND UPLOADED INTO RZ, **MUST BE SUBMITTED WITH IN 72 HOURS NOT INCLUDING WEEKENDS AND HOLIDAYS**

☐ Waivers (if applies)
☐ W4 ***2016 VERSION***

SF 1199-A

☐ SF 1199 Direct Deposit
☐ DA 3685 JSS Pay Elections

☐ DD 369 county(ies)
☐ AOC Upload as (DD 369-STATE)
  ☐ Court Documents (if applies)
  ☐ Paid Receipts (if applies)
☐ Live Scan Auth upload as (EBC RELEASE)
☐ Sex Offender File Search one
☐ Tattoo Form upload as (Tattoo Screening Form)
☐ Unit Vacancy Statement (VCN)

STATE SPECIFIC FORMS

☐ DD 2058 State of Legal Residence
☐ DD 2760 Qual To Possess Firearms
☐ SF 312
☐ Louisville MEPS Checklist

STATE INCENTIVE FORM

☐ Tuition Award Program

Louisville MEPS Request Form

FOR OFFICIAL USE ONLY WHEN FILLED IN

Request Date

Request Type

☐ SPF ☐ MEPS to MEPS Pull ☐ Fingerprints ☐ Papercase

Control Desk

Initials Date/Time

Requestor Name *(Last, First MI, Rank/Grade, Service)*	Position	RSID	SPF
Horn, Tony B. SFC E-7	☐ Service Liaison ☐ Service Recruiter	KYKG	DAG

Applicant Information

Name *(Last, First MI)*	SSN	Last Known SPF
		DMR

SPF Requested Information

Type of Change Requested: ☐ SSN ☐ Name ☐ Address ☐ SRV ☐ Other Has applicant been projected?

Additional Notes:

MEPS to MEPS Pull Requested Information

☐ Copy of Physical Examination Location of Exam; ☐ Other

Fingerprints

☐ Re-fingerprinting ☐ Re-submission Date last fingerprinted:

Reason: ☐ Machine down ☐ Expiration ☐ Results not received ☐ Results not favorable Other_____

Papercase

MEPS Physical Exam Performed At: Date of Last Physical Examination:

Medical Section Use Only

Chief Medical Officer Comments

__ Qualified- OK to process

__ Deferred- The information listed below is needed for further processing

__ Disqualified

Louisville MEPS Applicant High School Pull Request

SPF: DAG

FOR OFFICIAL USE ONLY WHEN FILLED IN

Request Date:

Requestor Name *(Last, First MI, Rank/Grade, Service)*	Position	RSID
Horn, Tony B. SFC E-7	☐ Service Liaison ☒ Service Recruiter	KYKG

Applicant Information

Name *(Last, First MI)*	SSN	Date Tested

School Tested At	City, State	County

Applicant Name (as it appears on Recruiter Service Copy)

MEPS Use Only

	Initials	Date	Time
Received			
Results Returned to Recruiting Service			

Testing Section Comments:

__ Duplicate Request

__ Student ASVAB Scores already requested by another service

__ Cannot locate Student ASVAB scores, verify applicant information and resubmit

__ Student ASVAB scores not valid for enlistment, schedule for re-test

__ Completed and in FILE ROOM

__ Other

_____

_____

_____

_____

_____

_____

PRINT KNOXVILLE

KNOXVILLE MEPS Applicant Processing Request Form (JUL 2015)

Note: Areas that are highlighted in yellow are drop down menus.

				PS
Applicant Last Name	First Name	Middle Name	Suffix	NPS/GNPS/PS

Applicant's SSN _____ Gender _____ Age _____ Education Level _____

THE FOLLOWING IS BEING REQUESTED FOR THE APPLICANT

1. Processing Date: _____ Enlisting Same Date; YES Hotel: YES

2. Projection Type WALK IN

3. High School Pull needed? NO High School _____ City/State _____

Date of Test _____

4. Does your applicant need Testing? NO Select Testing Type Initial Test

5. Does your applicant need Special Testing? NO Select Type: AUDIO PERCEPTION

6. Does your applicant need Medical Processing? NO Select Medical Type: REEXAMINATION

7. Does your applicant require special Medical Processing? If so, select option: QUAD

8. If your applicant requires a consult, please select type. UNKNOWN

8. Has your applicant processed with another service? NO Select Branch: COAST GUARD/COAST GUARD RESERVE

9. Do you require additional services? NO Select Type PS FINGERPRINTS

Horn, Tony B.	KYKG	(859) 329-9574
Type/Print RRNCO Name	RSID	Contact Phone Number

Email add: TONY.B.HORN2.MIL@MAIL.MIL

REMARKS:

This form MUST be faxed/emailed in with your Applicant signed and initialed USMEPCOM 680-3-AE and DD Form 2807-2. If your applicant is GPS or PS, you will need to include the LONG form DD 214 or NGB form 22 for the last period of service. If your applicant requires an RE-Code waiver, you must provide approved administrative waiver with the above mentioned documents (per USMEPCOM Reg 40-1, para 5-15a). In addition, Parental consent must accompany this request for applicants 17 years of age. It is the RRNCO's responsibility to have applicant projected by 1200hrs two days prior to processing.

EMAIL IS REQUIRED daniel.j.finstad.mil@mail.mil; darrell.e.douglas2.mil@mail.mil ; brenda.k.williamson4.civ@mail.mil, sara.j.konkol.mil@mail.mil

Crowne Plaza 401 West Summit Hill Dr, Knoxville TN 37902 865-522-2600

MEPS 710 Locust St, RM 634, Knoxville TN 37902 865-291-9348

FOR USE OF THIS FORM, SEE USMEPCOM REG 680-3 FOR OFFICIAL USE ONLY

REQUEST FOR EXAMINATION

THE INFORMATION PROVIDED CONSTITUTES AN OFFICIAL STATEMENT.

OMB No. 0704-0173
OMB approval expires Sep 30, 2021

Read Privacy Act Statement on back before completing form.

A. **SERVICE PROCESSING FOR** D A G

B. **PRIOR SERVICE** ☐ Yes ☐ No — NUMBER OF DAYS

C. **SELECTIVE SERVICE CLASSIFICATION**

D. **SELECTIVE SERVICE REGISTRATION NUMBER**

1. SOCIAL SECURITY NUMBER ___ - ___ - ____

2. NAME *(Last, First, Middle Name (and Maiden, if any), Jr., Sr., etc.)*

3. CURRENT ADDRESS *(Street, City, County, State, Country, ZIP Code)*

4. HOME OF RECORD ADDRESS *(Street, City, County, State, Country, ZIP Code)*

5. CITIZENSHIP *(X one)*

- ☐ a. U.S. AT BIRTH (*If this box is marked, also X (1) or (2)*)
  - ☐ (1) NATIVE BORN
  - ☐ (2) BORN ABROAD OF U.S. PARENT(S)
- ☐ b. U.S. NATURALIZED
- ☐ c. U.S. NON-CITIZEN NATIONAL
- ☐ d. IMMIGRANT ALIEN *(Specify)* _____
- ☐ e. NON-IMMIGRANT FOREIGN NATIONAL *(Specify)* _____
- f. ALIEN REGISTRATION NUMBER *(As applicable)*

6. SEX *(X one)* ☐ a. MALE ☐ b. FEMALE

8. MARITAL STATUS *(Specify)*

9. NUMBER OF DEPENDENTS

7.a. ETHNIC CATEGORY *(X one)* ☐ (1) HISPANIC OR LATINO ☐ (2) NOT HISPANIC OR LATINO

7.b. RACIAL CATEGORY *(X all that apply)*

- ☐ (1) AMERICAN INDIAN/ALASKA NATIVE
- ☐ (2) ASIAN
- ☐ (3) BLACK OR AFRICAN AMERICAN
- ☐ (4) NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
- ☐ (5) WHITE

10. DATE OF BIRTH *(YYYYMMDD)*

11. RELIGIOUS PREFERENCE *(Optional)*

12. EDUCATION *(Yrs/Highest Ed Gr completed)*

13. PROFICIENT IN FOREIGN LANGUAGE *(X one)* ☐ Yes ☐ No *(If Yes, specify)* — 1st 2nd

14. VALID DRIVER'S LICENSE *(X one) (If Yes, list State, number, and expiration date)* ☐ Yes ☐ No

15. PLACE OF BIRTH *(City, State, and Country)*

16. APTITUDE:

- a. ASVAB REQUIRED TO ENLIST? *(X one)* ☐ Yes ☐ No
- b. ENLIST UNDER STUDENT TEST *(X one)* ☐ Yes ☐ No
- c. TEST TYPE: ☐ INITIAL ☐ SPECIAL ☐ CONFIRMATION
- d. RETEST TYPE: ☐ 1ST RETEST ☐ 2ND RETEST ☐ 6 MONTH RETEST ☐ IMMED RETEST AUTHORIZED
- e. PREVIOUS TEST VERSIONS 1. 2.
- f. PREVIOUS TEST DATES *(YYYYMMDD)* 1. 2.

17.a. RECRUITER ID/SSN KKYKG

b. STATION ID KYKG

18. TEST ADMINISTRATOR SSN/ID

19. TEST ADMINISTRATOR SIGNATURE

20. MEDICAL:

- a. MEPS MEDICAL EXAM REQUIRED TO ENLIST? *(X one)* ☐ Yes ☐ No
- b. EXAM TYPE ☐ FULL ☐ INSPECT ☐ SPECIAL ☐ CONSULT ☐ RE-EXAM ☐ OTHER
- c. DATE LAST FULL MEDICAL EXAM *(YYYYMMDD)*

21. APPLICANT'S SIGNATURE

22. MIRS CODING

WKID	ST	DATE	INT	DATE	INT

23. APPLICANT CERTIFICATION IN PRESENCE OF TEST ADMINISTRATOR

I certify that I am the person identified on this form:

Photo ID? *(X one)* ☐ Yes ☐ No

If Yes, type/organization: _____

ID Number: _____

_____ *(Signature of Applicant)*

24. RIGHT THUMBPRINT

RIGHT THUMBPRINT, FIRST ATTEMPT *(Affix thumbprint with thumbnail pointed to the left.)*

IF SECOND ATTEMPT IS REQUIRED: Turn form over *(Top of form on the bottom)*. Affix right thumbprint on upper right corner, thumbnail pointed to the left.

25. APPLICANT CERTIFICATION IN PRESENCE OF RECRUITING PERSONNEL

I certify that I am the person identified on this form and the information about me shown there, including my Social Security Number is all true and correct to the best of my knowledge. I also certify that:

- ☐ a. I have never been tested ANYTIME or ANYWHERE with the ASVAB either for enlistment purposes or as a student under the ASVAB testing program.
- ☐ b. I was tested with the ASVAB on or about _____ *(Most Recent Date Tested)* at _____ *(School, City, and State)*
- ☐ c. Request for student test scores (high school look-up) _____ *(Most Recent Date Tested)* at _____ *(School, City, and State)*
- ☐ d. Yes, I want to keep my AFQT scores from the student test listed in "c" above.
- e. Current or last high school attended _____ *(High School)* / OR / _____ *(13 Digit Code)*
- f. _____ *(Signature of Applicant)* / _____ *(Social Security Number)* / _____ *(Date)*

MEDICAL RECORDS RELEASE AUTHORITY: I request and authorize individuals, businesses or organizations to release to Representatives of USMEPCOM my complete medical records. This release of medical information is for the sole purpose of further evaluation of my medical acceptability into the Armed Services. Hard-copy records are to be obtained by me at no cost to the Government and made available for medical pre-screening review. USMEPCOM has my permission to access/ obtain all electronic medical records for this purpose.

26. APPLICANT'S CURRENT MEDICAL INSURER NAME *(If none, sign your complete name to affirm you have no current medical insurer):* NONE

27. APPLICANT'S CURRENT MEDICAL PROVIDER NAME *(If none, sign your complete name to affirm you have no current medical provider):* NONE

28. MEDICAL INSURER ADDRESS *(Street, City, State, Country, ZIP Code)*

29. MEDICAL PROVIDER ADDRESS *(Street, City, State, Country, ZIP Code)*

30. CERTIFICATION BY RECRUITING PERSONNEL I certify that I have properly identified this applicant in accordance with my service directives, have reviewed for completeness and accuracy the information provided on this form, and have witnessed the applicant's signature:

_____ *(Signature of Recruiter (or representative, if authorized))* / Horn, Tony B. *(Printed/Typed Name of Recruiter or representative)* / _____ *(Date)*

_____ *(Printed/Typed Name of Recruiter (if not recorded above))*

KKYKG *(Recruiter ID/SSN)* / KYKG *(Local Recruiting Activity)* / HQ STARC KY ARNG *(Bn, NRD, Sq or RS Location)*

APPLICANT SSN

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, Under Secretary of Defense for Personnel and Readiness; 504, Persons Not Qualified; 505, Regular components: qualifications, term grade; and 12102, Reserve Components; Qualifications; 14 U.S.C. 351, Enlistments; term, grade; and 632, Functions and powers vested in the Commandant; DoDI 1304.2, Accession Processing Data Collection Forms; DoDI 1304.26, Qualification Standards for Enlistment, Appointment, and Induction; AR 601-270, OPNAVINST 1100.4C Ch-2, AFI 36-2003_IP, MCO 1100.75E, and COMDTINST M 1100.2E, Military Entrance Processing Station (MEPS); AR 601-210. Active and Reserve Components Enlist Program; AFPD 36-20, Accession of Air Force Military Personnel; and E.O. 9397 (SSN), as amended.

PURPOSE(S): Military recruiters use the information you provide on this form to collect additional information from the individuals, schools, and employers you list so that we can determine if you meet recruitment standards. If you do meet these standards and enlist, the information you provide on this form starts your Official Military Personnel File. During the recruiting process we use the information on this form to verify your identity. This form also contains a section where you are asked to provide your signed consent for your medical provider(s) to release your medical records to the Department of Defense.

ROUTINE USE(S): To the Selective Service System (SSS) to update the SSS registrant database; to local and state Government Agencies for compliance with laws and regulations governing control of communicable diseases. Additional routine uses are listed in the applicable system of records notices listed below.

DISCLOSURE: Voluntary. However, if you fail to provide the requested information you might not be able to enlist. Your Social Security Number is used during the recruiting process to conduct background screening (e.g., law enforcement, medical, or educational record checks, former employer checks, work status, etc.). Keep all of your records together during the enlistment process, and ensure your test results are properly recorded.

Applicable system of records notices:

Accession:

U.S. Military Entrance Processing Command:
http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570661/a0601-270-usmepcom-dod/
Army (http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570054/a0600-8-104-ahrc/)
Navy (http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570316/n01131-1/;
http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570318/n01133-2/)
Marine Corps (http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570628/m01133-3/)
Air Force (http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/569780/f036-aetc-r/)
Coast Guard (http://edocket.access.gpo.gov/2008/E8-29845.htm)

Official Military Personnel Files:
Army (http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570051/a0600-8-104b-ahrc/; http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570052/a0600-8-104b-ngb/)
Navy (http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570310/n01070-3/)
Marine Corps (http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570626/m01070-6/)
Air Force (http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/569821/f036-af-pc-c/)
Coast Guard (https://www.govinfo.gov/app/details/FR-2008-12-19/E8-29793)

INSTRUCTIONS FOR COMPLETING DD FORM 2807-2, ACCESSIONS MEDICAL HISTORY REPORT

1. This form is to be completed by each individual who requires medical processing in accordance with Department of Defense Instruction (DODI) 6130.03, "Physical Standards for Appointment, Enlistment, or Induction" and DODI 1304.02, "Accession Processing Data Collection Forms." This form must be completed by the applicant with the assistance of the recruiter, parent(s), or guardian, as needed.

2. Replaces the existing medical prescreen form (DD Form 2807-2, MAR 2015) and the DoD Medical Examination Review Board Report of Medical History (DD Form 2492, MAR 2008). Additional questions have been added to improve its usefulness to the accessions medical pre-screening process. The questions are intended to provide the U.S. Military Entrance Processing Command (USMEPCOM) and Department of Defense Medical Examination Review Board (DoDMERB) with health history information necessary to identify conditions commonly related to medical causes for separation during basic and follow-on training (per P.L. 105-85, Div. A, Title V, S 532).

3. Use of medical history information facilitates efficient, timely, and accurate medical processing of individuals applying for Service in the United States Armed Forces or United States Coast Guard. Positive responses do not automatically result in disqualification but are necessary to prompt further explanation that will be used to determine medical qualification. Medical history information assists USMEPCOM/DoDMERB medical personnel in the medical prescreening of applicants. Accurate responses to all questions are critical and all positive responses must be fully explained. Applicant responses to questions may be verified using electronically obtained medical history by the USMEPCOM/DoDMERB. Medical history information will be used by the Department of Defense for continuity of care purposes if and when an applicant accesses into the Armed Forces or Coast Guard. Supporting medical information in the form of historical medical records may also be attached to the Service member's medical record. Medical history information collected by the USMEPCOM/DoDMERB during accession medical processing will serve as the foundation for a Service member's lifecycle electronic medical treatment record.

4. If processing at a MEPS: The completed DD Form 2807-2 along with all substantiating and supporting medical documents must be delivered to USMEPCOM for review prior to scheduling the applicant for medical examination. All documents must be submitted for review in accordance with standards below. After review, the Military Entrance Processing Station (MEPS) will notify the Recruiting Service of the applicant's status.

- 1 processing day prior for applicants with no positive medical history (all items marked "NO" with the exception of items 9 (glasses/contacts), 11 (defective color vision), and 20 (braces) which can be "YES").

- 2 processing days prior; for applicants with ANY positive medical history (other than those noted above) and 5 OR LESS single-sided pages of supporting medical documents.

- 3 processing days prior; for applicants with ANY positive medical history (other than those noted above) and MORE THAN 5 single-sided pages of supporting medical documents.

Secure electronic submission is preferable; if not feasible bring/mail to the nearest MEPS which can be found at http://www.mepcom.army.mil/battalions/index.html. All supporting medical documentation must be present with the DD Form 2807-2 to meet the above timeframes for review. After review by a USMEPCOM provider, appropriate processing notification will be made.

5. If processing at a MEPS: If an applicant has been seen by any Health Care Provider (HCP) and/or has been hospitalized for any reason, medical records/documentation must be obtained and submitted along with a medical release to USMEPCOM. Provide all medical documents via secure electronic submission (if possible) to the nearest MEPS. If hand-carried or mailed, ensure they are sealed in an envelope marked: "CONFIDENTIAL: MEPS MEDICAL DEPARTMENT".

a. If the applicant was evaluated and/or treated on an outpatient basis, obtain a copy of actual treatment records of the private medical doctor/HCP including:

(1) office or clinic assessment and progress notes, including the initial assessment documents, subsequent evaluation and treatment documents, and record of date when released from care to full, unrestricted activity;

(2) emergency room (ER) report(s);

(3) study reports (e.g., x-ray, magnetic resonance imaging (MRI), Computerized Tomography (CT));

(4) procedure reports (e.g., arthroscopy, electroencephalogram (EEG; brain wave test), echocardiogram (ultrasound of the heart));

(5) pathology reports (e.g., tissue specimens sent to lab for microscopic diagnosis, abnormal PAP smear cytology);

(6) specialty consultation records (e.g., neurologist, cardiologist, OB/GYN, gastroenterologist, orthopedic surgeon, pulmonologist, allergist).

b. If the applicant was hospitalized, obtain a copy of the inpatient hospital record, to include (if any): ER report, admission history and physical, study reports, procedure reports, operative report (example: surgery to bone or joint), pathology report, specialty consultation reports, and discharge summary.

c. If an applicant has been diagnosed or treated for any attention disorder (Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD), etc.), academic skills or perceptual defect, or had an Individualized Education Plan or 504 Plan, call/contact the MEPS medical department for additional instructions.

d. Obtain any and all documents relating to any evaluation, treatment or consultation with a psychiatrist, psychologist-counselor, or therapist, on an inpatient or outpatient basis for any reason, including but not limited to counseling or treatment for adjustment or mood disorder, family or marriage problems, depression, treatment or rehabilitation for alcohol, drug, or substance abuse.

6. MEPS Chief Medical Officers (CMOs) or DoDMERB may locally modify the above instructions and instruct recruiters on what supporting medical documents they require to complete the DD Form 2807-2 medical prescreen review, if doing so enhances the efficiency of medical processing and is consistent with DODI 6130.03 and USMEPCOM/DoDMERB guidance.

7. If all attempts to obtain required substantiating and supporting medical documents fail, the recruiter must contact the appropriate medical department, "MEPS medical department for enlistment applicants" or DoDMERB for officer applicants, for guidance prior to submitting an incomplete medical prescreen packet.

ACCESSIONS MEDICAL HISTORY REPORT

OMB No. 0704-0413
OMB Approval Expires: September 30, 2021

PRIVACY ACT STATEMENT AUTHORITY: 10 U.S.C. 504, Persons not qualified; 10 U.S.C. 505, **Regular components: qualifications, term, grade;** 10 U.S.C. 507**, Extension of enlistment for members needing medical care or hospitalization;** 10 U.S.C. 532, Qualifications for original appointment as a commissioned officer; 10 U.S.C. 978, Drug and alcohol abuse and dependency: testing of new entrants; 10 U.S.C. 1201, Regulars and members on active duty for more than 30 days: retirement; 10 U.S.C. 1202, Regulars and members on active duty for more than 30 days: temporary disability retired list; 10 U.S.C. 4346, Cadets: requirements for admission; DoD Directive 1145.2, United States Military Entrance Processing Command; and E.O. 9397 (SSN), as amended. **PRINCIPAL PURPOSE(S):** To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces. **ROUTINE USE(S):** The Routine Uses are listed in the applicable system of records notice found at: http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570661/a0601-270-usmepcom-dod/ **DISCLOSURE:** Voluntary, however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status. **WARNING:** The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or $10,000 fine, or both), to anyone making a false statement. If you are selected for enlistment, commission or entrance into a commissioning program based on a false statement, you may be subject to prosecution under the Uniform Code of Military Justice or to administrative separation proceedings for discharge, and could receive a less than honorable discharge."

SECTION I - APPLICANT

1. LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	2. AGE	3. DATE OF BIRTH *(YYYYMMDD)*	4.a. SOCIAL SECURITY NUMBER	b. DoD ID NUMBER *(If applicable)*

5. *(X one)* a. SEX (at birth) b. GENDER	6. HEIGHT *(inches)*	7. WEIGHT *(lbs.)*	8.a. SERVICE *(X as applicable)*	8.b. COMPONENT *(X as applicable)*	9. DATE *(YYYYMMDD)*
☐ Male ☐ Male			☒ Army ☐ USMC	☐ Regular	
☐ Female ☐ Female			☐ Navy ☐ USCG	☐ Reserve	
			☐ USAF ☐ Other: _____	☒ National Guard	

10. PURPOSE OF EXAMINATION *(X as applicable)*	11. POSITION *(If a current Federal Employee) (Job Title, Grade, Component)*	12. USUAL OCCUPATION
☒ Enlistment ☐ U.S. Service Academy ☐ Commission ☐ ROTC Scholarship ☐ Retention ☐ Other *(Specify)* _____		

SECTION II - AUTHORIZATION STATEMENT

I (we), the undersigned:

- I Have read and understand the warning and penalties that are associated with providing a false statement.
- I Certify the information on this form is true and complete to the best of my knowledge and belief, and no person has advised me to conceal or falsify any information about my physical and mental history.
- I Authorize and understand that a physical examination is part of the accession evaluation, may require several visits to the Military Entrance Processing Station (MEPS), and Department of Defense Medical Examination Review Board (DoDMERB) contracted medical centers and that I may have blood work and/or other medical tests, procedures and/or specialty consultations performed as part of my processing. I understand that the results of the examination, tests, and consults will be reviewed and considered as part of my application file and are not performed as part of an individual healthcare treatment plan. The MEPS/DoDMERB medical staff are not my healthcare providers. If I do not receive notice of an abnormal test or consult, I am not to assume that the results are normal. Furthermore, if any test or consult results are abnormal, I am responsible for obtaining those results from the MEPS and for any necessary follow-up evaluations and/or treatment. If I am notified to return to the MEPS to discuss medical results, it is my responsibility to take quick action to return to the MEPS/DoDMERB to speak with the Chief Medical Officer (CMO). Any concerns that I have about my health and healthcare are my responsibility to address with my personal healthcare provider(s).
- I Understand that neither USMEPCOM nor DoDMERB are financially responsible for costs associated with any necessary follow-up evaluations and/or treatment based on my screening evaluation. Any concerns that I have about my health and healthcare are my responsibility to address with my personal healthcare provider(s).
- I Understand that I must provide required documentation regarding my health history which, upon my accession, will become part of my Service member lifecycle medical treatment record.
- I agree that all personal information or data disclosed by myself or others on my behalf with my consent during this process may be further disseminated as needed during the accession process and that my medical information is no longer protected by federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules.
- I Authorize release of records and information relating to grades, performance, individual education plans, and disciplinary proceedings. Under the Family Educational Rights and Privacy Act (FERPA) USMEPCOM/DoDMERB is authorized to receive all my education/disciplinary records for evaluation of my acceptability for Service in the Armed Forces.
- I Understand that I have the right to refuse to sign this authorization but also understand that failure to do so may cause me to be found disqualified for further processing.
- I Understand this authorization will expire four years from the date of the signature below or sooner if written request is received by USMEPCOM/DoDMERB Staff Judge Advocate's Office. I have the right to revoke this authorization in writing, except to the extent that the DoD has acted in reliance on this information.

1. APPLICANT

a. Signature	b. Date Signed *(YYYYMMDD)*

2. PARENT OR GUARDIAN SIGNATURE IS MANDATORY FOR MINOR APPLICANT, SIGNATURE IS OPTIONAL IF APPLICANT IS OF AGE

a. Name *(Last, First, Middle Initial)*	b. Signature	c. Date Signed *(YYYYMMDD)*

3. RECRUITING REPRESENTATIVE: *(If a representative was used)* **I certify all information is complete and true to the best of my knowledge.**

a. Name *(Last, First, Middle Initial)*	b. Recruiter Identification Number	c. Signature	d. Date Signed *(YYYYMMDD)*
Horn, Tony B.	KYKG		

SECTION III - MEDICAL HISTORY *(Continued)*. Check each item "Yes" or "No." All "Yes" items must be fully explained in Section IV.

CURRENTLY HAVE OR ANY HISTORY OF:	YES	NO	CURRENTLY HAVE OR ANY HISTORY OF:	YES	NO
EYES			**EYES**		
1. Double vision	☐	☒	4. Eye surgery to improve vision (RK, PRK, LASIK, etc.)	☐	☒
2. Detached retina or surgery to repair a detached retina	☐	☒	5. Night blindness	☐	☒
3. Cataracts or surgery for cataracts	☐	☒	6. Glaucoma	☐	☒

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER *(Last 4)*	DoD ID NUMBER *(If applicable)*

SECTION III - MEDICAL HISTORY *(Continued)*. Check each item "Yes" or "No." All "Yes" items must be fully explained in Section IV.

CURRENTLY HAVE OR ANY HISTORY OF:	YES	NO
EYES *(Continued)*		
7. Strabismus or "lazy eye" or any surgery to correct these	☐	☒
8. Any other eye condition, injury or surgery	☐	☒
VISION		
9. Worn/wear contact lenses or glasses (Bring your contact lens kit and solution so you can remove contacts during vision testing, or for best results remove 72 hours prior. Bring your eyeglasses no matter how old they are.)	☐	☒
10. Loss of vision in either eye	☐	☒
11. Color vision deficiency or color blindness	☐	☒
EARS		
12. Perforated ear drum or tubes in ear drum(s)	☐	☒
13. Ear surgery, to include mastoidectomy or repair of perforated ear drum	☐	☒
14. Loss of balance or vertigo	☐	☒
HEARING		
15. Hearing loss or wear a hearing aid	☐	☒
NOSE, SINUSES, MOUTH, AND LARYNX		
16. Ear, nose, or throat trouble including tonsillectomy	☐	☒
17. Chronic sinus infections or recurrent nose bleeds	☐	☒
18. Absence of, or disturbance of sense of smell	☐	☒
19. Any surgery of your face, mandible or jaw	☐	☒
DENTAL		
20. Do you wear dental braces or plan to wear braces? (If so, your orthodontist must submit a letter stating that active orthodontic treatment will be completed prior to active duty date: release form/ sample format can be found in the Recruiter's Medical Guide.)	☐	☒
21. Tooth or gum problems (other than cavities)	☐	☒
LUNGS, CHEST WALL, PLEURA, AND MEDIASTINUM		
22. Asthma	☐	☒
23. Wheezing	☐	☒
24. Shortness of breath	☐	☒
25. Bronchitis	☐	☒
26. Other breathing problems worsened by exercise, weather, pollens, etc	☐	☒
27. Used inhaler(s) or steroids for breathing problem(s)	☐	☒
28. Chronic cough or frequent coughing at night	☐	☒
29. Collapsed lung or other lung condition	☐	☒
30. History of chest, chest wall, or breast surgery	☐	☒
HEART		
31. Heart murmur, valve problem or mitral valve prolapse	☐	☒
32. Palpitation, pounding heart or abnormal heartbeat	☐	☒
33. Heart surgery	☐	☒
34. Pain or pressure in the chest	☐	☒
35. An abnormal electrocardiogram (EKG)	☐	☒
36. Any other heart problems	☐	☒
ABDOMINAL ORGANS AND GASTROINTESTINAL SYSTEM		
37. Stomach, esophageal or intestinal ulcer	☐	☒
38. Difficulty swallowing	☐	☒
39. Frequent indigestion or heartburn	☐	☒
40. Gall bladder trouble or gallstones	☐	☒
41. Jaundice (except neonatal) or hepatitis (liver disease)	☐	☒
42. Rupture/hernia	☐	☒
43. Surgery to remove or repair a portion of the intestine or spleen (other than the appendix)	☐	☒
44. Chronic or recurrent intestinal problem of the small or large bowel such as Irritable Bowel Syndrome, Crohn's disease, Ulcerative Colitis, or Celiac disease	☐	☒
45. Rectal disease, hemorrhoids, or blood from the rectum	☐	☒
46. Hemorrhoid surgery	☐	☒
47. Bariatric surgery (weight loss surgery)	☐	☒

CURRENTLY HAVE OR ANY HISTORY OF:	YES	NO
FEMALES ONLY:		
48. A change of menstrual pattern (other than pregnancy)	☐	☒
49. Pregnancy, abortion or miscarriage	☐	☒
50. Any abnormal PAP smear(s)	☐	☒
51. Date of last PAP smear *(YYYYMMDD)*		
52. Diagnosed with endometriosis or ovarian cysts	☐	☒
53. Evaluation, treatment or surgery for any other gynecological (female) disorder	☐	☒
54. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	☐	☒
55. First day of last menstrual period *(YYYYMMDD)*		
MALES ONLY:		
56. Missing a testicle, testicular implant, or undescended testicle	☐	☒
57. Varicocele, hydrocele, or any scrotal mass, swelling or pain	☐	☒
58. Prostate problems	☐	☒
59. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	☐	☒
URINARY SYSTEM		
60. Missing a kidney	☐	☒
61. Kidney stone, infection or disease	☐	☒
62. Kidney or urinary tract surgery of any kind	☐	☒
63. Blood or protein in urine	☐	☒
64. Painful or difficult urination	☐	☒
65. Bedwetting or treatment for bedwetting (previous 12 months)	☐	☒
66. Hernia	☐	☒
SPINE AND SACROILIAC JOINTS		
67. Back pain or back problem	☐	☒
68. Herniated disk	☐	☒
69. Neck pain	☐	☒
70. Back or neck surgery	☐	☒
71. Abnormal curvature of your spine (any part)	☐	☒
UPPER EXTREMITIES		
72. Painful shoulder, elbow, wrist, hand or fingers	☐	☒
73. Dislocated shoulder, elbow, wrist, hand or fingers	☐	☒
LOWER EXTREMITIES		
74. Foot trouble (e.g., pain, corns, bunions, warts, ingrown toenails, etc.)	☐	☒
75. Knee trouble (e.g., locking, giving out, or ligament injury, etc.)	☐	☒
76. Painful hip, knee, ankle, foot or toes	☐	☒
77. Dislocated hip, knee, ankle, foot or toes	☐	☒
MISCELLANEOUS CONDITIONS OF THE EXTREMITIES		
78. Bone, joint, or other orthopedic deformity	☐	☒
79. Loss of finger or toe, or extra finger or toe	☐	☒
80. Loss of the ability to fully flex (bend) or fully extend a finger, toe, or other joint	☐	☒
81. Impaired use of arms, hands, legs, or feet (any reason)	☐	☒
82. Arthritis, rheumatism, gout, or bursitis	☐	☒
83. Any swollen joint(s)	☐	☒
84. Surgery on any joint/bone (including arthroscopy)	☐	☒
85. Plate(s), screw(s), rod(s) or pin(s) in any bone	☐	☒
86. Pain or swelling at the site of an old fracture	☐	☒
87. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics	☐	☒
88. Any other orthopedic, muscle, or sports injury problems	☐	☒
VASCULAR		
89. High or low blood pressure	☐	☒
90. Raynaud's phenomenon or disease	☐	☒
91. Deep Vein Thrombosis (blood clot; leg or elsewhere)	☐	☒
92. Pulmonary embolism (blood clot in lung)	☐	☒

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER *(Last 4)*	DoD ID NUMBER *(If applicable)*

SECTION III - MEDICAL HISTORY *(Continued)*. Check each item "Yes" or "No." All "Yes" items must be fully explained in Section IV.

CURRENTLY HAVE OR ANY HISTORY OF:	YES	NO
SKIN AND CELLULAR		
93. Acne		X
94. Atopic dermatitis or eczema		X
95. Psoriasis		X
96. Large or painful scars		X
97. Any other skin problems		X
BLOOD AND BLOOD FORMING TISSUES		
98. Anemia (iron deficiency, sickle cell, thalassemia)		X
99. Blood clots requiring blood thinner medicine		X
100. Absence or removal of the spleen		X
101. Prolonged bleeding (after an injury or tooth extraction)		X
102. Any other blood or circulation problems		X
SYSTEMIC		
103. Adverse reaction to medication (describe reaction in Section IV)		X
104. Adverse reaction to serum, insect bites, or stings		X
105. Allergy to foods (milk, eggs, fish, meat, nuts, etc.)		X
106. Allergy to wool, latex, or other material		X
107. Tuberculosis or lived with someone who had tuberculosis		X
108. Positive test for tuberculosis (PPD or blood test)		X
109. Malaria		X
110. Disorder(s) of your immune system (including HIV)		X
111. Car, train, sea, or air sickness		X
ENDOCRINE AND METABOLIC		
112. Thyroid trouble or goiter		X
113. High or low blood sugar		X
114. Diabetes or told that you should be tested for diabetes		X
NEUROLOGIC		
115. Cerebrovascular incident (stroke)		X
116. Frequent or severe headaches, including migraines		X
117. Taking medication to prevent headaches		X
118. Lost time from work or school due to frequent or severe headaches		X
119. A skull fracture		X
120. A head injury, memory loss, or amnesia		X
121. A period of unconsciousness or concussion		X
122. Loss of memory or amnesia, or neurological symptoms		X
123. Paralysis		X
124. Meningitis, encephalitis, or other neurological problems		X
125. Seizures, convulsions, epilepsy or fits		X
126. Dizziness or fainting spells		X
127. Any other neurologic problems		X
SLEEP DISORDERS		
128. Sleepwalking or narcolepsy		X
129. Frequent trouble sleeping		X
130. Sleep apnea or severe snoring		X
LEARNING, PSYCHIATRIC. AND BEHAVIORAL		
131. Evaluated or treated for Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD)		X
132. Taken (or taking) medication, drugs, or any substance to improve attention, behavior, or physical performance		X
133. Diagnosed with a learning disorder, to include dyslexia		X
134. Received counseling of any type		X
135. Seen a psychiatrist, psychologist, social worker, counselor or other professional for any reason (inpatient or outpatient) including counseling or treatment for school, adjustment, family, marriage, divorce, depression, anxiety, or treatment of alcohol, drug or substance abuse (Applicant or recruiter will request sealed medical supporting documents from health care providers marked "CONFIDENTIAL: MEPS MEDICAL DEPARTMENT" and submit directly to MEPS medical personnel.)		X

CURRENTLY HAVE OR ANY HISTORY OF:	YES	NO
LEARNING, PSYCHIATRIC. AND BEHAVIORAL *(Continued)*		
136. Been expelled or suspended from school		X
137. Been kicked out or removed from your home		X
138. Been arrested or other encounters with law enforcement		X
139. Been evaluated or treated, either with medication or counseling, for a mental condition, depression or excessive worry		X
140. Nervous trouble of any sort (anxiety or panic attacks)		X
141. Anorexia, bulimia, or other eating disorder		X
142. Habitual stammering or stuttering		X
143. Have you ever purposely cut or harmed yourself		X
144. Have you ever attempted or considered suicide		X
145. Used illegal drugs or abused prescription drugs		X
146. Have you been evaluated, treated, or hospitalized for substance abuse, addiction or dependence (including illegal drugs, prescription medications or other substances)		X
147. Have you been evaluated, treated, or hospitalized for alcohol abuse, dependence, or addiction		X
148. Post-Traumatic Stress Disorder or excessive stress requiring counseling and/or medication following a traumatic experience		X
149. Any other learning, psychiatric, or behavioral problems		X
TUMORS AND MALIGNANCIES		
150. Tumor, growth, cyst, or cancer of any type		X
MISCELLANEOUS		
151. Cold injury, frostbite or cold intolerance		X
152. Heat injury, heat stroke or heat intolerance		X
SUPPLEMENTAL QUESTIONS		
153. Are you taking any medications, to include over the counter medications (OTCs), vitamin, herbal, or nutritional supplements (If "yes", list all in Section IV.)		X
154. Any recent unexplained gain or loss of weight		X
155. Artificial or replacement body part (eye, bone, palate, hip, knee, joint, leg, arm, etc.)		X
156. Have you ever had any illness or injury other than those already noted? (If "yes", specify when, where and give details in Section IV.)		X
157. Have you ever been treated in an Emergency Room? (If "yes", explain in Section IV.)		X
158. Have you ever been a patient in any type of hospital (including being kept overnight)? (If "yes", specify when, where, why, and name of doctor and complete address of hospital in Section IV.)		X
159. Have you ever had, or have you been advised to have any operations or surgery? (If "yes", describe and give age at which occurred in Section IV.)		X
160. Have you ever been rejected for military Service for any reason? (If "yes", give date and reason in Section IV.)		X
161. Have you ever been discharged from the military Service for any reason? (If "yes", give date, reason, and type of discharge, whether honorable, other than honorable, for unfitness or unsuitability in Section IV.)		X
162. Have you ever been refused employment or been unable to hold a job or stay in school because of any of the following: (If "yes", answer a - d below and give reasons in Section IV.)		X
a. Sensitivity to chemicals, dust, sunlight, etc.		X
b. Inability to perform certain motions		X
c. Inability to stand, sit, kneel, lie down, etc.		X
d. Other medical reasons		X
163. Applied for and/or received disability evaluation and/or compensation for an injury or other medical conditions (If "yes", provide details in Section IV.)		X
164. Have you ever been denied life insurance? (If "yes", provide reason(s) in Section IV.)		X

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER *(Last 4)*	DoD ID NUMBER *(If applicable)*

SECTION IV - APPLICANT COMMENTS. Explain all "Yes" answers to questions 1 - 164 above.
Begin with the item Number. Describe answer(s) fully: provide date(s) of problem(s)/condition(s); provide names of Health Care Providers (HCPs), Clinic(s) and/or Hospital(s) along with the City and State; explain what was done (e.g., evaluation and/or treatment); and describe your current medical status. Attach additional sheet(s) if necessary and sign and date each additional page. Obtain and attach copies of applicable medical evaluation and treatment records.

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER *(Last 4)*	DoD ID NUMBER *(If applicable)*

SECTION V - HEALTH CARE PROVIDER/INSURANCE CARRIER CONTACT INFORMATION:
Current/Previous Primary Care Physician(s)/Practitioner(s) and/or Clinic(s) where care is received and Current/Previous Insurance Carrier(s) information. Attach additional sheets if necessary.

1. CURRENT PRIMARY CARE PHYSICIAN(S)/PRACTITIONER(S) AND/OR CLINIC(S)

a. NAME(S)	b. ADDRESS *(Include ZIP Code)*	c. TELEPHONE *(Include Area Code)*

2. PREVIOUS PRIMARY CARE PHYSICIAN(S)/PRACTITIONER(S) AND/OR CLINIC(S)

a. NAME(S)	b. ADDRESS *(Include ZIP Code)*	c. TELEPHONE *(Include Area Code)*

3. CURRENT INSURANCE AND/OR PHARMACY BENEFIT MANAGER(S)

a. NAME(S)	b. ADDRESS *(Include ZIP Code)*	c. TELEPHONE *(Include Area Code)*

4. PREVIOUS INSURANCE AND/OR PHARMACY BENEFIT MANAGER(S)

a. NAME(S)	b. ADDRESS *(Include ZIP Code)*	c. TELEPHONE *(Include Area Code)*

5. ADDITIONAL INSURANCE AND/OR PHARMACY BENEFIT MANAGER(S)

a. NAME(S)	b. ADDRESS *(Include ZIP Code)*	c. TELEPHONE *(Include Area Code)*

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER *(Last 4)*	DoD ID NUMBER *(If applicable)*

SECTION VI - MEDICAL RECORDS RELEASE

Applicant (Patient) Name:		Social Security Number:
Date of Birth: *(MM/DD/YYYY)*	Phone:	Address:

1. I authorize the release of the following information by *ALL* holders of my medical records/information (check all applicable) Choosing not to release all records will delay medical qualification determination.

☒ All records	☐ Abstract	☐ Inpatient medical records
☐ Outpatient medical records	☐ Laboratory/pathology records	☐ X-ray films/radiology records
☐ Billing records	☐ Pharmacy/prescription records	☐ Psychotherapy/psychiatric care records
☐ HIV, drug and/or alcohol use records	☐ Other	

Describe specifically:

2. Please send my records listed above to:

Name:	Address:
Louisville MEPS	600 Dr. Martin Luther King Jr. Pl Louisville, KY 40202
Phone: (502) 540-8350	Fax: (502) 582-6566

3. I authorize the release of the medical records that I marked above through an electronic health exchange if available.

4. I understand that if the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.

5. This authorization for medical records release will expire no later than 4 years from the date of signature or as directed by local laws. I understand written notification is necessary to cancel this authorization before such date and can be addressed to the department listed at item 2 of this form. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.

6. I understand that this disclosure may include information regarding drug abuse, alcoholism, or alcohol abuse, psychiatric or mental illness, Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV regulated by Federal Statute (42 CFR Part 2).

7. Applicant

a. Signature	b. Date Signed *(YYYYMMDD)*

8. Parent or Guardian Signature is mandatory for minor applicant, signature is optional if applicant is of age

a. NAME *(Last, First, Middle Initial)*:	b. Signature	c. Date Signed *(YYYYMMDD)*

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER *(Last 4)*	DoD ID NUMBER *(If applicable)*

SECTION VII - MEDICAL PROVIDER'S SUMMARY AND DESCRIPTION OF PERTINENT INFORMATION:

Review and comment on all medical records, electronically provided medical history information, and other electronic data **available** in the Department of Defense Accessions Processing System. Medical providers may also develop any additional medical history deemed important and record significant findings here or by interview and document them on the DD Form 2808, "Report of Medical Examination." Attach additional sheet(s) if necessary.

COMMENTS:

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER *(Last 4)*	DoD ID NUMBER *(If applicable)*

SECTION VIII - MEDICAL PROVIDER'S PRESCREEN DETERMINATION BASED ON AVAILABLE INFORMATION:

1.a. DATE *(YYYYMMDD)*	b. MEDICAL PROCESSING STATUS						c. IF NOT WITHIN STANDARDS:				d. PROVIDER INITIALS
	PA	PRW	PH	RJ	METR	PNJ	ICD	CONDITION	PULHES	SMWRA INPUT	

KEY: PA = Processing Authorized; PRW = Processing Requested by SMWRA; PH = Processing Hold; RJ = Return Justified; METR = Medical Evaluation and/or Treatment Records; PNJ = Processing Not Justified; ICD = International Classification of Disease Code; PULHES = P (Physical Capacity), U (Upper Extremities), L (Lower Extremities), H (Hearing), E (Eyes), S (Psychiatric); SMWRA = Service Medical Waiver Review Authority.

2. *FOR MEPS USE ONLY:

ON EXAM:	a. PSN COMP	b. PSN INCOM	c. NPS	d. *AE	e. *RE	f. *ME	g. *OE	h. DATE *(YYYYMMDD)*	i. PROVIDER INITIALS

3. AUTHORIZING MEDICAL PROVIDER

a. NAME *(Last, First, Middle Initial)*	b. SIGNATURE	c. DATE SIGNED *(YYYYMMDD)*

4. EXAMINING PROVIDER

a. NAME *(Last, First, Middle Initial)*	b. SIGNATURE	c. DATE SIGNED *(YYYYMMDD)*	d. NUMBER OF ADDITIONAL SHEETS PROVIDED

RECRUIT/TRAINEE PROHIBITED ACTIVITIES ACKNOWLEDGMENT

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, Under Secretary of Defense for Personnel and Readiness; DoD Instruction 1304.33, Standardized Protection Policies Prohibiting Inappropriate Relations Between Recruiters and Recruits, and Trainers and Trainees.
PRINCIPAL PURPOSE(S): To document your understanding of the prohibitions identified in section 7 of this form.
ROUTINE USE(S): The DoD Blanket Routine Uses found at http://dpclo.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx apply to this collection.
DISCLOSURE: Voluntary. However, if you fail to provide the requested information or complete this form, you might not be able to complete your enlistment or receive training.

INSTRUCTIONS

In accordance with DoDI 1304.33, this form will be read and signed no later than the first visit with a recruiter following a recruit's entry into the Delayed Entry Program or read and signed no later than the first day of entry-level training for a trainee. As a minimum, the signed original will be retained in the recruit's file until they enter active duty or in the trainee's file until they detach from the training command or school they are attending. Please initial beside each entry acknowledging that you have read and understand the statement.

1. RECRUIT/TRAINEE NAME *(Last, First, Middle)*	2. PAY GRADE	3. RECRUITING OFFICE/TRAINING COMMAND
		B CO DET 1 KY R&R BN
4. RECRUITING OFFICE/TRAINING COMMAND ADDRESS *(City, State, ZIP Code)*	**5. DATE SIGNED** *(YYYYMMDD)*	**6. SIGNATURE**
Richmond, KY 40475		

7. I ACKNOWLEDGE AND UNDERSTAND THAT AS A RECRUIT OR TRAINEE, I WILL NOT:

(Initial)	
_____	a. Develop, attempt to develop, or conduct a personal, intimate, or sexual relationship with a recruiter or trainer. This includes, but is not limited to, dating, handholding, kissing, embracing, caressing, and engaging in sexual activities. Prohibited personal, intimate, or sexual relationships include those relationships conducted in person or via cards, letters, e-mails, telephone calls, instant messaging, video, photographs, social networking, or any other means of communication.
_____	b. Establish a common household with a recruiter/trainer, that is, share the same living area in an apartment, house, or other dwelling.
_____	c. Consume alcohol with a recruiter/trainer on a personal social basis.
_____	d. Attend social gatherings, clubs, bars, theaters or similar establishments on a personal social basis with a recruiter/trainer.
_____	e. Allow entry of any recruiter/trainer in my dwelling or privately-owned vehicle except to conduct official business. Exceptions are permitted for official business when the safety or welfare of the recruiter/trainer is at risk.
_____	f. Gamble with a recruiter/trainer.
_____	g. Make sexual advances toward, or seek or accept sexual advances or favors from, a recruiter/trainer.
_____	h. Lend money to, borrow money from, or otherwise become indebted to a recruiter/trainer.

8. EXCEPTIONS. Exceptions may be granted to accommodate relationships that existed prior to the start of the recruiting process or prior to the trainee starting the formal training process. These relationships include, but are not limited to, family members. Only the Recruit's or Trainee's Commander, O-4 or higher, or higher level authority, has the authority to approve these exceptions. Approved exceptions will be documented below and signed by the Recruit's or Trainee's Commander, O-4 or higher, or a higher-level authority.
DESCRIPTION OF EXCEPTION(S):

(Initial)	
_____	**9. VIOLATIONS.** Violations of any part of paragraph 7.a. through 7.h., not granted an exception in paragraph 8, may result in disciplinary action.

10. APPROVED BY

a. NAME *(Last, First, Middle Initial)*	b. TITLE	c. DATE SIGNED *(YYYYMMDD)*	d. SIGNATURE/RANK

REQUEST FOR CONVICTION RECORDS - EMPLOYMENT/PROFESSIONAL LICENSE

Request is made for any record of conviction found in the files of the Kentucky centralized criminal history record information system regarding the person identified herein. This information shall be released to:

Kentucky Army National Guard c/o: Horn, Tony B.

Agency/Organization Name and Address

ACKNOWLEDGMENT BY APPLICANT

I am requesting that the Kentucky State Police provide the above named agency/organization with any record of conviction found in the files of the Kentucky centralized criminal history record information system. I know that I have the right to inspect my criminal history record and to request correction of any inaccurate information. If I do not exercise that right, I agree to hold harmless the Kentucky State police and any Kentucky State Police employee(s) from any claim for damages arising from the dissemination of inaccurate information.

APPLICANT INFORMATION (**PLEASE PRINT**)

NAME: _____ _____ _____ _____
First Middle Last Maiden

ADDRESS: _____ _____ _____ _____
Street City State Zip

SEX: Female ACE: Black BIRTH: _____ SOC SEC NO: _____

_____ _____
Signature Date Witness Date

INSTRUCTIONS:

Requesting agencies/organizations should ensure that all application information is completed.

Requesting agencies/organizations should forward a check or money order made payable to the **Kentucky State Treasurer** in the amount of **$20.00** for each submitted form. Requests should be accompanied by **two, self –addressed stamped envelopes** – one bearing the name and address of the requesting agency/organization and the other bearing the name and address of the applicant.

The Kentucky State Police will charge a $25.00 fee on each returned check.

RETURN THIS FORM TO:

Kentucky State Police
Criminal Identifications and Records Branch
Criminal Records Dissemination Section
1266 Louisville Road
Frankfort, KY 40601

Visit us online @ http:\\kentuckystatepolice.org

Revised 10/08

POLICE RECORD CHECK

1. DATE OF REQUEST *(YYYYMMDD)*

OMB No. 0704-0007
OMB approval expires Dec 31, 2018

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO ADDRESS SHOWN AT BOTTOM OF FORM.

SECTION I - *(To be completed by Recruiting Service)*

2. NAME OF APPLICANT *(Last, First, Middle Name(s), Alias)*	3. SEX	4. PLACE OF BIRTH		
	X MALE FEMALE	a. CITY	b. COUNTY	c. STATE

5. DATE OF BIRTH *(YYYYMMDD)*	6.a. ETHNIC CATEGORY	b. RACIAL CATEGORY *(X one or more)*	7. SOCIAL SECURITY NUMBER
	(1) HISPANIC OR LATINO (2) NOT HISPANIC OR LATINO	(1) AMERICAN INDIAN/ALASKA NATIVE (2) ASIAN (3) BLACK OR AFRICAN AMERICAN (4) NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER (5) WHITE	

8. ADDRESS IN ADDRESSEE'S JURISDICTION *(See "MAIL TO" block)*				9. DATES RESIDED AT THIS ADDRESS	
a. NUMBER AND STREET *(Include apartment no.)*	b. CITY	c. STATE	d. ZIP CODE	a. FROM *(YYYYMMDD)*	b. TO *(YYYYMMDD)*
1812 Irvine Road	Richmond,	KY	40475		

10. PERSON MAKING THIS REQUEST			
a. NAME *(Last, First, Middle Name(s))*	b. RANK	c. SIGNATURE	d. TITLE
Horn, Tony B.	SFC		Recruiter / RRNCO

SECTION II - *(To be completed by Applicant)*

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. Sections 136, 504, 505, 12102; 14 U.S.C. Sections 351 and 632; DoDI 1304.2; DoDI 1304.26; AR 601-270; OPNAVINST 1100.4C Ch-1; AFI 36-2003_IP; MCO 1100.75E; COMDTINST M 1100.2E; AR 601-210; and E.O. 9397, as amended (SSN).

PRINCIPAL PURPOSE(S): The information collected on this form is used to screen and identify applicants to the Armed Forces who may have discreditable involvement with the police or other law enforcement agencies. Completed forms are used to conduct background records checks used to determine eligibility of applicants for accession into the Armed Forces. Completed forms are covered by recruiting and official military personnel SORNs maintained by each of the Services.

ROUTINE USE(S): DoD "Blanket Routine Use" 2, Disclosure When Requesting Information Routine Use, specifically applies: A record from a system of records maintained by a DoD Component may be disclosed as a routine use to a Federal, State, or local agency maintaining civil, criminal, or other relevant enforcement information or other pertinent information, such as current licenses, if necessary to obtain information relevant to a DoD Component decision concerning the hiring or retention of an employee, the issuance of a security clearance, the letting of a contract, or the issuance of a license, grant, or other benefit. The DoD Blanket Routine Uses at https://dpclo.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx apply.

DISCLOSURE: Voluntary. However, failure of the applicant to complete Section II may result in refusal of enlistment in the Armed Forces of the United States. An applicant's SSN is used to conduct the police records check and keep all records together during the enlistment process.

The data are for OFFICIAL USE ONLY and will be maintained and used in strict confidence in accordance with Federal law and regulations. Making a knowing and willful false statement on this DD Form 369 may be punishable by fine or imprisonment or both. All information provided by you, which possibly may reflect adversely on your past conduct and performance, may have an adverse impact on you in your military career in situations such as consideration for special assignment, security clearances, court martial and administrative proceedings, etc.

11. I HEREBY CONSENT TO RELEASE FROM YOUR FILES THE INFORMATION REQUESTED BELOW.	SIGNATURE

SECTION III - *(To be completed by Police or Juvenile Agency)*

The person described above, who claims to have resided at the address shown above, has applied for enlistment in the Armed Forces of the United States. Please furnish from your files the information relative to Section III below. A return envelope is provided for your convenience.

12. DOES THE APPLICANT HAVE A POLICE OR JUVENILE RECORD, TO INCLUDE MINOR TRAFFIC VIOLATIONS? ☐ YES ☐ NO
(If YES, what was the offense or charge, date, disposition and sentence?)

13. IS APPLICANT NOW UNDERGOING COURT ACTION OF ANY KIND? *(If YES, give details.)* ☐ YES ☐ NO

THIS IS TO CERTIFY THAT THE ABOVE DATA, AS CORRECTED, ARE TRUE AND CORRECT ACCORDING TO THE RECORD ON FILE IN THIS OFFICE. THIS INFORMATION IS CONFIDENTIAL AND CANNOT BE USED IN ANY OTHER MANNER EXCEPT FOR OFFICIAL PURPOSES.

14. DATE *(YYYYMMDD)*	15. TITLE	16. VERIFIED BY *(Signature)*

LAW ENFORCEMENT AGENCY MAIL TO:	RECRUITING AGENCY MAIL FROM:
	B CO DET 1 KY R&R BN 1812 Irvine Road Richmond, KY 40475

LIVE SCAN CONSENT FOR ENLISTMENT

The proponent for this form is ARNG-HRR. For use of this form, see Accession Options Criteria.

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC Section 503, Enlistments: recruiting campaigns.
PRINCIPLE PURPOSE(s): The purpose of this form is to obtain consent of applicant's fingerprints prior to enlistment to prevent fraudulent entry. Applicants are required to disclose information in the questions listed.
ROUTINE USE(s): This form is only used when an applicant agrees for processing at the MEPS.
DISCLOSURE: VOLUNTARY, failure to agree to fingerprint collection could result in inability to process for enlistment.

Name:	PRID:

The applicant processing for enlistment must understand fingerprinting is a requirement for processing the background investigation for entry into the Army National Guard. With the completion of this document, the applicant does consent to the capturing and transmitting of fingerprints to the U.S. Office of Personnel Management (OPM) and the Federal Bureau of Investigations (FBI), for the purpose of processing an investigation. Refusal to have fingerprints processed for a background investigation, may result in inability to process for enlistment.

It is the policy of the Army National Guard, that applicants for enlistment disclose all activity with law enforcement and court officials, regardless of the disposition of the case. All incidents with law enforcement agencies will be listed below, regardless of whether the applicant was arrested, charged, cited, held, or detained in any way by any Local, State, or Federal agency, including Juvenile Authorities, Police Officers, Sheriff, Department of Natural Resources, Fish and Game Wardens, Military Police, etc.

Recruiters will ask each applicant the following questions and select the appropriate answer. All yes answers require an explanation in the remarks section and for all law enforcement incidents list the following details: approximate date of the offense(s); City, County and State of the police and court(s); and the disposition or outcome. Prior service applicants must list all violations that occurred prior to, during and/or after enlistment into military service. For applicants who answer no to all questions, the remarks page is not required.

Questions related to an applicant's history.	Yes	No
1. Have you ever been arrested, detained or interviewed as suspect by any law enforcement agency, issued a summons, citation, or ticket by any law enforcement agency, or required to perform any type of conditions by police or court officials regardless of disposition of the case?		
2. Have you ever been fingerprinted for any reason?		
3. Have you been told by a lawyer, Judge, Prosecutor, Recruiter, Family Member, Friend or Probation Officer not to disclose your law violation because the offense would not show up on a background check or because it has been removed, expunged, set aside or sealed?		
4. Have you ever entered into any type of program that would remove the charge(s) after completion of the program? (for example: Diversion, Deferred Prosecution, Pre-Trial Intervention, ordered to take classes, Community Service, write a letter, etc.)		
5. Have you ever had any governmental agency (Police, Sheriff, Game Warden, etc.), impose penalties on you so the offense would not be filed, or told that the offense will go away as if it never happened?		
6. Would you have answered yes to any question above, but were told to answer NO due to police or court record checks processed by your Recruiter prior to being fingerprinted?		
7. If you have ever served in any component of the U.S. Military, Active or Reserve, have you ever received UCMJ action, including Article-15, Captain's Mast, Court Marshal, Official or Unofficial letter of Reprimand?		
8. Have you ever been suspended from, or served detention in any school for any reason?		

Recruiter Name	Recruiter Signature	Date
Horn, Tony B.		

Remarks.

I verify that all Yes answers have been listed on this form and are true and accurate to the best of my knowledge.

Recruiter name	Recruiter signature	Date
Horn, Tony B.		

Standard From 1199A (EG)
(Rev. June 187)
Prescribed by Treasury Department
Treasury Dept. Cir. 1076

OMB No. 1510-0007

DIRECT DEPOSIT SIGN-UP FORM

DIRECTIONS

- To sign up for Direct Deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The Completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit
- The claim number and type of payment are printed on Government checks. (see the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payee must keep the Government agency informed of any address changes in order to receive important about benefits and to remain qualified for payments.

SECTION 1 *(TO BE COMPLETED BY PAYEE)*

A NAME OF PAYEE *(last, first, middle initial)*

ADDRESS *(street, route, P.O. Box, APO/FPO)*

CITY | STATE | ZIP CODE

TELEPHONE NUMBER
AREA CODE

B NAME OF PERSON*(S)* ENTITLED TO PAYMENT

C CLAIM OR PAYROLL ID NUMBER

Prefix | Suffix

D TYPE OF DEPOSITOR ACCOUNT ☒ CHECKING ☐ SAVINGS

E DEPOSITOR ACCOUNT NUMBER

F TYPE OF PAYMENT *(Check only one)*

- ☐ Social Security
- ☐ Supplemental Security Income
- ☐ Railroad Retirement
- ☐ Civil Service Retirement *(OPM)*
- ☐ VA Compensation or Pension
- ☐ Fed. Salary/Mil. Civilian Pay
- ☐ Mil. Active
- ☐ Mil. Retire.
- ☐ Mil. Survivor
- ☒ Other National Guard *(specify)*

G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY *(if applicable)*

TYPE	AMOUNT

PAYEE/JOINT PAYEE CERTIFICATION

I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.

SIGNATURE	DATE
SIGNATURE	DATE

JOINT ACCOUNT HOLDERS' CERTIFICATION *(optional)*

I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.

SIGNATURE	DATE
SIGNATURE	DATE

SECTION 2 *(TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)*

GOVERNMENT AGENCY NAME	GOVERNMENT AGENCY ADDRESS
KYARNG, USPFO-KY	BOONE NG CENTER 120 MINUTEMAN PARKWAY FRANKFORT, KY 40601-6192

SECTION 3 *(TO BE COMPLETED BY FINANCIAL INSTITUTION)*

NAME AND ADDRESS OF FINANCIAL INSTITUTION

ROUTING NUMBER | CHECK DIGIT

DEPOSITOR ACCOUNT TITLE

FINANCIAL INSTITUTION CERTIFICATION

I confirm the identity of the above-named payee(s) and the account number and title. AS representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.

PRINT OR TYPE REPRESENTATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE NUMBER	DATE

Financial institution should refer to the GREEN BOOK for further instructions.

THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

NSN 7540-01-058-0224

PAYEE COPY

1199-207
Designed using Perform Pro, WHS/DIOR, Mar 97

JUMPS - JSS PAY ELECTIONS

For use of this form, see AR 37-104-3; the proponent agency is ASA(FM)

PRIVACY ACT STATEMENT

Authority: Title 37 USC, Section 101.

Principal Purpose: To provide the service member a means of electing the manner in which he or she desires to receive pay and allowances.

Routine Use: To establish the pay account of the MMPF.

Disclosure: Disclosure of your social security number *(SSN)* and other personal information is voluntary; however, without the requested information, the Finance Office cannot identify members, or take the requested action.

1. HOW DO YOU WANT TO BE PAID? *(X one item.)*		2. METHOD OF PAYMENT *(X one item.)*	
X	a. Once a Month	X	a. Sure Pay/Direct Deposit *(Complete Section 4.)*
	b. Twice a Month		b. Check to Address *(Complete 5.)*

3. HELD PAY *(NOTE: All amounts may be withdrawn at any time upon application to your Finance Officer.)*		b. SPECIFY AMOUNT
	a. If a held pay amount is also desired, check box and enter amount.	$

4. SURE PAY/DIRECT DEPOSIT *(X one box.)*

X	a. SF 1199A attached. *(Complete items (1) through (5)).*		b. SF 1199A on file. *(Use this box if you already have SURE PAY/DIRECT DEPOSIT to this financial institution)* ***(Do not complete items (1) through (5)).***

	(1) NAME OF FINANCIAL ORGANIZATION	
	(2) SAVINGS OR CHECKING ACCOUNT NO	(3) NAME OF ACCOUNT HOLDER
	(4) STREET NO., RR NO., P.O. BOX	(5) CITY, STATE, ZIP CODE *(Or Country)*

5. CHECK TO ADDRESS *(Provide complete mailing address.)*

a. STREET NO., RR NO., P.O. BOX			
b. CITY	c. STATE	d. ZIP CODE	e. COUNTRY

6. REMARKS

7. *I HEREBY AUTHORIZE PAYMENT AS SPECIFIED ABOVE.*

a. TYPED OR PRINTED NAME	e. NAME AND ADDRESS OF ORGANIZATION
b. SSN	B Co. Det 1 (RSP) 233 Battlefield Memorial Hwy Richmond, KY 40475 W90UB1
c. SIGNATURE / d. DATE	

STATE OF LEGAL RESIDENCE CERTIFICATE

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Tax Reform Act of 1976, Public Law 94-455.

PURPOSE: Information is required for determining the correct State of legal residence for purposes of withholding State income taxes from military pay.

ROUTINE USES: Information herein will be furnished State authorities and to Members of Congress.

MANDATORY OR VOLUNTARY DISCLOSURE: Disclosure is voluntary. If not provided, State income taxes will be withheld based on the tax laws of the State previously certified as your legal residence, or in the absence of a prior certification, the tax laws of the applicable State based on your home of record.

NAME *(Last, first, middle initial)*	**SOCIAL SECURITY NUMBER** *(SSN)*

LEGAL RESIDENCE/DOMICILE *(City or county and State)*

INSTRUCTIONS FOR CERTIFICATION OF STATE OF LEGAL RESIDENCE

The purpose of this certificate is to obtain information with respect to your legal residence/domicile for the purpose of determining the State for which income taxes are to be withheld from your "wages" as defined by Section 3401(a) of the Internal Revenue Code of 1954. PLEASE READ INSTRUCTIONS CAREFULLY BEFORE SIGNING.

The terms "legal residence" and "domicile" are essentially interchangeable. In brief, they are used to denote that place where you have your permanent home and to which, whenever you are absent, you have the intention of returning. The Soldiers' and Sailors' Civil Relief Act protects your military pay from the income taxes of the State in which you reside by reason of military orders unless that is also your legal residence/domicile. The Act further provides that no change in your State of legal residence/domicile will occur solely as a result of your being ordered to a new duty station.

You should not confuse the State which is your "home of record" with your State of legal residence/domicile. Your "home of record" is used for fixing travel and transportation allowances. A "home of record" must be changed if it was erroneously or fraudulently recorded initially.

Enlisted members may change their "home of record" at the time they sign a new enlistment contract. Officers may not change their "home of record" except to correct an error, or after a break in service. The State which is your "home of record" may be your State of legal residence/domicile only if it meets certain criteria.

The formula for changing your State of legal residence/domicile is simply stated as follows: physical presence in the new State with the simultaneous intent of making it your permanent home and abandonment of the old State of legal residence/domicile. In most cases, you must actually reside in the new State at the time you form the intent to make it your permanent home. Such intent must be clearly indicated. Your intent to make the new State your permanent home may be indicated by certain actions such as: (1) registering to vote; (2) purchasing residential property or an unimproved residential lot; (3) titling and registering your automobile(s); (4) notifying the State of your previous legal residence/domicile of the change in your State of legal residence/domicile; and (5) preparing a new last will and testament which indicates your new State of legal residence/domicile. Finally, you must comply with the applicable tax laws of the State which is your new legal residence/domicile.

Generally, unless these steps have been taken, it is doubtful that your State of legal residence/domicile has changed. Failure to resolve any doubts as to your State of legal residence/domicile may adversely impact on certain legal privileges which depend on legal residence/domicile including among others, eligibility for resident tuition rates at State universities, eligibility to vote or be a candidate for public office, and eligibility for various welfare benefits. If you have any doubt with regard to your State of legal residence/domicile, you are advised to see your Legal Assistance Officer (JAG Representative) for advice prior to completing this form.

I certify that to the best of my knowledge and belief, I have met all the requirements for legal residence/domicile in the State claimed above and that the information provided is correct.

I understand that the tax authorities of my former State of legal residence/domicile will be notified of this certificate.

SIGNATURE	**CURRENT MAILING ADDRESS** *(Include ZIP Code)*	**DATE**

DD Form 2058, FEB 77

Reset

QUALIFICATION TO POSSESS FIREARMS OR AMMUNITION

PRIVACY ACT STATEMENT

AUTHORITY: 18 U.S.C. 922(g)(9); E.O. 9397.

PRINCIPAL PURPOSE(S): To obtain information to determine if you have been convicted of a crime of domestic violence which would disqualify you from shipping, transporting, possessing or receiving either Government-issued or private firearms or ammunition and to determine if reassignment, reclassification, detail or other administrative action is warranted. Your Social Security Number is solicited solely for purposes of verifying your identity.

ROUTINE USE(S): To the Department of Justice so that such information can be included in the National Instant Criminal Background Check System which may be used by firearm licensees (importers, manufacturers or dealers) to determine whether individuals are qualified to receive or possess firearms and ammunition.

DISCLOSURE: Mandatory for all personnel who are required to certify. Failure to provide the information may result in (1) (military only) the imposition of criminal or administrative penalties for failing to obey a lawful order, and (2) (civilian only) the imposition of administrative penalties, to include removal from Federal service. However, neither your answers nor information or evidence gained by reason of your answers can be used against you in any criminal prosecution for a violation of Title 18, United States Code, Section 922(g)(9), including (military only) prosecutions under the Uniform Code of Military Justice, based on a violation of Section 922(g)(9), for conduct which occurred prior to the completion of this form. The answers you furnish and any information resulting therefrom, however, may be used against you in a criminal or administrative proceedings if you knowingly and willfully provide false statements or information.

SECTION I - INSTRUCTIONS

An amendment to the Gun Control Act of 1968 (18 U.S.C. 922) makes it a felony for anyone who has been convicted of a misdemeanor crime of domestic violence to ship, transport, possess, or receive firearms or ammunition. It is also a felony for any person to sell or otherwise dispose of a firearm to any person so convicted.

The Department of Defense has, by policy, expanded the prohibitions contained in Title 18 Section 922(g)(9) to those military or civilian personnel who have felony convictions for crimes of domestic violence. Convictions of crimes of domestic violence do not include summary court-martial convictions, the imposition of nonjudicial punishment (Article 15, UCMJ), or deferred prosecutions (or similar alternative dispositions) in civilian courts. Furthermore, a person shall not be considered as having committed a "crime of domestic violence" for purposes of the firearms restriction of the Gun Control Act unless all of the following elements are present:

(1) the person was convicted of a crime;

(2) the offense has as its factual basis the use or attempted use of physical force, or threatened use of a deadly weapon;

(3) the convicted offender was at the time of the offense:
- (a) a current or former spouse, parent or guardian of the victim,
- (b) a person with whom the victim shared a child in common,
- (c) a person who was cohabiting with or has cohabited with the victim as a spouse, parent, or guardian, or
- (d) a person who was similarly situated to a spouse, parent, or guardian of the victim;

(4) the convicted offender was represented by counsel, or knowingly and intelligently waived the right to counsel;

(5) if entitled to have the case tried by jury, the case was actually tried by jury or the person knowingly and intelligently waived the right to have the case tried by jury;

(6) the conviction has not been expunged or set aside, or the convicted offender has not been pardoned for the offense or had civil rights restored, unless the pardon, expungement, or restoration of civil rights provides that the person may not ship, transport, possess or receive firearms.

If you have ever received a domestic violence conviction: (1) you may not possess any firearm or ammunition; and (2) you must return any Government-issued firearm or ammunition to your commander or immediate supervisor; and (3) you must take steps to relinquish possession of any privately owned firearms or ammunition. Furthermore, any previously issued authorization to possess a firearm or ammunition is revoked.

If you have any questions, or you are uncertain if you have such a conviction, you may wish to contact a legal assistance attorney, if eligible, or a private attorney, at your own expense.

SECTION II - QUALIFICATION INQUIRY *(Complete and return to your commander or immediate supervisor within 10 days of receipt)*

1. HAVE YOU EVER BEEN CONVICTED OF A CRIME OF DOMESTIC VIOLENCE AS DESCRIBED ABOVE: *(Initial and date)*

YES	NO	I DON'T KNOW *(Provide explanation on reverse)*

2. IF YOU ANSWERED "YES" TO THE FIRST QUESTION, PROVIDE THE FOLLOWING INFORMATION WITH RESPECT TO THE CONVICTION:

a. COURT/JURISDICTION	b. DOCKET/CASE NUMBER
c. STATUTE/CHARGE	**d. DATE SENTENCED** *(YYYYMMDD)*

3. CERTIFICATION. I hereby certify that, to the best of my information and belief, all of the information provided by me is true, correct, complete, and made in good faith. I understand that false or fraudulent information provided herein may be grounds for criminal and/or administrative proceedings, to include (if civilian) adverse action, up to and including removal, and (if military) disciplinary action under the Uniform Code of Military Justice. I further understand that I have a continuing obligation to inform my Commander or Supervisor should I be convicted of a crime of domestic violence in the future.

a. NAME *(Last, First, Middle Initial)*	b. RANK/GRADE	c. SOCIAL SECURITY NUMBER

d. ORGANIZATION	e. SIGNATURE	f. DATE SIGNED *(YYYYMMDD)*
B Co. Det 1 (RSP)		

CLASSIFIED INFORMATION NONDISCLOSURE AGREEMENT

AN AGREEMENT BETWEEN AND THE UNITED STATES

(Name of Individual - Printed or typed)

1. Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to classified information. As used in this Agreement, classified information is marked or unmarked classified information, including oral communications, that is classified under the standards of Executive Order 13526, or under any other Executive order or statute that prohibits the unauthorized disclosure of information in the interest of national security; and unclassified information that meets the standards for classification and is in the process of a classification determination as provided in sections 1.1, 1.2, 1.3 and 1.4(e) of Executive Order 13526, or under any other Executive order or statute that requires protection for such information in the interest of national security. I understand and accept that by being granted access to classified information, special confidence and trust shall be placed in me by the United States Government.

2. I hereby acknowledge that I have received a security indoctrination concerning the nature and protection of classified information, including the procedures to be followed in ascertaining whether other persons to whom I contemplate disclosing this information have been approved for access to it, and that I understand these procedures.

3. I have been advised that the unauthorized disclosure, unauthorized retention, or negligent handling of classified information by me could cause damage or irreparable injury to the United States or could be used to advantage by a foreign nation. I hereby agree that I will never divulge classified information to anyone unless: (a) I have officially verified that the recipient has been properly authorized by the United States Government to receive it; or (b) I have been given prior written notice of authorization from the United States Government Department or Agency (hereinafter Department or Agency) responsible for the classification of information or last granting me a security clearance that such disclosure is permitted. I understand that if I am uncertain about the classification status of information, I am required to confirm from an authorized official that the information is unclassified before I may disclose it, except to a person as provided in (a) or (b), above. I further understand that I am obligated to comply with laws and regulations that prohibit the unauthorized disclosure of classified information.

4. I have been advised that any breach of this Agreement may result in the termination of any security clearances I hold; removal from any position of special confidence and trust requiring such clearances; or termination of my employment or other relationships with the Departments or Agencies that granted my security clearance or clearances. In addition, I have been advised that any unauthorized disclosure of classified information by me may constitute a violation, or violations, of United States criminal laws, including the provisions of sections 641, 793, 794, 798, *952 and 1924, title 18, United States Code; *the provisions of section 783(b), title 50, United States Code; and the provisions of the Intelligence Identities Protection Act of 1982. I recognize that nothing in this Agreement constitutes a waiver by the United States of the right to prosecute me for any statutory violation.

5. I hereby assign to the United States Government all royalties, remunerations, and emoluments that have resulted, will result or may result from any disclosure, publication, or revelation of classified information not consistent with the terms of this Agreement.

6. I understand that the United States Government may seek any remedy available to it to enforce this Agreement including, but not limited to, application for a court order prohibiting disclosure of information in breach of this Agreement.

7. I understand that all classified information to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of the United States Government unless and until otherwise determined by an authorized official or final ruling of a court of law. I agree that I shall return all classified materials which have, or may come into my possession or for which I am responsible because of such access: (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me a security clearance or that provided me access to classified information; or (c) upon the conclusion of my employment or other relationship that requires access to classified information. If I do not return such materials upon request, I understand that this may be a violation of sections 793 and/or 1924, title 18, United States Code, a United States criminal law.

8. Unless and until I am released in writing by an authorized representative of the United States Government, I understand that all conditions and obligations imposed upon me by this Agreement apply during the time I am granted access to classified information, and at all times thereafter.

9. Each provision of this Agreement is severable. If a court should find any provision of this Agreement to be unenforceable, all other provisions of this Agreement shall remain in full force and effect.

10. These provisions are consistent with and do not supersede, conflict with, or otherwise alter the employee obligations, rights, or liabilities created by existing statute or Executive order relating to (1) classified information, (2) communications to Congress, (3) the reporting to an Inspector General of a violation of any law, rule, or regulation, or mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health or safety, or (4) any other whistleblower protection. The definitions, requirements, obligations, rights, sanctions, and liabilities created by controlling Executive orders and statutory provisions are incorporated into this agreement and are controlling.

(Continue on reverse.)

11. These restrictions are consistent with and do not supersede, conflict with, or otherwise alter the employee obligations, rights, or liabilities created by Executive Order No. 13526 (75 Fed. Reg. 707), or any successor thereto section 7211 of title 5, United States Code (governing disclosures to Congress); section 1034 of title 10, United States Code, as amended by the Military Whistleblower Protection Act (governing disclosure to Congress by members of the military); section 2302(b) (8) of title 5, United States Code, as amended by the Whistleblower Protection Act of 1989 (governing disclosures of illegality, waste, fraud , abuse or public health or safety threats); the Intelligence Identities Protection Act of 1982 (50 U.S.C. 421 et seq.) (governing disclosures that could expose confidential Government agents); sections 7(c) and 8H of the Inspector General Act of 1978 (5 U.S.C. App.) (relating to disclosures to an inspector general, the inspectors general of the Intelligence Community. and Congress); section 103H(g)(3) of the National Security Act of 1947 (50 U.S.C. 403-3h(g)(3) (relating to disclosures to the inspector general of the Intelligence Community); sections 17(d)(5) and 17(e)(3) of the Central Intelligence Agency Act of 1949 (50 U.S.C. 403g(d)(5) and 403q(e)(3)) (relating to disclosures to the Inspector General of the Central Intelligence Agency and Congress); and the statutes which protect against disclosure that may compromise the national security, including sections 641, 793, 794, 798, *952 and 1924 of title 18, United States Code, and *section 4 (b) of the Subversive Activities Control Act of 1950 (50 U.S.C. section 783(b)). The definitions, requirements, obligations, rights, sanctions, and liabilities created by said Executive Order and listed statutes are incorporated into this agreement and are controlling.

12. I have read this Agreement carefully and my questions, if any, have been answered. I acknowledge that the briefing officer has made available to me the Executive Order and statutes referenced in this agreement and its implementing regulation (32 CFR Part 2001 , section 2001 .80(d)(2)) so that I may read them at this time, if I so choose.

* NOT APPLICABLE TO NON-GOVERNMENT PERSONNEL SIGNING THIS AGREEMENT.

SIGNATURE	DATE	SOCIAL SECURITY NUMBER *(See Notice below)*

ORGANIZATION (IF CONTRACTOR, LICENSEE, GRANTEE OR AGENT, PROVIDE: NAME, ADDRESS, AND, IF APPLICABLE, FEDERAL SUPPLY CODE NUMBER) *(Type or print)*

Richmond, Ky. 40475

B Co. Det 1 (RSP) 233 Battlefield Memorial Hwy Richmond, KY 40475

WITNESS		ACCEPTANCE	
THE EXECUTION OF THIS AGREEMENT WAS WITNESSED BY THE UNDERSIGNED.		THE UNDERSIGNED ACCEPTED THIS AGREEMENT ON BEHALF OF THE UNITED STATES GOVERNMENT.	
SIGNATURE	DATE	SIGNATURE	DATE
NAME AND ADDRESS *(Type or print)*		NAME AND ADDRESS *(Type or print)*	
Horn, Tony B. SFC B CO DET 1 KY R&R BN 1812 Irvine Road Richmond, KY 40475			

SECURITY DEBRIEFING ACKNOWLEDGEMENT

I reaffirm that the provisions of the espionage laws, other federal criminal laws and executive orders applicable to the safeguarding of classified information have been made available to me; that I have returned all classified information in my custody; that I will not communicate or transmit classified information to any unauthorized person or organization; that I will promptly report to the Federal Bureau of Investigation any attempt by an unauthorized person to solicit classified information, and that I (have) (have not) (strike out inappropriate word or words) received a security debriefing.

SIGNATURE OF EMPLOYEE	DATE

NAME OF WITNESS *(Type or print)*	SIGNATURE OF WITNESS

NOTICE: The Privacy Act, 5 U.S.C. 552a, requires that federal agencies inform individuals, at the time information is solicited from them, whether the disclosure is mandatory or voluntary, by what authority such information is solicited, and what uses will be made of the information. You are hereby advised that authority for soliciting your Social Security Number (SSN) is Public Law 104-134 (April 26, 1996). Your SSN will be used to identify you precisely when it is necessary to certify that you have access to the information indicated above or to determine that your access to the information indicated has been terminated. Furnishing your Social Security Number, as well as other data, is voluntary, but failure to do so may delay or prevent you being granted access to classified information.

DEPARTMENT OF THE ARMY
HEADQUARTERS, KENTUCKY ARMY NATIONAL GUARD
BOONE NATIONAL GUARD CENTER
100 MINUTEMAN PARKWAY
FRANKFORT, KENTUCKY 40601-6168

KG-G1-ED 1 December 2011

MEMORANDUM FOR ALL MEMBERS KENTUCKY ARMY NATIONAL GUARD

SUBJECT: Kentucky Army National Guard Tuition Award Program

1. The intent of this memorandum is to clarify submission for the Kentucky National Guard State Tuition Award Program. This procedure will allow Soldiers to go online from home and/or unit to enter their application.

2. The link for the Student Module is as follows: https://ky.ngb.army.mil/TuitionStudent/ .

3. Soldiers will select the "Student Module" and login by selecting from the drop down menu either Kentucky Army Guard and entering their Social Security Number and their Pay Entry Basic Date (PEBD) MM/DD/YYYY. The PEBD can be found on the Leave and Earnings Statement (LES) in the block titled "Pay Date". After the application is entered and submitted, the applicant cannot make changes. If the student must make changes, the State TA Administrator is the only one authorized to make changes to submitted information.

4. Personnel must have completed basic training or be a contracted SMP with the Kentucky National Guard to receive State TA. Soldiers must have a passing APFT, meet height weight standards, not currently be flagged and have no AWOL periods within the previous 12 months. Individuals have to wait one year from the date of the last AWOL period to be eligible to apply. The deadlines for submitting applications are as follows: 1 October for the spring term and 1 April for the summer and fall terms. Thus, if applicants try to enter an application after 1 October or 1 April, the application will automatically be rejected. Only under extraordinary circumstances or reasons approved by The Adjutant General's Policy Letter will applicants be authorized funds after the deadline dates.

5. Service members who wish to change enrollment status (either credit hours, or institutions), must coordinate this with the Education Office 30 days prior to the beginning of the semester. First priority of funding is those soldiers who do not have a four year degree. As always this program is based on the availability of funds.

KG-G1-ED
SUBJECT: Kentucky National Guard State Tuition Award Program

7. The Administrative Regulation 106 KAR 3:010E governs the program and is available at your unit for review.

I hereby acknowledge receipt of the letter regarding the Kentucky National Guard Tuition Award Program.

_____ _____

Signature Date

Dist:
Individual
IPERMS
Unit

Prudential

Office of Servicemembers' Group Life Insurance

Servicemembers' Group Life Insurance Election and Certificate

The SGLI Online Enrollment System (SOES) is the official system of record for Servicemembers' Group Life Insurance for the United States Navy, the United States Army and the United States Air Force. All coverage and beneficiary elections for members of the Navy, the Army and the Air Force should be made in SOES. This form should only be used in special circumstances as defined by the United States Navy, the United States Army and the United States Air Force.

1. About You

Print Name (First, Middle, Last)	Rank, title or grade	Social Security Number

Duty Location	Branch of Service	Current Amount of SGLI
B CO DET 1 KY R&R BN Richmond, Ky. 40475	United States Army	$ 400,000

☐ Married ☐ Single

If married, spouse's name

Spouse's Date of Birth

2. About Your Coverage *This form replaces all prior designations.*

I am completing this form to: (Check all that apply)

☐ Name or update my SGLI beneficiary. *You must complete sections 3 & 5.*

☐ Increase or restore my SGLI coverage to $ _____. *You must complete sections 3, 4 & 5.*
(Increasing SGLI does not automatically increase FSGLI, if FSGLI was < $100,000.)

☐ Reduce my SGLI coverage to $ $50,000. *You must complete sections 3 & 5.*

☐ Decline or cancel SGLI coverage. Write below "I do not want insurance at this time." *You must complete Section 5 only.*
" _____."

SGLI coverage is available in increments of $50,000 up to a maximum of $400,000. Traumatic Injury Protection (TSGLI) coverage is automatic with SGLI coverage.

3. About Your Beneficiaries *Please always complete this section unless you are declining coverage. If you do not specifically name beneficiaries, your insurance will be paid by law. Please read the information on page 3 before selecting your beneficiaries.*

Primary Name and Address	Social Security Number *(If available)*	Relationship to you	Share to each (%) – *The sum of shares must equal 100%. Each share must be greater than 0%.*	Payment Option *(Lump sum* or 36 equal monthly payments)*
1.	☐☐☐ ☐☐ ☐☐☐☐			**LUMP SUM**
2.	☐☐☐ ☐☐ ☐☐☐☐			
3.	☐☐☐ ☐☐ ☐☐☐☐			
4.	☐☐☐ ☐☐ ☐☐☐☐			

Secondary Name and Address	Social Security Number *(If available)*	Relationship to you	Share to each (%) – *The sum of shares must equal 100%. Each share must be greater than 0%.*	Payment Option *(Lump sum* or 36 equal monthly payments)*
1.				LUMP SUM
2.				
3.				
4.				

☐ Have more beneficiaries? Check this box if 1) You have additional beneficiaries and are completing the Supplemental SGLI Beneficiary Form, SGLV 8286S or, 2) You are attaching additional documentation to complete your beneficiary designation noted above.

*If the insured member elects a lump sum payment, the beneficiary(ies) will be given the option of receiving the lump sum payment through the Prudential Alliance Account ®, by check, or Electronic Funds Transfer (EFT). Alliance Account is not available for payments less than $5,000, payments to individuals residing outside the United States and its territories, and certain other payments. These will be paid by check.

The Bank of New York Mellon is the Administrator of the Prudential Alliance Account Settlement Option, a contractual obligation of The Prudential Insurance Company of America, located at 751 Broad Street, Newark, NJ 07102-3777. Draft clearing and processing support is provided by The Bank of New York Mellon. Alliance Account balances are not insured by the Federal Deposit Insurance Corporation (FDIC). The Bank of New York Mellon is not a Prudential Financial company.

4. About Your Health *Complete this section ONLY if you are restoring or increasing coverage.*

Your date of birth (MM, DD, YYYY) | Your weight | Your height | Your gender ☐ Female ☒ Male

Have you had, been treated for, or had known indications of:	Yes	No
a. A heart condition?	☐	☐
b. High blood pressure?	☐	☐
c. A neurological disorder?	☐	☐
d. Diabetes?	☐	☐
e. Cancer or tumors?	☐	☐
f. Have you ever been diagnosed as having a disease of the immune system?	☐	☐
g. Do you have any known physical impairments, deformities, or ill health not covered above?	☐	☐

Did you answer "YES" to any question? If so, reference the question by letter and list date, duration and details below. Please attach additional documentation if necessary.

If you answered "yes" to any question above, a request to increase coverage does not take effect until approved by the Office of Servicemembers' Group Life Insurance (OSGLI). If you answered "no" to all the questions above, your request for increased coverage takes effect immediately.

5. Your Signature *You must complete this section.*

I have read the information on page 3 and instructions on page 4 and understand that:

- This form replaces any prior beneficiary or payment instructions.
- I can have SGLI and Veterans' Group Life Insurance (VGLI) at the same time, but the combined amount cannot be more than $400,000. VGLI is lifetime renewable post-separation coverage available to Service Members who separate with SGLI coverage.
- Reducing SGLI coverage can affect the amount of my family coverage (FSGLI) and VGLI coverage (see instructions on page 4).
- By declining or canceling SGLI coverage, I am also declining family coverage (FSGLI) and Traumatic Injury Protection (TSGLI). I am also not eligible for any post-separation coverage (see instructions on Page 4).

Please take note:

If my spouse is…	and…	then…
also a member of the uniform services	we married on or after January 2, 2013	spouse SGLI coverage is not automatic, but I may apply for spouse coverage by completing SGLV 8286A.
not a member of the uniformed services	I am married, or get married after completing this form, and have not declined SGLI,	spouse SGLI automatically covers my spouse. I must register my spouse in DEERS so my branch of service can deduct premiums from my pay. Failure to do so will result in a debt for unpaid premiums. I can decline spouse coverage by completing SGLV 8286A.

- I am free to name anyone I want as my beneficiary. I understand if I am married and have designated someone other than my spouse or child as my beneficiary, the person I have named is the person I intend to receive my insurance proceeds. I also understand that my spouse may be notified that he/she (or my child) is not my designated beneficiary.

I certify that, to the best of my knowledge and belief, the above statements are complete and true. Any deception or false statement, either by reference, omission, or otherwise can result in loss of coverage or denial of a claim for benefits. If declining or reducing SGLI coverage, I have received the appropriate general information concerning life insurance from my Unit Personnel Clerk.

Service Member Signature	Social Security Number	Date Signed (MM, DD, YYYY)

Address

Submit this form to your Unit Personnel Clerk. By completing this section the Unit Personnel Clerk acknowledges that they have counseled the Service Member in regards to the information provided on page 4 of this form.

For Branch of Service Use Only	For OSGLI Use Only
Name of Personnel Clerk Horn, Tony B.	Representative
Rank, title or grade SFC RRNCO E-7	Approve ☐
Contact telephone/email (859) 329-9574 TONY.B.HORN2.MIL@MAIL.MIL	Disapprove ☐
Date	Date
Address 1812 Irvine Road Richmond, KY 40475	

State Sponsored Life Insurance (SSLI) Survivor Benefit

Enrollment Form

Offered through AFBA Multi-Association Group Insurance Alliance Trust

Office Use Only:
Cert Number _____
Coverage Effective Date _____

Association Information

Association Name National Guard Association of Kentucky

Guard Member Information

Name (last, first, middle) _____ Rank _____ SSN _____

DOB _____ (Mo/Day/Year) Height _____ ft _____ in Weight _____ lbs

☒ Male ❒ Female ❒ Married ❒ Not-Married

Mailing Address _____ (Street) (City) (State) (Zip)

Home Phone Number _____ Cell Phone Number _____

Civilian Email Address _____

NG Unit B CO DET 1 KY R&R BN Richmond, Ky. 40475 Date of Enlistment _____ (Mo/Day/Year)

As applicant, I designate beneficiary(ies) to receive benefits as indicated below.

Beneficiary _____ (First Name) (Last Name) (SSN) (Relationship) (DOB)

Optional Dependent Information

Spouse Name (last, first, middle) _____ ❒ Male ❒ Female

DOB _____ (Mo/Day/Year) Height _____ ft _____ in Weight _____ lbs

NOT APPLICABLE

Number of Children _____

Child 1 Name (last, first, middle) _____ DOB _____ ❒ Male ❒ Female

Child 2 Name (last, first, middle) _____ DOB _____ ❒ Male ❒ Female

Child 3 Name (last, first, middle) _____ DOB _____ ❒ Male ❒ Female

Child 4 Name (last, first, middle) _____ DOB _____ ❒ Male ❒ Female

Coverage

This application is requested for: ☒ New Enrollment ❒ Change

Guard Member - Coverage (monthly contributions)	Spouse	Dependent(s)
☒ $10,000 ($3.66)		

Benefits Underwritten by 5Star Life Insurance Company (a Lincoln, Nebraska company)
Admin. Office: 1117 Louisville Road, Frankfort, KY 40601
1-502-564-7500 • www.ngaky.org

Statement of Health

Answer each question TO THE BEST OF YOUR KNOWLEDGE AND BELIEF. Circle the specific condition and give full details to any "yes" answers on a separate 8 1/2 x 11 piece of paper (include name, DOB, and question # the answer refers to).

	Member Yes	Member No	Spouse Yes	Spouse No
I. In the past 10 years, has any Applicant:				
A. Had a life or health insurance application declined, postponed, modified or rated?	❒	❒	❒	❒
B. Been diagnosed, advised, or treated by a physician or health advisor for the listed conditions: Heart attack, coronary artery disease, or any heart disorder, stroke, high blood pressure, blood or circulatory disorder, diabetes, cancer, tumor, chronic obstructive pulmonary disease (COPD) or any lung or respiratory disorder, liver disorder, alcohol or drug abuse, kidney disorder, disorder of the pancreas, paralysis, epilepsy, or mental, nervous or emotional disorder?	❒	❒	❒	❒
II. In the past 5 years, has any Applicant been admitted or confined to any hospital or medical treatment facility or consulted a physician or health advisor for any disease not listed above, or been advised to have any surgical operation or diagnostic tests (excluding genetic tests and screenings)?	❒	❒	❒	❒
III. Has any Applicant ever been diagnosed or treated by a physician or tested positive for Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), or AIDS-Related Complex (ARC)?	❒	❒	❒	❒

IV. For each Applicant list any prescribed medication taken regularly or frequently: _____

_____

_____

Conditions Relating to This Enrollment Form

Eligibility: I am eligible to apply for this benefit as a Guard Member per the Master Group Policy.

Agreement: I, as Guard Member, have the appropriate knowledge to answer the health questions for my spouse. I represent that all statements and answers in this enrollment form are complete, true and correctly recorded **TO THE BEST OF MY KNOWLEDGE AND BELIEF**. I agree that: 1) upon approval of this enrollment form by 5Star Life Insurance Company, it and the Certificate of insurance coverage issued to fund my benefit will describe the benefits and terms of coverage provided under the Master Group policy; and 2) if within 180 days of receipt of all required documentation this enrollment form is not approved, it will become void and any contributions paid will be refunded; I will be so notified.

Authorization: I authorize 5 Star Life Insurance Company to collect medical information or investigation reports about proposed insureds named in this application. I authorize those with such information or reports to release them to 5 Star Life. I give 5Star Life permission to send such information or reports to its reinsurers, any Insurance Representative who solicited the application, and any third parties who administer the policies issued by 5Star Life. I authorize MIB, Inc. ("MIB") and any MIB member insurer, to provide any medical or personal information that it has about me to 5Star Life, its reinsurer or any MIB-authorized third party administrator performing underwriting services on 5Star Life's behalf. I also authorize 5Star Life, its reinsurer or authorized third-party administrator, to make a brief report of my personal health information to MIB. This authorization shall remain in effect for the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery, but in no event more than 24 months from the date I sign below.

Acknowledgement: I acknowledge that I am, or my authorized representative is, entitled to receive a copy of this authorization upon request. Signature must be personal.

Sign Here

Member's Signature _____ Date _____

Signed at (City, State) Richmond, KY

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

KY

AUTHORIZATION TO START, STOP OR CHANGE AN ALLOTMENT

PRIVACY ACT STATEMENT

AUTHORITY: 37 U.S.C. Section 701, E.O. 9397.

PRINCIPAL PURPOSE: To permit starts, changes, or stops to allotments. To maintain a record of allotments and ensure starts, changes, and stops are in keeping with member's desires.

ROUTINE USES: In addition to those disclosures generally permitted under 5 U.S.C. Section 552a(b) of the Privacy Act, these records of information contained therein may specifically be disclosed outside the DoD as a routine use to the Federal Reserve banks to distribute payments made through the direct deposit system to financial organizations or their processing agents authorized by individuals to receive and deposit payments in their accounts. It may also be disclosed to the Treasury Department, Internal Revenue Service, Social Security Administration, Department of Veterans Affairs, Federal, state and local agencies for civil or criminal law enforcement. In addition it can be released for any of the blanket routine uses published at the beginning of the DFAS compilation of system of record notices.

DISCLOSURE: Voluntary; however, failure to provide the requested information as well as the Social Security number may result in the member not being able to start, change, or stop allotments.

TO BE COMPLETED BY ALLOTTER

1. BRANCH OF SERVICE *(X One)*

	AIR FORCE		MARINE CORPS
X	ARMY		NAVY

2. NAME OF ALLOTTER *(Last, First, Middle Initial) (Print or Type)*

3. SSN

4. PAY GRADE

5. ADDRESS OF ALLOTTER *(Street or Box Number, City, State, Zip Code)*

6. DAYTIME TELEPHONE NUMBER *(Include Area Code)*

7. EFFECTIVE DATE *(YYYYMM)*

8. MONTHLY AMOUNT OF ALLOTMENT

$ 3.66

9. NAME OF ALLOTTEE *(First, Middle Initial, Last)*

NGAKY

10. ALLOTMENT ACTION *(X One)*

X	START		STOP		CHANGE

11. TERMS IN MONTHS

12

12. CREDIT LINE *(If Applicable)*

13. ALLOTMENT OF CLASS AUTHORIZED *(X One)*

	C - CHARITY/CFC
X	D - DISCRETIONARY ALLOTMENTS *(Includes dependent support, payment to financial institution, insurance, repayment of home loan, rent, etc. (Notes 1 and 2))*
	F - CHARITY - EMERGENCY/ASSISTANCE FUND CONTRIBUTION
	L - REPAYMENT OF LOAN TO SERVICE ORGANIZATION *(Red Cross, Relief Society, etc. - Navy and Marine Corps only)*
	N - NSLI OR USGLI INSURANCE PREMIUM
	T - PAYMENT OF DEBTS TO U.S., DELINQUENT STATE OR LOCAL INCOME/EMPLOYMENT TAXES
	- OTHER *(Specify)*

14. ALLOTTEE'S MAILING ADDRESS *(Street or Box Number, City, State, Zip Code)*

1117 LOUISVILLE ROAD
FRANKFORT, KY 40601

15. IF FOREIGN ADDRESS COMPLETE AS FOLLOWS *(Province, Country)*

16. REMARKS (Personal E-mail)

17. COMPANY CODE/FINANCIAL INSTITUTION/ROUTING TRANSIT NUMBER

18. ACCOUNT NUMBER/POLICY NUMBER

X	CHECKING
	SAVINGS

19. TOTAL CLASS L AMOUNT
$

20. TOTAL CLASS T AMOUNT
$

STATEMENT OF UNDERSTANDING

I understand that this allotment is legal and that by voluntarily completing this form, I am responsible for:

- **Ensuring** that the information is correct;
- **Reviewing** my Leave and Earnings Statement to ensure the allotment stops, starts, or changes as directed including amount and payee;
- **Collecting** overpayments from the receiver (payee) of the allotment, if I do not change or stop the allotment after a loan is repaid;
- **Contacting** the receiver (payee) of the allotment, at my expense, to obtain monthly statements for my personal records.

I also understand that any problems once the allotment is delivered to the receiver (payee) are beyond the control of the Defense Finance and Accounting Service (DFAS) and that DFAS is only responsible for ensuring proper delivery of any voluntary allotment for the period directed. I further understand that pursuant to conditions listed in the DoD 7000.14-R, Volume 7A, changes can be made by DFAS to an allottee's name, address, or account number.

Under penalty of the Uniform Code of Military Justice, I certify that this allotment is NOT for the purchase, lease, or rental of personal property or payment toward personal property.

21. SIGNATURE OF ALLOTTER

22. DATE *(YYYYMMDD)*

NOTE 1. Must be different address than allotter. Each Dependent allotment must have a different credit line. Only one support allotment per dependent is allowed.
NOTE 2. This is a voluntary allotment and can be to any payee you desire.

Form W-4 (2019)

Future developments. For the latest information about any future developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. You may claim exemption from withholding for 2019 if **both** of the following apply.

- For 2018 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2019 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married filing jointly and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. ***Head of household please note:*** Generally, you may claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you may be eligible to claim a child tax credit for each of your eligible children. To qualify, the child must be under age 17 as of December 31, must be your dependent who lives with you for more than half the year, and must have a valid social security number. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line F. Credit for other dependents. When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total

---

Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2019

1 Your first name and middle initial	Last name	**2 Your social security number**
Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married filing separately, check "Married, but withhold at higher Single rate."	
City or town, state, and ZIP code	**4 If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card.** ► ☐	

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2019, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ►	**7**	

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ► **Date** ►

8 Employer's name and address (**Employer:** Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	**9** First date of employment	**10** Employer identification number (EIN)

Standard Form 86
Revised July 2017
U.S. Office of Personnel Management

5 CFR Parts 731, 732, and 736
OMB No. 3206 0005

QUESTIONNAIRE FOR NATIONAL SECURITY POSITIONS

UNITED STATES OF AMERICA

AUTHORIZATION FOR RELEASE OF INFORMATION

Carefully read this authorization to release information about you, then sign and date it in ink.

I Authorize any investigator, special agent, or other duly accredited representative of the authorized Federal agency conducting my background investigation, reinvestigation, or ongoing evaluation (i.e. continuous evaluation) of my eligibility for access to classified information or, when applicable, eligibility to hold a national security sensitive position to obtain any information relating to my activities from individuals, schools, residential management agents, employers, criminal justice agencies, credit bureaus, consumer reporting agencies, collection agencies, retail business establishments, or other sources of information. This information may include, but is not limited to current and historic academic, residential, achievement, performance, attendance, disciplinary, employment, criminal, financial, and credit information, and publicly available social media information. I authorize the Federal agency conducting my investigation, reinvestigation, or ongoing evaluation (i.e. continuous evaluation) of eligibility to disclose the record of investigation or ongoing evaluation to the requesting agency for the purpose of making a determination of suitability, or initial or continued eligibility for a national security position or eligibility for access to classified information.

I Understand that, for these purposes, publicly available social media information includes any electronic social media information that has been published or broadcast for public consumption, is available on request to the public, is accessible on-line to the public, is available to the public by subscription or purchase, or is otherwise lawfully accessible to the public. I further understand that this authorization does not require me to provide passwords; log into a private account; or take any action that would disclose non-publicly available social media information.

I Authorize the Social Security Administration (SSA) to verify my Social Security Number (to match my name, Social Security Number, and date of birth with information in SSA records and provide the results of the match) to the United States Office of Personnel Management (OPM) or other Federal agency requesting or conducting my investigation for the purposes outlined above. I authorize SSA to provide explanatory information to OPM, or to the other Federal agency requesting or conducting my investigation, in the event of a discrepancy.

I Understand that, for financial or lending institutions, medical institutions, hospitals, health care professionals, and other sources of information, separate specific releases may be needed, and I may be contacted for such releases at a later date.

I Authorize any investigator, special agent, or other duly accredited representative of the OPM, the Federal Bureau of Investigation, the Department of Defense, the Department of Homeland Security, the Office of the Director of National Intelligence, the Department of State, and any other authorized Federal agency, to request criminal record information about me from criminal justice agencies for the purpose of determining my eligibility for assignment to, or retention in, a national security position, in accordance with 5 U.S.C. 9101. I understand that I may request a copy of such records as may be available to me under the law.

I Authorize custodians of records and other sources of information pertaining to me to release such information upon request of the investigator, special agent, or other duly accredited representative of any Federal agency authorized above regardless of any previous agreement to the contrary.

I Understand that the information released by records custodians and sources of information is for official use by the Federal Government only for the purposes provided in this Standard Form 86, and that it may be disclosed by the Government only as authorized by law.

I Authorize the information to be used to conduct officially sanctioned and approved personnel security-related studies and analyses, which will be maintained in accordance with the Privacy Act.

Photocopies of this authorization with my signature are valid. This authorization shall remain in effect so long as I occupy a national security sensitive position or require eligibility for access to classified information.

Signature *(Sign in ink)*	Full name *(Type or print legibly)*			Date signed *(mm/dd/yyyy)*
Other names used			Date of birth	Social Security Number
Current street address Apt. #	City *(Country)*	State KY	ZIP Code	Telephone number

Standard Form 86
Revised July 2017
U.S. Office of Personnel Management
5 CFR Parts 731, 732, and 736

QUESTIONNAIRE FOR NATIONAL SECURITY POSITIONS

Form approved:
OMB No. 3206 0005

UNITED STATES OF AMERICA

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

If you answered "Yes" to Section 21 of the Standard Form 86 (SF-86), carefully read this authorization to release information about you, then sign and date it in ink.

This is an authorization for the investigator to ask your health practitioner(s) the questions below concerning your mental health consultations. The U.S. government recognizes the critical importance of mental health and advocates proactive management of mental health conditions to support the wellness and recovery of Federal employees and others. The government recognizes that mental health counseling and treatment may provide important support for those who have experienced traumatic events, as well as for those with other mental health conditions. While most individuals with mental health conditions do not present security risks, there may be times when such a condition can affect a person's eligibility for a security clearance. Seeking or receiving mental health care for personal wellness and recovery may contribute favorably to decisions about your eligibility. Your signature will allow the practitioner(s) to answer only those questions identified below.

Authorization

I am seeking assignment to or retention in a national security sensitive position. As part of the investigative process, I hereby authorize the investigator, special agent, or duly accredited representative of the authorized Federal agency conducting my background investigation, reinvestigation, or ongoing evaluation (i.e. continuous evaluation) of eligibility for access to classified information or eligibility to hold a national security sensitive position to request, and my health practitioner(s) to provide, the information requested below, relating to my mental health consultations.

In accordance with HIPAA, I understand that I have the right to revoke this authorization at any time by writing to my health care provider/entity. Revocation of this authorization is not effective until received by my health care provider/entity. I understand that I may revoke this authorization, except to the extent that action has already been taken based on this authorization. Further, I understand that this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

I understand the information disclosed pursuant to this authorization for use by the Federal Government only for purposes provided in the Standard Form 86 will no longer be covered by the HIPAA Privacy Rule, and that the Federal Government may redisclose the information as authorized by law, subject to Privacy Act safeguards.

Photocopies of this authorization with my signature are valid. This authorization is valid for one (1) year from the date signed or upon termination of my affiliation with the Federal Government, whichever is sooner.

Signature *(Sign in ink)*	Full name *(Type or print legibly)*			Date signed *(mm/dd/yyyy)*
Other names used				Social Security Number
Current street address Apt. #	City *(Country)*	State KY	ZIP Code	Telephone number

For Use By Practitioner(s) Only

Does the person under investigation have a condition that could impair his or her judgment, reliability, or trustworthiness?

☐ YES ☐ NO

If so, describe the nature of the condition and the extent and duration of the impairment or treatment.

What is the prognosis?

Dates of treatment?

Signature *(Sign in ink)*	Practitioner name	Date signed *(mm/dd/yyyy)*

Tattoo Screening Form

The proponent agency is ARNG-GSS

Tattoo Description	Compliant (Y/N)	Location	Compliant(Y/N)	Meaning

☐ Applicant has no tattoos

Applicant:	Signature of Applicant:_____ Date:_____
GC:	
RRC:	***I certify that all tattoos are in compliance with AR 670-1

AUTHORIZATION TO START, STOP, OR CHANGE BASIC ALLOWANCE FOR QUARTERS *(BAQ)*, AND/OR VARIABLE HOUSING ALLOWANCE *(VHA)*

For use of this form, see AR 37-104-4; the proponent agency is ASA (FM)

PRIVACY ACT STATEMENT

AUTHORITY: 37 USC 403; Public Law 96-343; EO 9397.

PRINCIPLE PURPOSE: To start, adjust or terminate military member's entitlement to basic allowance for quarters *(BAQ)* and/or variable housing allowance *(VHA)*.

ROUTINE USE: To adjust member's military pay record, information may be disclosed to Army components, such as USAFAC, major commands, and other Army installations; to other DOD components; other federal agencies such as IRS, Social Security Administration and VA, GAO, members of Congress; State and local government; US and State courts, and various law enforcement agencies. Social Security Number (SSN) is used for positive identification.

DISCLOSURE IS VOLUNTARY: Nondisclosure may result in nonpayment of BAQ and/or VHA. Disclosure of your SSN is voluntary. However, this form will not be processed without your SSN because the Army identifies you for pay purposes by your SSN.

1. NAME *(Last, First, MI)*

2. SOCIAL SECURITY NUMBER

3. GRADE

4. TYPE OF ACTION

☐ START ☐ CANCEL ☐ CHANGE ☐ REPORT
☐ CORRECT ☐ STOP ☐ RECERTIFICATION

5. DUTY LOCATION *(Include Station, Name, City, State, and Zip Code)*

6. DATE/ACTION *(YYYYMMDD)*

7. BAQ TYPE
☐ WITH DEPENDENTS ☐ PARTIAL
☐ WITHOUT DEPENDENTS

8. MARITAL/DEPENDENCY STATUS
☐ a. SINGLE ☐ b. MARRIED *(see blocks (1), (2) & (3))* ☐ c. DIVORCED *(see blocks (1), (2) & (3))*
☐ d. LEGALLY SEPARATED *(see blocks (1), (2) & (3))* ☐ e. DEPENDENT CHILD *(see blocks (4), (5) & (6))*

(1) Spouse/Former Spouse SSN
(2) Spouse/Former Spouse Duty Station
(3) Date of Marriage, Divorce/Separation

(4) Child in Custody of: ☐ Member ☐ Spouse ☐ Former Spouse ☐ Other

(5) If you check "OTHER" above, prepare DD Form 137 to establish dependency.

(6) If child support received from another military member, complete (1), (2) & (3).

9. QUARTERS ASSIGNMENT/AVAILABILITY
☐ a. ADEQUATE *(see block (1))* ☐ b. INADEQUATE *(see blocks (1), (2) & (4))*
☐ c. TRANSIENT *(see block (3))* ☐ d. NOT AVAILABLE

(1) QUARTERS NO. _____
(2) FAIR RENTAL VALUE $ _____

(3) FROM: _____ TO: _____

(4) ☐ MEMBER ELECTION *(Member in grade E7 and above)* ☐ COMMANDER DETERMINATION *(Attached)*

10. DEPENDENTS/SHARERS *(Continue on back if required)*

NAME OF DEPENDENT/SHARER	COMPLETE CURRENT ADDRESS *(Include ZIP Code)*	RELATIONSHIP	DOB OF CHILDREN

11. CERTIFICATION OF DEPENDENT SUPPORT

☐ I certify that I provide, or am will to provide adequate support for the above named dependents. I am aware that failure to support the above named dependents may result in stopping BAQ and recouping BAQ for any prior periods/nonsupport.

☐ IAW service regulations, I certify that the dependency status of my primary dependents, on whose behalf I am receiving BAQ, has not changed so as to affect my entitlement thereto for the period

12. EXPENSES, IF AUTHORIZED, I AM REQUESTING VHA BASED ON

☐ My permanent duty station: ☐ My dependent's location: ☐ Both my permanent duty station and dependent's location.

a. Monthly Expenses:	Member	Dependent
(1) Mortgage *(PITI)* or Rent		
(2) Insurance		
(3) Other		
TOTALS		

b. Sharer/Lease Information
(1) Rental/Residential Address:
(2) Effective Date: (3) Expiration Date:
(4) Number of Sharers *(show name(s) and address in block 10.)*

c. Address Information
(1) Landlord's Name and Address:
(2) Landlord's Phone No.

I certify ALL information regarding this authorization is correct. I will immediately notify the FAO/HRO of any changes in the information above, due to divorce, marriage, death, living in government quarters etc, which could affect by BAQ or VHA entitlement.
IMPORTANT: Making a false statement or claim against the US Government is punishable by courts-martial. The penalty for willfully making a false claim or a false statement in connection with claims is a maximum fine of $10,000 or imprisonment for 5 years, or both.

13. MEMBER'S SIGNATURE	14. DATE	15. CERTIFYING OFFICER'S SIGNATURE	16. DATE

OPEN A CHECKING ACCOUNT

Phone 844-72-SERVE | www.afbank.com/openrecruit | 320 Kansas Ave. Ft. Leavenworth KS 66027 | Fax 816-412-0055

ARMED FORCES BANK

Important Information About Procedures for Opening a New Account: To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account.

PLEASE ATTACH A COPY OF A GOVERNMENT ISSUED PHOTO ID

RESET

ACCOUNT OPTIONS

Account Type: [X] Checking Account Select if desired: [ ] Debit Card [ ] Savings Account

Ownership: [ ] Single/Individual Owner [ ] Joint Owners With Right of Survivorship

MILITARY INFORMATION

Basic Active Duty Service Date or Date Expected to Ship:

Branch of Service: [ ] Army [ ] Army Reserve [ ] Air Force [ ] Navy [ ] Marines [ ] National Guard

Recruiter's Name: Horn, Tony B. Recruiter's Phone: (859) 329-9574

SINGLE ACCOUNT HOLDER INFORMATION

Printed Name:

Email: **Current email required** TONY.B.HORN2.MIL@MAIL.MIL **IMPORTANT: Email used for primary communication**

Phone No:

Are you a U.S. citizen under U.S. state or federal law?

Place of Birth: Date of Birth: MM/DD/YYYY Yes: [ ] No: [ ]

LAST 4: Mother's Maiden Name:

Street Address:

City: State: Zip Code:

mailing address if different

Street Address:

City: State: Zip Code:

JOINT ACCOUNT HOLDER INFORMATION (if applicable)

Printed Name:

Place of Birth: Date of Birth: MM/DD/YYYY

SSN: Mother's Maiden Name:

Email Address: Phone Number:

3 SIMPLE STEPS

1. Fill out this form and attach a photo ID.
2. Scan it to us! recruit@afbank.com or Fax it in! 816-412-0055
3. We'll call you with an account number in minutes.

QUESTIONS?

Contact us
844 72 SERVE
recruit@afbank.com
M-F 0800-1830 Central Time
Sat 0900-1400 Central Time

For Bank Personnel Only:

Port:

DDA:

SAV:

PROD.

BR: 24

The applicant(s) signing is requesting the opening of an Armed Forces Bank Checking Account. Subject to account holder agreement, Armed Forces Bank VISA Debit Card will be issued to each account holder. By using the Account, the applicant(s) agrees to abide by the Agreements contained within the Deposit Account Agreement and Disclosures, which shall be provided upon acceptance of this application and before the first deposit is made. If this is a Joint Account, each Account Holder agrees that they open this Account as joint tenants with rights-of-survivorship.

TIN/Backup Withholding: Under penalties of perjury, I certify that the Social Security Number shown is my correct taxpayer identification number and that I am not subject to backup withholding, because I am exempt from backup withholding and I am a U.S. citizen or other U.S. person, or because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or because the IRS has notified me that I am no longer subject to backup withholding.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

SIGNATURES

Single Account Holder: _____ Date: _____

Joint Account Holder: _____ Date: _____

MEMBER FDIC

HIGH SCHOOL VERIFICATION

The proponent agency is ARNG-HRR. For use of this form see ARNG Accessions Options Criteria

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC Section 503, Enlistments: recruiting campaigns; compilation of directory information.
PRINCIPAL PURPOSE(s): The purpose(s) for which the information is to be used, is to verify applicant(s) who claim to be high school junior(s) or senior(s) and are in good standing to graduate. Used to verify the mandatory date of return to school, and establishes the date the school will resume in the next school calendar year.
ROUTINE USE(s): None
DISCLOSURE: Voluntary, however, failure to disclose the information may delay entry into the split training program.

Section I. Student Information

1. Students Name (Last, First, Middle): _____

2. (State) Kentucky _____ Army National Guard

Section II. School Information

3a. School Name: _____

3b. School Address: _____

(City) _____ (State) Kentucky _____ (zip code) _____

4. Student Current Grade Level: _____

a. There is reasonable assurance that the student will graduate on: _____

b. The last regularly scheduled day of school for current school year: _____

c. The first regularly scheduled day of the start of the upcoming school year (Leave blank for seniors): _____

Typed/Printed Name (School Official)	School Official Signature	Title
School Official Phone Number	School Official Email Address	Date

Section III. Consent and Authorization

5. I hereby give permission for school official(s) to allow the above named student, to miss the listed number of days below from either the current school year or the beginning of the upcoming school year in order to meet the minimum (75 -day) training requirements under the Split Training Option as outlined in TR 350-6.

Number of days authorized to miss: _____

By signing this form, I authorize the school official(s) to release school transcripts as listed for the above named student. (parental consent is required, if student is a minor.)

Typed/Printed Name of Student	Signature of Student	Date
Typed/Printed Name of Parent/Guardian	Signature of Parent/Guardian	Date
Horn, Tony B.		
Typed/Printed Name of Recruiter/Representative	Signature of Recruiter/Representative	Date

38. NAME *(Last, First, Middle Initial)*	39. SOCIAL SECURITY NUMBER

USE THIS DD FORM 1966 PAGE ONLY IF EITHER SECTION APPLIES TO THE APPLICANT'S RECORD OF MILITARY PROCESSING.

SECTION VIII - PARENTAL/GUARDIAN CONSENT FOR ENLISTMENT

40. PARENT/GUARDIAN STATEMENT(S) *(Line out portions not applicable)*

a. I/we certify that *(Enter name of applicant)* _____

has no other legal guardian other than me/us and I/we consent to his/her enlistment in the United States *(Enter Branch of Service)*

ARMY NATIONAL GUARD

I/we acknowledge/understand that he/she may be required upon order to serve in combat or other hazardous situations. I/we certify that no promises of any kind have been made to me/us concerning assignment to duty, training, or promotion during his/her enlistment as an inducement to me/us to sign this consent. I/we hereby authorize the Armed Forces representatives concerned to perform medical examinations, other examinations required, and to conduct records checks to determine his/her eligibility. I/we relinquish all claim to his/her service and to any wage or compensation for such service. I/we authorize him/her to be transported unsupervised to/from the Military Entrance Processing Station via public conveyance and to stay unsupervised at a government contracted hotel facility.

b. FOR ENLISTMENT IN A RESERVE COMPONENT.

I/we understand that, as a member of a reserve component, he/she must serve minimum periods of active duty for training unless excused by competent authority. In the event he/she fails to fulfill the obligations of his/her reserve enlistment, he/she may be recalled to active duty as prescribed by law. I/we further understand that while he/she is in the ready reserve, he/she may be ordered to extended active duty in time of war or national emergency declared by the Congress or the President or when otherwise authorized by law, and may be required upon order to serve in combat or other hazardous situations.

c. PARENT		
(1) TYPED OR PRINTED NAME *(Last, First, Middle Initial)*	(2) SIGNATURE	(3) DATE SIGNED *(YYYYMMDD)*
d. WITNESS		
(1) TYPED OR PRINTED NAME *(Last, First, Middle Initial)*	(2) SIGNATURE	(3) DATE SIGNED *(YYYYMMDD)*
SFC Horn, Tony B.		
e. PARENT		
(1) TYPED OR PRINTED NAME *(Last, First, Middle Initial)*	(2) SIGNATURE	(3) DATE SIGNED *(YYYYMMDD)*
f. WITNESS		
(1) TYPED OR PRINTED NAME *(Last, First, Middle Initial)*	(2) SIGNATURE	(3) DATE SIGNED *(YYYYMMDD)*
SFC Horn, Tony B.		

41. VERIFICATION OF SINGLE SIGNATURE CONSENT

These documents must be turned in as soon as possible to your recruiter if they are applicable.

Identification Documents/ Banking information

___ Driver's License

___Social Security Card

___ Birth Certificate

___Direct Deposit Form

___ Passport

Educational Documents

___ High School Diploma

___College Transcripts

___ High School Letter

___ROTC Certificate

___ High School Transcripts

Dependents Identification Documents

These documents are needed to get your family members in our system for additional benefits you can receive while serving.

___ Marriage /Divorce Cert.

___Spouse Driver's License

___ Spouse SS Card

___Child's Birth Certificate

___Child's SS Card

Miscellaneous Documentation

___Medical Documents

___DD214

Waiver Documents

___Personal Letter

___ 2 Character Reference Letters

If you have any issues obtaining these documents contact

SFC Horn, Tony B.

(859) 329-9574

COMPLETE THE FOLLOWING FORM COMPLETELY AND HONESTLY

PPLICANT'S INITIALS

1	DO YOU HAVE PSORIASIS, ACNE, OR SCALY SKIN?	YES		NO	
2	DO YOU HAVE ANY SORES ON YOUR BODY	YES		NO	
3	DO YOU HAVE ANY RASHES ON YOUR BODY OR JOCK ITCH	YES		NO	
4	DO YOU HAVE ANY WARTS ON YOUR BODY?	YES		NO	
5	ARE YOU ALLERGIC TO ANYTHING?	YES		NO	
6	HAVE YOU EVER HAD HAY FEVER?	YES		NO	
7	DO YOU WHEEZE WHILE DOING PHYSICAL ACTIVITIES?	YES		NO	
8	HAVE YOU EVER HAD SHORTNESS OF BREATH?	YES		NO	
9	HAVE YOU EVER HAD ASTHMA?	YES		NO	
10	HAVE YOU EVER HAD A COLLAPSED LUNG?	YES		NO	
11	DO YOU EVER HYPERVENTILATE?	YES		NO	
12	HAVE YOU EVER HAD A HEAD INJURY?	YES		NO	
13	DOES THE SIGHT OF BLOOD BOTHER YOU?	YES		NO	
14	DO YOU HAVE FAINTING SPELLS OR DIZZINESS?	YES		NO	
15	DO YOU HAVE SEVERE OR FREQUENT HEADACHES?	YES		NO	
16	IS YOUR VISION LESS THAN 20/20?	YES		NO	
17	DO YOU WEAR GLASSES?	YES		NO	
18	DO YOU WEAR CONTACT LENSES?	YES		NO	
19	IF YES, IS YOUR PRESCRIPTION LESS THAN 12 MOS OLD?	YES		NO	
21	DO YOU HAVE HEARING LOSS IN EITHER EAR?	YES		NO	
22	HAVE YOU EVER HAD TUBES IN YOUR EARS?	YES		NO	
23	DO YOU HAVE BRACES ON YOUR TEETH?				
24	DO YOU HAVE ANY RETAINERS IN YOUR MOUTH?	YES		NO	
25	HAVE YOU EVER HAD YOUR ADENOIDS OR TONSILS REMOVED?	YES		NO	
26	HAVE YOU EVER HAD HIGH BLOOD PRESSURE?	YES		NO	
27	DO YOU HAVE A HEART MURMUR?	YES		NO	
29	DO YOU HAVE AN IRREGULAR HEARTBEAT?	YES		NO	
30	HAVE YOU EVER BEEN GIVEN AN INHALER?	YES		NO	
31	DO YOU GET CHEST PAINS?	YES		NO	
32	HAVE YOU EVER TAKEN AN EKG?	YES		NO	
33	HAVE YOU EVER HAD ANY ULCERS?	YES		NO	
34	HAVE YOU EVER HAD YOUR APPENDIX REMOVED?	YES		NO	
35	HAVE YOU EVER HAD A HERNIA?	YES		NO	
36	HAVE YOU EVER HAD A KIDNEY DISEASE?	YES		NO	
37	ARE YOU MISSING EITHER KIDNEY?	YES		NO	
38	HAVE YOU EVER HAD A TUMOR?	YES		NO	
39	HAVE YOU EVER HAD A CYST REMOVED?	YES		NO	
40	ARE YOU MISSING ANY FINGERS?	YES		NO	
41	DO YOU HAVE ANY FINGERS YOU CAN'T BEND?	YES		NO	
42	HAVE YOU EVER HAD A DISLOCATED SHOULDER?	YES		NO	
43	DO YOU LOSE FEELING IN YOUR ARMS OR LEGS?	YES		NO	
44	DO YOU HAVE ANY ABNORMAL CURVATURE OF THE SPINE (SCOLIOSIS)?	YES		NO	
45	HAVE YOU EVER WORN A BRACE ON YOUR BODY?	YES		NO	
46	DO YOU HAVE BACK PAINS?	YES		NO	
47	HAVE YOU EVER HAD A SLIPPED DISC IN YOUR BACK?	YES		NO	
48	HAVE YOU EVER BROKEN ANY BONES?	YES		NO	
49	HAVE YOU EVER HAD WATER ON THE KNEE?	YES		NO	
53	ARE YOU MISSING ANY TOES?	YES		NO	
57	HAVE YOU EVER HAD ANY INJURIES OR OPERATIONS?	YES		NO	
58	HAVE YOU EVER HAD ANY X-RAYS OR STITCHES?	YES		NO	
59	HAVE YOU EVER HAD ANY SURGERIES?	YES		NO	
60	DO YOU HAVE ANY SCARS ON YOUR BODY?	YES		NO	
61	DO YOU HAVE ANY TATTOOS?	YES		NO	
62	HAVE YOU EVER HAD PINS, SCREWS, PLATES, OR RODS IN YOUR BODY?	YES		NO	
64	HAVE YOU EVER HAD SEIZURES?	YES		NO	
65	HAVE YOU EVER HAD ANY BODY PARTS PIERCED?	YES		NO	

66	HAVE YOU EVER BEEN SEEN IN A HOSPITAL EMERGENCY ROOM?	YES		NO	
67	HAVE YOU EVER BEEN TREATED FOR DRUG OR ALCOHOL ABUSE?	YES		NO	
68	HAVE YOU EVER THOUGHT OF OR ATTEMPTED SUICIDE?	YES		NO	
69	HAVE YOU EVER TALKED TO A PSYCHIATRIST OR PSYCHOLOGIST?	YES		NO	
	HAVE YOU EVER CUT YOURSELF?	YES		NO	
70	HAVE YOU EVER BEEN COUNSELED FOR EMOTIONAL PROBLEMS?	YES		NO	
71	HAVE YOU EVER BEEN COUNSELED FOR FAMILY PROBLEMS?	YES		NO	
72	DO YOU HAVE ATTENTION DEFICIT DISORDER?	YES		NO	
73	HAVE YOU EVER BEEN GIVEN MEDICATION FOR ADHD/ADD?	YES		NO	
74	HAVE YOU EVER WALKED IN YOUR SLEEP?	YES		NO	
75	HAVE YOU EVER WET IN THE BED SINCE AGE 12?	YES		NO	
76	DO YOU HAVE PERIODS OF DEPRESSION?	YES		NO	
77	HAVE YOU EVER TAKEN ANY MEDICATIONS?	YES		NO	
78	HAVE YOU EVER SEEN A PHYSICIAN FOR ANY MEDICAL PROBLEMS?	YES		NO	
79	HAVE YOU EVER BEEN HOSPITALIZED?	YES		NO	
80	HAVE YOU EVER HAD A MISCARRIAGE OR ABORTION? IF SO, WHEN?	YES		NO	
81	HAVE YOU EVER BEEN PREGNANT? # OF TIMES: _____	YES		NO	
82	IS THERE ANY REASON TO BELIEVE YOU ARE PREGNANT NOW?	YES		NO	
83	ARE YOU CURRENTLY ON ANY MEDICATION FOR BIRTH CONTROL?	YES		NO	
84	HAVE YOU EVER GIVEN BIRTH? IF SO HOW MANY TIMES? _____	YES		NO	
85	HAVE YOU EVER HAD AN IRREGULAR MENSTRUAL CYCLE?	YES		NO	
86	HAVE YOU EVER BEEN DIVORCED OR SEPARATED?	YES		NO	
87	ARE YOU COURT ORDERED TO PAY CHILD SUPPORT?	YES		NO	
88	DO YOU HAVE A SPOUSE?	YES		NO	
89	HAS YOUR SPOUSE BEEN MARRIED BEFORE?	YES		NO	
90	DOES YOUR SPOUSE HAVE CHILDREN FROM A PREVIOUS MARRIAGE?	YES		NO	
91	IS YOUR SPOUSE IN ANY OF THE ARMED FORCES TO INCLUDE THE RESERVES?	YES		NO	
92	HAVE YOU PREVIOUSLY BEEN A MEMBER OF THE ARMED FORCES?	YES		NO	
93	HAVE YOU EVER USED MARIJUANA? HOW MANY TIMES?____ WHEN WAS LAST USE?_____	YES		NO	
94	DO YOU HAVE A CHILD LIVING WITH YOU OR SOMEONE ELSE?	YES		NO	
95	HAVE YOU EVER USED COCAINE? HOW MANY TIMES? ____ WHEN?_____	YES		NO	
96	HAVE YOU EVER EXPERIMENTED WITH ANY ILLEGAL DRUGS? WHAT?_____	YES		NO	
97	HAVE YOU EVER SPOKE TO POLICE TO INCLUDE JUVENILE OFFICERS?	YES		NO	
98	DO YOU HAVE ANY UNPAID TICKETS?	YES		NO	
99	HAVE YOU EVER BEEN ISSUED A TRAFFIC OR PARKING TICKET?	YES		NO	
100	HAVE YOU EVER HAD YOUR LICENSE SUSPENDED?	YES		NO	
101	HAVE YOU EVER BEEN TO A POLICE STATION FOR ANY REASON?	YES		NO	
102	HAVE YOU EVER BEEN QUESTIONED BY A LAW OFFICER?	YES		NO	
103	HAVE YOU EVER BEEN SUSPENDED OR EXPELLED FROM SCHOOL?	YES		NO	
104	HAVE YOU EVER BEEN IN THE DELAYED PROGRAM FOR ANY SERVICE?	YES		NO	
105	HAVE YOU EVER BEEN DISQUALIFIED FOR SERVICE AT ANY MEPS?	YES		NO	
106	HAVE YOU EVER PROCESSED FOR AT MEPS?	YES		NO	
108	ARE YOU COLOR BLIND?	YES		NO	
109	HAVE YOU EVER BEEN TREATED FOR A THYROID CONDITION?	YES		NO	
110	DO YOU HAVE GALL STONES OR KIDNEY STONES?	YES		NO	
113	HAVE YOU EVER BEEN ON PROBATION?	YES		NO	
114	HAVE YOU EVER BEEN FINGERPRINTED?	YES		NO	
115	HAVE YOU EVER BEEN HANDCUFFED?	YES		NO	
116	HAVE LAW ENFORCEMENT OFFICIALS EVER DETAINED YOU?	YES		NO	
118	HAVE YOU EVER HAD ANY CHARGES DISMISSED/EXPUNGED?	YES		NO	
119	HAVE YOU EVER HAD YOUR MIRANDA RIGHTS READ TO YOU?	YES		NO	
121	HAVE YOU EVER BEEN OVER 90 DAYS DELINQUENT ON ANY BILL?	YES		NO	
122	HAVE YOU EVER BOUNCED ANY CHECKS?	YES		NO	
123	ARE YOU ALLERGIC TO ANYTHING AT ALL? (MILK, WOOL, BEES, MEDS, ETC)	YES		NO	
125	HAVE YOU EVER BEEN IN A CAR ACCIDENT?	YES		NO	
126	MY CURRENT DRIVER LICENSE EXPIRES ON?	YES		NO	
127	MY DRIVERS LICENSE IS A PERMIT NOT A DRIVERS LICENSE	YES		NO	