Electronic Line by Line Enlistment Timesaving Template

Applicant Information

Ensure Javascript Is Enabled Before Attempting to Use! (Bar should be Purple)

(LEAVE BLANK IF NMN)

LAST	FIRST	MIDDLE	
SUFFIX	PLACE OF BIRTH: CITY	COUNTY	STATE
SSN	DATE MOVED TO ADDRESS	ADDRESS	
CITY	STATE / ZIP	COUNTY	
ENLISTING GRADE	PHONE	DOB: _____	
MALE ☐	MARRIED ☐		
FEMALE ☐	SINGLE ☐		
HEIGHT: FEET ____ INCHES____ TOTAL INCHES____	RACIAL CATEGORY: AMERICAN INDIAN/ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐		
WEIGHT / MAX WEIGHT	ETHNIC CATEGORY: HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐		

RRNCO Information

RS COMMANDER (for tattoo form)
NAME / GRADE / RSID

LAST, FIRST MI		E-MAIL	
PHONE	RSID	GRADE	LAST 4
ADDRESS		CITY, STATE ZIP	

Bank Information

BANK NAME	ADDRESS
CITY, STATE ZIP	ROUTING NUMBER
ACCOUNT NUMBER	

Beneficiary Information

PRIMARY	NAME	ADDRESS	CITY, STATE, ZIP
SSN	RELATIONSHIP	PERCENT	PAYMENT OPTION
SECONDARY	NAME	ADDRESS	CITY, STATE, ZIP
SSN	RELATIONSHIP	PERCENT	PAYMENT OPTION

Electronic **L**ine by **L**ine **E**nlistment **T**imesaving **T**emplate

Date will be one year from enlistment month in yyyymm format.

Miscellaneous Information			
SGLI AMOUNT		NGAI EFFECTIVE DATE	
ENLISTMENT: _____	ENLIST MONTH (FULL)	PACKET DATE: _____	DATED IN CITY, STATE

List Applicants Tattoos Below From Top to Bottom	
1.	2.
3.	4.
5.	6.

USMEPCOM 680-3A-E

THE FOLLOWING PAGE INCLUDES A USMEPCOM 680-3A-E. BY DEFAULT IT IS SET FOR A FIRST TIME ASVAB / PHYSICAL APPLICANT. IF FILLED OUT IN COMPLETION, THIS CAN BE USED FOR ANY APPLICANT. **IF IN DOUBT, USE THE RECRUITER ZONE GENERATED COPY.**

DD FORM 2807-2

IMMEDIATELY FOLLOWING THE USMEPCOM 680-3A-E YOU WILL FIND A DD FORM 2807-2. ON PAGE 2, BOX F YOU WILL SEE MAXIMUM WEIGHT PER AR 600-9. http://www.nationalguard.com/guard-basics/eligibility-requirements HAS A CALCULATOR FOR YOUR CONVENIENCE. **IF IN DOUBT, USE THE RECRUITER ZONE GENERATED COPY.**

QUICK LINKS

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

REQUEST FOR EXAMINATION

THE INFORMATION PROVIDED CONSTITUTES AN OFFICIAL STATEMENT

FOR OFFICIAL USE ONLY

PRIVACY ACT STATEMENT AUTHORITY: Sections 505, 508, 510, and 3012 of Title 10 U.S. Code and Executive Order 9397. **PRINCIPAL PURPOSE:** The requested information on this form will be used to properly process and identify the individual requesting an examination at a military entrance processing station (MEPS). **ROUTINE USE:** Record is maintained with other enlistment processing records. **DISCLOSURE:** Voluntary; refusal to provide required data could result in denial of enlistment.

A. **SERVICE PROCESSING FOR**

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. **RACIAL CATEGORY** *(X one or more)*

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

7.b. **ETHNIC CATEGORY** *(X One)*

- [ ] (1) HISPANIC OR LATINO
- [ ] (2) NOT HISPANIC OR LATINO

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)* [ ] YES [ ] NO *(If Yes, list State, number, and expiration date)*

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

16. **APTITUDE:**

a. ASVAB REQUIRED TO ENLIST? *(X One)* [ ] YES [ ] NO

b. ENLIST UNDER STUDENT TEST SCORES? (X One) [ ] YES [ ] NO

c. TEST TYPE [ ] INITIAL [ ] SPECIAL [ ] CONFIRMATION

d. RETEST TYPE [ ] 1ST RETEST [ ] 6 MONTH RETEST [ ] 2ND RETEST [ ] IMMED RETEST AUTHORIZED

e. PREVIOUS TEST VERSIONS 1. 2.

f. PREVIOUS TEST DATES *(YYYYMMDD)* 1. 2.

17. a. **RECRUITER ID/SSN** b. **STATION ID**

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 [ ] SPECIAL [ ] RE-EXAM [ ] INSPECT [ ] CONSULT [ ] 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)

Red Boxes indicate required selections. Ensure every section is answered. If in doubt, use the RZ generated form.

24. **RIGHT THUMBPRINT**

RIGHT THUMBPRINT, FIRST ATTEMPT *(AFFIX THUMBPRINT WITH 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)*

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*

MEDICAL RECORDS RELEASE AUTHORITY: I request and authorize individuals/organizations listed below to release to the MEPS a complete transcript of my medical records. This release is for the purpose of further evaluation of my medical acceptability under military medical fitness standards. The medical records are to be obtained by this examinee at no cost to the Government and made available for review during the pre-enlistment physical.

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

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

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 rep, if auth))* / _____ *(Printed/Typed Name of Recruiter or Rep)* / _____ *(Date)*

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

_____ *(Recruiter ID/SSN)* / _____ *(Local Recruiting Activity)* / _____ *(Bn, NRD, Sq or RS Location)*

APPLICANT SSN

MEPS PROCESSING CHECKLIST

Applicant _____ **SSN** _____ **Phone** _____

☐ PS ☐ NPS ☐ SPLIT ☐ OSUT ☐ AIRBORNE Desired Ship date _____ Term _____ Pay grade _____

1 MOS _____ PARA/LINE _____ PRN _____ UIC _____ Unit _____ ZIP _____

Unit Verification POC _____ Phone _____ E-mail _____

2 MOS _____ PARA/LINE _____ PRN _____ UIC _____ Unit _____ ZIP _____

Unit Verification POC _____ Phone _____ E-mail _____

3 MOS _____ PARA/LINE _____ PRN _____ UIC _____ Unit _____ ZIP _____

Unit Verification POC _____ Phone _____ E-mail _____

RRNCO _____ **RRNCO PHONE** _____ **SOL** _____

☐ Patriot Academy enlistment (if applicable)

☐ University Library acceptance letter
RTRS'D as "High School Letter"

☐ Patriot Academy remarks in 1966 series

☐ Active First enlistment (if applicable)

☐ Active First remarks in 1966 series

PRESCREEN DOCUMENTS
ALL SCANNED IN RTRS BY 1000 48 HOURS PRIOR TO PHYSICAL

☐ USMEPCOM FORM 680-3A-E DTD OCT 05
RTRS as "680-3A-E"

☐ DD form 214 , NGB 22 , REDD response /PERNET
RTRS as applicable name

☐ DD form 2807-2 DTD MAR 07
RTRS as "DD 2807-2"

☐ DD form 368 DTD NOV 04 (*if currently in other service)
RTRS as "DD368"

☐ USAREC FORM 1241 DTD SEP 09
RTRS w/ "DD2807-2"

☐ Citizenship/ birth/ name verification (*must have one)
RTRS as "Birth Certificate" OR "DD form 372"

☐ DD form 1966/5 DTD MAR 07 (*if under 18 yrs)
RTRS as DD form "1966 Parental Consent"

☐ Social Security verification (*must have one)
RTRS as "Social Security Card" OR as "Numident"

ENLISTMENT DOCUMENTS
ALL SCANNED IN RTRS BY 1000 HOURS 48 HOURS PRIOR TO ENLISTMENT

☐ SF 1199 DTD JUN 87 (direct deposit) AND DA3685 DTD SEP 90
RTRS as "SF1199-A"

☐ SGLV 8286 MAY 09
RTRS as "SGLV 8286"

☐ W-4 DTD 2011 (tax exemption)
RTRS as "IRS W-4 form"

☐ SGLV 8286-A JUL 06 (Spouse election life Insurance) *if married
RTRS as "SGLV 8286"

☐ DA form 5960 DTD SEP 90 (auth to start /stop BAQ)
RTRS as "DA 5960"

☐ Education office verified College Transcripts (*if applicable)
RTRS as "College Transcripts"

☐ BAH documents (*if applicable) Either Utility Bill, Lease, or Mortgage
RTRS as DA 5960

☐ NSLDS Aid summary Sheet AND NSLDS Detail Loan Info Sheet(s)
RTRS as "Promissory Note 1"

☐ Administrative Waiver Memo (*if applicable)
RTRS as "Waiver Cover Letter"

☐ Dependents BC and SSN (*if applicable)
RTRS as "Dependents Birth Certificate, Childs Name"

☐ REDD Response/PERNET (*if prior service)
RTRS as "REDD/ PERNET report"

☐ Spouse ID Card (*if applicable)
RTRS as "Dependent ID Card"

☐ DD form 2558 DTD SEP 02 AND NGAI life ins enrollment form both
RTRS as "State Specific forms"

☐ DD form 369 DTD MAR 07 (police check) AND BMV check both
RTRS as "DD 369"

☐ MEPS checklist AND SF 312 DTD APR 10
RTRS both as "Other Core Admin Documents"

☐ EBC (Electronic Background Check)
RTRS as "EBC results"

Education Verification *must have at least one of the following:

☐ Marriage Certificate (*if applicable)
RTRS as "Marriage Certificate"

☐ HS Diploma
RTRS as" HS Diploma"

☐ HS Transcripts
RTRS as "High School Transcripts"

☐ Divorce Decree (*if applicable)
RTRS as "Divorce Decree"

☐ GED
RTRS as "GED"

☐ HS letter
RTRS as "H.S. Letter"

☐ Drivers license
RTRS as "Drivers License"

☐ DD form 370 DTD MAR 09
RTRS as "DD Form 370"

☐ Valid state permit/ State ID
RTRS as "Valid State Permit OR Identification Card"

INSTRUCTIONS FOR DD FORM 2807-2, MEDICAL PRESCREEN OF MEDICAL HISTORY REPORT

1. This form is to be completed by each individual who requires medical processing in accordance with Army Regulation 40-501 Chapter 2 standards, or Department of Defense Directive 6130.3, "Physical Standards for Appointment, enlistment, or Induction." The form should be completed by the applicant with the assistance of the recruiter, parent(s), or guardian, as needed (see page 2).

2. Use of this form will also facilitate efficient, timely, and accurate medical processing of individuals applying for service in the United States Armed Forces or Coast Guard. The form is designed to assist recruiters in the medical pre-screening of applicants.

3. The individual completing the DD Form 2807-2 will submit the form, at a minimum, 1 processing day in advance to the MEPS projected to process the individual. A minimum of 2 processing days in advance is required if support documentation (e.g., private physicians paperwork, treatment records, etc.) is required to augment the MEPS CMO review.

EXPLANATION OF CODES.

Items are followed by numbers that refer to the following:

(1) If the applicant has been seen by a physician and/or has been hospitalized for the condition, obtain medical documentation with a medical release form and submit records to the MEPS Medical Section. After the MEPS Medical Officer reviews the provided information, the appropriate recruiting service member will be informed of the examinee's processing status, or if additional record review or specialty consultation may be required for further processing or qualification determination.

a. If the applicant was evaluated and/or treated on an out-patient basis, obtain a copy of actual treatment records of the private medical doctor (PMD) or health care provider (HCP), to include (if any):
- office or clinic assessment and progress notes, including the initial assessment documents, subsequent evaluation and treatment documents, and record and date when released from doctor's care to full, unrestricted activity;
- emergency room (ER) report;
- study reports (e.g., x-ray report(s), magnetic resonance imaging (MRI) report(s), or Computerized Tomography (CT) scan report(s), etc.);
- procedure reports (e.g., arthroscopy, electroencephalogram (EEG; brain wave test), echocardiogram (ultrasound of the heart), etc.);
- pathology reports (e.g., if tissue specimens taken from the body and sent to lab for microscopic diagnosis, etc.);
- specialty consultation records (e.g., neurologist, cardiologist, OB/Gynecologist, gastroenterologist, orthopedic surgeon, pulmonologist, allergist, etc.).

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

(2) If an applicant has been diagnosed or treated since age 12 for any attention disorder (Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD), etc.), academic skills or perceptual defect, or has had an Individual Education Plan (IEP), call the MEPS for additional instructions.

(3) Condition to be discussed with the examining Medical Officer at time of the medical examination.

(4) Call MEPS Medical Section to discuss examinee's medical history BEFORE sending the individual in for physical examination.

(5) Send medical reports to MEPS for review before sending applicant for physical ("papers only" medical review), and MEPS Medical Section will advise regarding further medical processing. Records pertaining to non-psychiatric diagnoses may be sent to the Medical Section of the processing MEPS, with the envelope stating: "CONFIDENTIAL: MEPS MEDICAL SECTION."

(6) Send all documentation relating to ANY past or present evaluation, treatment or consultation with a psychiatrist, psychologist, counselor or therapist, on an inpatient or out-patient basis for any reason, including but not limited to counseling or treatment for adjustment or mood disorder, family or marriage problem, depression, treatment or rehabilitation for alcohol, drug or other substance abuse, directly from the treating clinician and/or hospital to the MEPS Chief Medical Officer. The envelope must bear the following statement: "CONFIDENTIAL: FOR EYES OF THE MEDICAL OFFICER ONLY."

(7) May require an orthopedic consult, scheduling to be coordinated by the MEPS CMO and Medical Section.

MEDICAL PRESCREEN OF MEDICAL HISTORY REPORT

(Chapter #2 Physicals Only)

OMB No. 0704-0413
OMB approval expires Aug 31, 2014

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, DoD Instruction 6130.03, and E.O. 9397 (SSN).

PRINCIPAL PURPOSE(S): The primary collection of this information is from individuals seeking to join the Armed Services. The information collected on this form is used to obtain medical data for a determination of medical fitness for enlistment, induction and applintment of individuals to the Armed Forces.

ROUTINE USE(S): The DoD Blanket Routine Uses found at http://dpclo.defense.gov/privacy/SORNs/blanket_routine_uses.html apply to this collection.

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.

By default all boxes are marked "NO". Change any to "YES" that apply. MAKE SURE TO ANNOTATE THOSE CHANGES ON THE NEXT PAGE!

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a $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 can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.

1. APPLICANT

a. LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	b. DATE OF BIRTH *(YYYYMMDD)*	c. SOCIAL SECURITY NUMBER

d. HEIGHT	e. WEIGHT	f. MAXIMUM WEIGHT	g. SERVICE/COMPONENT						h. DATE SCREENED *(YYYYMMDD)*
	lbs.		☐ Army	☐ Marine Corps	☐ Coast Guard	☐ Regular	☐ Reserve	☐ National Guard	
			☐ Navy	☐ Air Force					

2. Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 2b.

a. HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
(1) Asthma, wheezing, or inhaler use (4)		
(2) Dislocated joint, including knee, hip, shoulder, elbow, ankle or other joint (1)(7)		
(3) Epilepsy, fits, seizures, or convulsions (4)		
(4) Sleepwalking (4)		
(5) Recurrent neck or back pain (4)(1)(7)		
(6) Rheumatic fever (4)		
(7) Foot pain (3)		
(8) A swollen, painful, or dislocated joint or fluid in a joint *(knee, shoulder, wrist, elbow, etc.)* (1)(7)		
(9) Double vision (4)		
(10) Periods of unconsciousness (4)		
(11) Frequent or severe headaches causing loss of time from work or school or taking medication to prevent frequent or severe headaches (4)		
(12) Wear contact lenses *(If so, bring your contact lens kit and solution so you can remove your contact when we test your vision at the MEPS; also, if you have a pair of eyeglasses, bring them with you no matter how old they are.)*		
(13) Fainting spells or passing out (4)		
(14) Head injury, including skull fracture, resulting in concussion, loss of consciousness, headaches, etc. (4)		
(15) Back surgery (4)		
(16) 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 or any other problem, to include depression, or treatment for alcohol, drug or substance abuse (6)(2)*		
(17) Any of the following skin diseases:		
(a) Eczema (5)		
(b) Psoriasis (5)		
(c) Atopic dermatitis (5)		
(18) Irregular heartbeat, including abnormally rapid or slow heart rates (4)		
(19) Allergic to bee, wasp, or other insect stings *(itching/swelling all over and/or get short of breath)* (4)		
(20) Heart murmur, valve problem or mitral valve prolapse (4)		
(21) Allergic to wool (4)		
(22) Heart surgery (4)		
(23) Been rejected for military service *(temporary or permanent) for medical or other reasons* (4)		

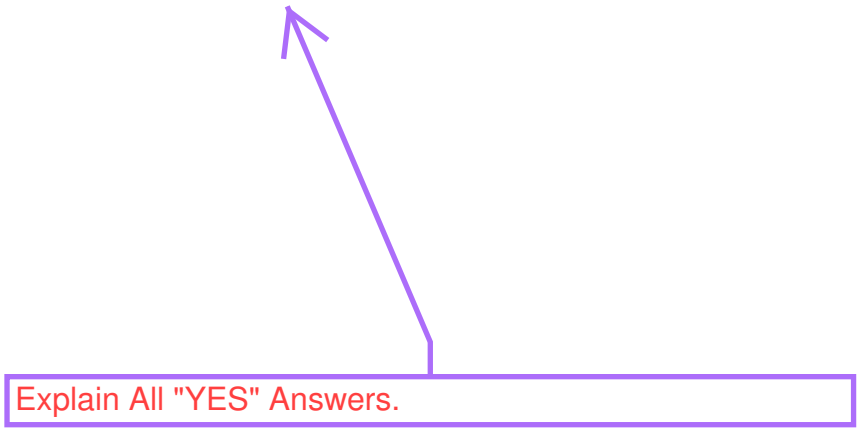
	YES	NO
(24) Any other heart problems (4)		
(25) High blood pressure (4)		
(26) Discharged from military service for medical reasons (4)		
(27) Ulcer *(stomach, duodenum or other part of intestine)* (4)		
(28) Received disability compensation for an injury or other medical condition (4)		
(29) Hepatitis *(liver infection or inflammation)* (4)		
(30) Intestinal obstruction *(locked bowels)*, or any other chronic or recurrent intestinal problem, including small intestine or colon problems, such as Crohn's disease or colitis (4)		
(31) Detached retina or surgery for a detached retina (4)		
(32) Surgery to remove a portion of the intestine *(other than the appendix)* (4)		
(33) Any other eye condition, injury or surgery (4)		
(34) Are you over 40? *(If so, call the MEPS for information on special requirements for over-40 physicals)* (4)		
(35) Gall bladder trouble or gall stones (4)		
(36) Jaundice (4)		
(37) Missing a kidney (4)		
(38) Allergy to common food *(milk, bread, eggs, meat, fish or other common food)* (4)		
(39) *(Females only)* Abnormal PAP smear or gynecological problem (4)		
(40) *(Males only)* Missing a testicle, testicular implant, or undescended testicle (4)		
(41) Broken bone requiring surgery to repair *(with or without pins, plates, screws or other metal fixation devices used in repair)* (1)(7)		
(42) Ruptured or bulging disk in your back or surgery for a ruptured or bulging disk (4)		
(43) Thyroid condition or take medication for your thyroid (4)		
(44) Limitation of motion of any joint, including knee, shoulder, wrist, elbow, hip or other joint (4)(1)(7)		
(45) Drug or alcohol rehab (4)		
(46) Kidney, urinary tract or bladder problems, surgery, stones or other urinary tract problems (4)		
(47) Sugar, protein or blood in urine (4)		
(48) Surgery on a bone or joint *(knee, shoulder, elbow, wrist, etc.) including Arthroscopy with normal findings* (1)(7)		
(49) Taking any medications *(If so, list reason in Item 2b.)*		

MEDICAL PRESCREEN

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER

2a. (Continued) HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO		YES	NO
(50) Pain or swelling at the site of an old fracture (4)(1)(7)			(64) Shoulder, knee, or elbow problem *(out of place)* (4)(1)(7)		
(51) Perforated ear drum or tubes in ear drum(s) (4)			(65) Locking of the knee or other joint (4)(1)(7)		
(52) Anemia (4)			(66) Giving way of knee or other joint (4)(1)(7)		
(53) Ear surgery, to include mastoidectomy or repair of perforated ear drum, hearing loss or need/use a hearing aid (4)			(67) Cataracts or surgery for cataracts (4)		
			(68) Eye surgery, including radial keratotomy, lens implant or other eye surgery to improve your vision (4)		
(54) Night blindness (4)					
(55) Arthritis (4)			(69) Collapsed lung or other lung condition (4)		
(56) Absence or disturbance of the sense of smell (4)			(70) Bed wetting since age 12 (4)		
(57) Absence or removal of the spleen, or rupture or tear of the spleen without removal (4)			(71) Evaluation, treatment, or hospitalization for alcohol abuse, dependence, or addiction (4)(6)		
(58) Anorexia or other eating disorder (4)			(72) Taken medication, drugs, or any substance to improve attention, behavior, or physical performance (2)(1)(6)		
(59) Cracked bone or fracture(s) (4)					
(60) Bursitis (4)			(73) Do you smoke? *(If yes:)*		
(61) Braces *(If you wear or are planning on obtaining braces for your teeth, have the orthodontist submit a letter stating that braces will be removed before active duty date; release form and sample format can be found in the Recruiter's Medical Guide.)*			(a) Type ☐ Cigarettes ☐ Cigars ☐ Smokeless tobacco		
			(b) How many per day? / (c) Date last used		
(62) Loss of finger, toe or part thereof (4)			(74) Evaluation, treatment, or hospitalization for substance use, abuse, addiction or dependence *(including illegal drugs, prescription medications, or other substances)*		
(63) Loss of the ability to fully flex *(bend)* or fully extend a finger, toe or other joint (4)(1)(7)			(75) Any illnesses, surgery, or hospitalization not listed above		

b. EXPLAIN ALL "YES" ANSWERS TO QUESTIONS (1) - (75) ABOVE. *(Describe answer(s), give date(s) of problems, name doctor(s), clinic(s), hospital(s), treatment given and current medical status. Attach additional sheet(s) if necessary.)*



LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER

b. EXPLAIN ALL "YES" ANSWERS TO QUESTIONS (1) - (74) ABOVE. *(Continued)*

3. CURRENT PRIMARY CARE PHYSICIAN(S)/PRACTITIONER(S) AND/OR CLINIC(S) *(Attach additional sheets if necessary)*

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

4. PREVIOUS PRIMARY CARE PHYSICIAN(S)

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

5. CURRENT INSURANCE PROVIDER

a. NAME	b. ADDRESS *(Include ZIP Code)*	c. INSURANCE ID NUMBER

6. PREVIOUS INSURANCE PROVIDER(S)

a. NAME(S)	b. ADDRESS *(Include ZIP Code)*	c. INSURANCE ID NUMBER

STOP AND READ: THE FOLLOWING STATEMENTS APPLY TO SIGNATURES AT ITEMS 7 AND 8

- 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 further understand that I may be requested to provide medical documentation regarding issues within my medical history.
- I authorize any of the doctors, hospitals, clinics or insurance company(ies) to furnish the Department of Defense medical authority a complete transcript of my medical record for purposes of processing my application for military service.

7. APPLICANT

a. SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*

8. PARENT OR GUARDIAN SIGNATURE FOR MINOR *(Mandatory)* **OR PARENT ASSISTING TO COMPLETE FORM** *(Voluntary)*

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

9. RECRUITING REPRESENTATIVE: I certify all information is complete and true to the best of my knowledge. I have conducted the medical prescreening requirements as directed by service regulations.

a. NAME *(If representative was used)* *(Last, First, Middle Initial)*	b. PAY GRADE	c. SIGNATURE	d. DATE SIGNED *(YYYYMMDD)*

MEDICAL PRESCREEN

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER

10. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician shall comment on all positive answers in questions (1) - (74). Physician may develop by interview any additional medical history deemed important, and record any significant findings here.)*

a. COMMENTS

11. MEDICAL OFFICER'S PRESCREENING COMMENTS: Based on information provided, further processing is:

a. ON PRESCREEN:

☐ **(1) AUTHORIZED**

☐ **(2) NOT JUSTIFIED** *(Permanent Disqualification (PDQ))*:
- ☐ (a) Profile Serial _____ ICD _____
- ☐ (b) Process for Waiver *(CMO initials)* _____

☐ **(3) DEFERRED** *(See Comments above)*:
- ☐ (a) Pending review of additional documentation
- ☐ (b) RJ Date *(If applicable)* _____ *(CMO initials)* ____

b. ON EXAM:

☐ **(1) APPROVED**

☐ **(2) DEFERRED:/**

☐ **(3) NOT JUSTIFIED:**
- ☐ (a) Additional information needed *(See DD Form 2808)*
- ☐ (b) Information different than on prescreen
- ☐ (c) Form not prescreened by MEPS

(4) MEPS USE:
- ☐ (a) AE
- ☐ (b) RE
- ☐ (c) PRI
- ☐ (d) N/A

c. TYPED OR PRINTED NAME OF EXAMINER	d. SIGNATURE	e. DATE SIGNED *(YYYYMMDD)*	12. NUMBER OF ATTACHED SHEETS

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER

13. COMMENTS *(Continued)*

TATTOO SCREENING

(For use of this form see USAREC Reg 601-96)

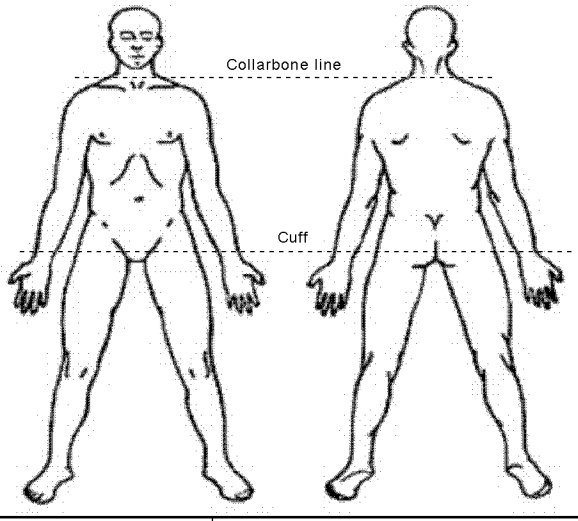
PRIVACY ACT STATEMENT

AUTHORITY: Collection of this information is authorized by 10 USC, sections 503, 505, 532, 12102, and Executive Order 9397.

PRINCIPAL PURPOSE: Information collected will be used to assist in the prequalification process.

ROUTINE USES: Blanket routine use disclosures as described in AR 340-21, paragraph 3-2.

DISCLOSURE: Voluntary; however, failure to provide the information may delay or terminate the enlistment process.



- Mark tattoo/brand on body at left with a number.
- Describe tattoo meaning below.

1	
2	
3	
4	
5	
6	

INSTRUCTIONS

- Recruiter, Recruiting Station (RS) Commander, Company Commander or First Sergeant, and Guidance Counselor (GC):
  - Review tattoos/brands in accordance with AR 670-1 and current policy.
  - Forward questionable and all above-collarbone tattoos/brands through the Company Commander or First Sergeant to the battalion with drawings and photos.
- Battalion Commander or Executive Officer (XO):
  - Review all questionable, above-collarbone, and hand tattoos for compliance with AR 670-1 and current policy and approve or disapprove individual for processing.
  - Return determination to initiating office (Company or GC) for appropriate action.

☐ I do not have any tattoos/brands.

☐ I do have tattoos/brands and I certify the above tattoos and brands list completely and accurately describes all my tattoos and brands. _____ *(Initials)*

APPLICANT TYPED NAME	APPLICANT SIGNATURE	DATE	DEP-IN	DEP-OUT
			☐	☐

The above tattoos/brands ☐ are ☐ are not ☐ may not be in accordance with AR 670-1 and current policy.

RECRUITER TYPED NAME, GRADE, AND RSID	RECRUITER SIGNATURE	DATE	DEP-IN	DEP-OUT
			☐	☐

The above tattoos/brands ☐ are ☐ are not ☐ may not be in accordance with AR 670-1 and current policy.

RS COMMANDER TYPED NAME, GRADE, AND RSID	RS COMMANDER SIGNATURE	DATE	DEP-IN	DEP-OUT
			☐	☐

The above tattoos/brands ☐ are ☐ are not ☐ may not be in accordance with AR 670-1 and current policy.

COMPANY COMMANDER OR FIRST SERGEANT TYPED NAME, GRADE, AND RSID	COMPANY COMMANDER OR FIRST SERGEANT SIGNATURE	DATE	DEP-IN	DEP-OUT
			☐	☐

If applicant has tattoos, mark boxes appropriately.

The above tattoos/brands ☐ are ☐ are not ☐ may not be in accordance with AR 670-1 and current policy.

GC TYPED NAME, GRADE, AND MEPS	GC SIGNATURE	DATE	DEP-IN	DEP-OUT
			☐	☐

The above tattoos/brands are ☐ approved ☐ disapproved in accordance with AR 670-1 and current policy.

BATTALION COMMANDER OR XO TYPED NAME AND GRADE	SIGNATURE	DATE	DEP-IN	DEP-OUT
			☐	☐

POLICE RECORD CHECK

1. DATE OF REQUEST (YYYYMMDD)	OMB No. 0704-0007 OMB approval expires Oct 31, 2014

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		
	☐ MALE ☐ FEMALE	a. CITY	b. COUNTY	c. STATE

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

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)

10. PERSON MAKING THIS REQUEST			
a. NAME (Last, First, Middle Name(s))	b. RANK	c. SIGNATURE	d. TITLE

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 found at http://privacy.defense.gov/blanket_uses.shtml apply to this collection.

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:

Standard Form 1199A (EG)
(Rev. June 1987)
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.
- Payees must keep the Government agency informed of any address changes in order to receive important information 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 *(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

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 institutions 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

GOVERNMENT AGENCY 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.)***	
	a. Once a Month		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.)***

	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		
c. SIGNATURE	d. DATE	

Form W-4 (2012)

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. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2012 expires February 18, 2013. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $950 and includes more than $300 of unearned income (for example, interest and dividends).

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2012. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. The IRS has created a page on IRS.gov for information about Form W-4, at *www.irs.gov/w4*. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted on that page.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A** _____
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	**B** _____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C** _____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D** _____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	**E** _____
F	Enter "1" if you have at least $1,900 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F** _____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $61,000 ($90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to seven eligible children or **less** "2" if you have eight or more eligible children. • If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child	**G** _____
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ►	**H** _____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($10,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

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

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

Employee's Withholding Allowance Certificate

► **Whether you are 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

2012

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, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	City or town, state, and ZIP code	**4** **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	
5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)		**5**
6	Additional amount, if any, you want withheld from each paycheck		**6** $
7	I claim exemption from withholding for 2012, 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 lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

APPLICATION FOR LIFE INSURANCE IN THE NATIONAL GUARD ASSOCIATION OF INDIANA

Policy Number _____ Effective Date _____ Unit Code No. 1010

I am now an active member of The National Guard. I hereby make application for life insurance for which I am eligible under the Group Insurance Contract issued to The National Guard by American Life and Casualty Insurance Company of Des Moines, Iowa. The following statements and answers are true and correct to the best of my knowledge and belief.

NAME _____ GRADE _____ SSN _____
Last First Middle

MAILING ADDRESS _____
No. (RFD) Street City State Zip

BENEFICARY _____ RELATIONSHIP _____

NATIONAL GUARD UNIT _____ HOME STATION _____

MEMBER'S DATE OF BIRTH _____ PLACE OF BIRTH _____ DATE OF ENLISTMENT _____
Mo/Day/Year (State) Mo/Day/Year

1. Height _____ Ft. _____ In. _____ Weight _____ Lbs. Married ☐ Single ☐
2. Do you know of any impairments now existing in your health or physical condition ?…….. ☐ Yes ☒ No
3. Have you or your dependents had any illness or injuries during the past 3 years ?……..…..…… ☐ Yes ☒ No
4. Have you or your dependents ever had any of the following: Tuberculosis, Rheumatism, Disease of Heart, Lungs, Stomach, Kidney, Liver, Brain or any other disease ?……..…….. ☐ Yes ☒ No
5. Have you or your dependents been absent from your requlardutieson account of illness or injury during the past six months ?……...……..…….. ☐ Yes ☒ No
6. Have you ever been refused, postponed or rated - up by a Life Insurance Company ?……..…….....…… ☐ Yes ☒ No
If so, give name of Company, date and cause _____

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, INDICATE BELOW THE NATURE OF THE ILLNESS OR INJURY, DURATION, SEVERITY, WITH DATES AND DETAILS AND THE NAME OF PHYSICIAN. _____

THIS APPLICATION IS REQUIRED FOR: ☒ NEW ENROLLMENT ☐ INCREASE

GUARDMEMBER:		DEPENDENT:	SPOUSE:
x x xxx,xxx xxx,xxx	x x xxx,xxx xxx,xxx	x x xxx,xxx xxx,xxx	x x xxx,xxx xxx,xxx
2. ☒ $10,000 ($3.66)	x x xxx,xxx xxx,xxx	x x xxx,xxx xxx,xxx	x x xxx,xxx xxx,xxx
x x xxx,xxx xxx,xxx			x x xxx,xxx xxx,xxx
x x xxx,xxx xxx,xxx			x x xxx,xxx xxx,xxx
x x xxx,xxx xxx,xxx			x x xxx,xxx xxx,xxx

COMPLETE FOR DEPENDENT OR SPOUSE COVERAGE

Spouse: _____ Spouse DOB: _____
(Last) (First) (Middle) Mo/Day/Year

Number of Children Under Age 21: _____ DOB of Oldest Child Under age 21: _____
Mo/Day/Year

AUTHORIZATION: I hereby authorize any physican, hospital, clinic, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or of any member of my family or my (our) health or address to give this requested information to the American Life & Casualty Insurance Company (or its reinsures). A photographic copy of this authorization shall be valid as the original. I hereby assign any experience premium refunds to National Guard Association of Indiana to be used for the purposes which benefit the policies and programs of The National Guard Association of Indiana. I also acknowledge receipt of the Important Notice, Form S - V (6/76).

Dated In _____ this _____ day of _____ _____
City State

_____ _____
SIGNATURE OF WITNESS SIGNATURE OF MEMBER

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)	2. NAME OF ALLOTTER (Last, First, Middle Initial) (Print or type)	3. SSN	4. PAY GRADE
☐ AIR FORCE ☐ MARINE CORPS ☐ ARMY ☐ NAVY			

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 $

9. NAME OF ALLOTTEE (First, Middle Initial, Last)	10. ALLOTMENT ACTION (X one)	11. TERM IN MONTHS
	☐ START ☐ STOP ☐ CHANGE	

12. CREDIT LINE (If applicable)	13. ALLOTMENT CLASS AUTHORIZED (X one)
	☐ C - CHARITY/CFC
14. ALLOTTEE'S MAILING ADDRESS (Street or Box Number, City, State, ZIP Code)	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)
15. IF FOREIGN ADDRESS COMPLETE AS FOLLOWS (Province, Country)	☐ N - NSLI OR USGLI INSURANCE PREMIUM
	T - PAYMENT OF DEBTS TO U.S., DELINQUENT STATE OR LOCAL INCOME/ EMPLOYMENT TAXES
16. REMARKS	☐ - OTHER (Specify)

17. COMPANY CODE/FINANCIAL INSTITUTION/ROUTING TRANSIT NUMBER	18. ACCOUNT NUMBER/POLICY NUMBER	☐ 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.

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.

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 12958, 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 1.2, 1.3, and 1.4(e) of Executive Order 12958, 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 the 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 the 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 Section 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.

(Continue on reverse.)

10. These restrictions are consistent with and do not supersede, conflict with or otherwise alter the employee obligations, rights or liabilities created by Executive Order 12958; 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 (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 expose confidential Government agents), 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 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.

11. 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 Section 2003.20) so that I may read them at this time, if I so choose.

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)*

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)*	

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 Account Number (SSN) is Executive Order 9397. Your SSN will be used to identify you precisely when it is necessary to 1) certify that you have access to the information indicated above or 2) determine that your access to the information indicated has terminated. Although disclosure of your SSN is not mandatory, your failure to do so may impede the processing of such certifications or determinations, or possibly result in the denial of your being granted access to classified information.

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

Prudential

Office of Servicemembers' Group Life Insurance

Servicemembers' Group Life Insurance Election and Certificate

1. About You

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

Duty Location	Branch of Service

2. About Your Coverage

If applicant selects less than $400,000, Mark "Reduce SGLI coverage and enter amount. If declined mark box and select statement in drop down.

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 **$**_____. *You must complete sections 3, 4, & 5.*
- ☐ Reduce my SGLI coverage to **$**_____. *You must complete sections 3 & 5.*
- ☐ Decline (cancel) SGLI coverage. Write below "I do not want insurance at this time." *You must complete section 5.*

" _____ **"**.

Coverage is available in increments of $50,000 up to a maximum of $400,000

3. About Your Beneficiaries *Complete this section unless you are declining coverage*

Primary Name and Address	Social Security Number *(If available)*	Relationship to you	Share to each *(% or $ amounts)*	Payment Option *(Lump sum* or 36 equal monthly payments)*
1.				
2.				
3.				
4.				

Secondary

1.				
2.				
3.				
4.				

☐ **Have more beneficiaries?** Check the box and complete Supplemental SGLI Beneficiary Form, SGLV 8286S

If you do not name beneficiaries above, your insurance will be paid by law (see page 3).

*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.

Open Solutions Inc. is the Service Provider 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. Check clearing is provided by JPMorgan Chase Bank, N.A. and processing support is provided by First Data Payment Services (FDPS). **Alliance Account balances are not insured by the Federal Deposit Insurance Corporation (FDIC).** Open Solutions Inc., JPMorgan Chase Bank, N.A., and First Data Payment Services are not Prudential Financial companies.

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?	☐	☐

Any request to increase coverage does not take effect until approved by OSGLI.

Did you answer "YES" to any question? If so, reference the question by letter and list date, duration and details below.

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

I have read the instructions and understand that:

- This form cancels any prior beneficiary or payment instructions.
- I can have SGLI and VGLI coverage at the same time, but the combined amount cannot be more than $400,000.
- Reducing or declining SGLI coverage can affect the amount of my family coverage, traumatic injury coverage and post-separation coverage (see instructions for details).
- If I am married or get married after completing this form and have not declined SGLI, Family 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 register my spouse in DEERS will result in my owing debts for unpaid premiums.* I can decline Family SGLI coverage by completing SGLV 8286A.
- I certify that the information provided on this form is true and correct to the best of my knowledge and belief. Any deception or knowingly false statement either by inference or omission may result in cancellation of the insurance or in the refusal to pay a claim.

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

Current Amount of SGLI | Address

For Branch of Service Use Only	For OSGLI Use Only
Name of Personnel Clerk	Representative
Rank, title or grade	Approve ☐
Contact telephone/email	Disapprove ☐
Date	Date
Address	

Standard Form 86
Revised September 1995
U.S. Office of Personnel Management
5 CFR Parts 731, 732, and 736

Form approved:
OMB No. 3206-0007
NSN 7540-00-634-4036
86-111

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, 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, my academic, residential, achievement, performance, attendance, disciplinary, employment history, criminal history record information, and financial and credit information. I authorize the Federal agency conducting my investigation to disclose the record of my background investigation to the requesting agency for the purpose of making a determination of suitability or eligibility for a security clearance.

I Understand that, for financial or lending institutions, medical institutions, hospitals, health care professionals, and other sources of information, a separate specific release will be needed, and I may be contacted for such a release at a later date. Where a separate release is requested for information relating to mental health treatment or counseling, the release will contain a list of the specific questions, relevant to the job description, which the doctor or therapist will be asked.

I Further Authorize any investigator, special agent, or other duly accredited representative of the U.S. Office of Personnel Management, the Federal Bureau of Investigation, the Department of Defense, the Defense Investigative Service, 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 access to classified information and/or for assignment to, or retention in a sensitive 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 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 redisclosed by the Government only as authorized by law.

Copies of this authorization that show my signature are as valid as the original release signed by me. This authorization is valid for five (5) years from the date signed or upon the termination of my affiliation with the Federal Government, whichever is sooner. Read, sign and date the release on the next page if you answered "Yes" to question 21.

Signature *(Sign in ink)*	Full Name *(Type or Print Legibly)*		Date Signed
Other Names Used			Social Security Number
Current Address *(Street, City)*	State	ZIP Code	Home Telephone Number *(Include Area Code)*

Standard Form 86
Revised September 1995
U.S. Office of Personnel Management
5 CFR Parts 731, 732, and 736

Form approved:
OMB No. 3206-0007
NSN 7540-00-634-4036
86-111

UNITED STATES OF AMERICA

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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

Instructions for Completing this Release

This is a release for the investigator to ask your health practitioner(s) the three questions below concerning your mental health consultations. Your signature will allow the practitioner(s) to answer only these questions.

I am seeking assignment to or retention in a position with the Federal government which requires access to classified national security information or special nuclear information or material. As part of the clearance process, **I hereby authorize** the investigator, special agent, or duly accredited representative of the authorized Federal agency conducting my background investigation, to obtain the following information relating to my mental health consultations:

Does the person under investigation have a condition or treatment that could impair his/her judgment or reliability, particularly in the context of safeguarding classified national security information or special nuclear information or material?

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

What is the prognosis?

I understand the information released pursuant to this release is for use by the Federal Government only for purposes provided in the Standard Form 86 and that it may be redisclosed by the Government only as authorized by law.

Copies of this authorization that show my signature are as valid as the original release signed by me. This authorization is valid for 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
Other Names Used			Social Security Number
Current Address *(Street, City)*	State	ZIP Code	Home Telephone Number *(Include Area Code)*

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)*

_____

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)*
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)*

41. VERIFICATION OF SINGLE SIGNATURE CONSENT

HIGH SCHOOL VERIFICATION LETTER

(SECTION 1) **ONLY an authorized School Representative complete this section**

High School (name/city/state):_____

Student_____ is applying for enlistment into the Indiana Army National Guard.

This student is currently in good standing as a: ☐ Junior (or) ☐ Senior at the High School indicated above.

There is reasonable assurance this student will graduate High School in (month/year): _____

The last regularly scheduled day of school for the current year is (month/day/year):_____

The first regularly scheduled school day for the beginning of the next school year is (month/day/year):_____

We understand that in order for the above listed student to complete the 75 day minimum basic military training requirements under the Split Training Option, the above named student is authorized to leave school no earlier than (month/day/year) _____ or return for next year's classes no later than (month/day/year) _____ without being penalized.

School Remarks (optional):_____

Print Name of School Official	Signature of School Official	Official Title
School Officials e-mail address	Direct Phone Line	Date (month/day/year)

SECTION 2 **Minor Applicants Parents/Guardian complete this section**

SUBJECT: Minor Applicants Parental/Guardian acknowledgement of early release/late return from/to high school for completion of Basic Combat Training.

TO: The State of Indiana Adjutant General

I consent to the release of all school records and/or transcripts to the Army National Guard to verify my child is meeting and continues to meet all requirements to graduate high school as projected above.

Print Parent/Guardian Name	Signature of Parent/Guardian	Date (month/day/year)
Parent/Guardian/Witness Name (print)	Signature	Date (month/day/year)
Applicant Name (print)	Signature	Date (month/day/year)

Note: Applicants in High School over the age of 18 do not require a Parent/Guardian signature.
