

**SAMPLE
HIRE PACKET
For
Temporary Appointment**

** Note: Some forms change annually. Ensure you use the latest.*

REQUEST FOR PERSONNEL ACTION

PART A - Requesting Office (Also complete Part B, Items 1, 7-22, 32, 33, 36, and 39.)

1. Actions Requested APPOINTMENT	2. Request Number
3. For Additional Information Call (Name and Telephone Number)	4. Proposed Effective Date
5. Action Requested By (Typed Name, Title, Signature, and Request Date) UNIT COMMANDER	6. Action Authorized by (Typed Name, Title, Signature, and Concurrence Date) GROUP COMMANDER / CHIEF OF STAFF

PART B - For Preparation of SF 50 (Use only codes in FPM Supplement 292-1. Show all dates in month-day-year order.)

1. Name (Last, First, Middle)	2. Social Security Number	3. Date of Birth	4. Effective Date								
FIRST ACTION		SECOND ACTION									
5-A. Code	5-B. Nature of Action	6-A. Code	6-B. Nature of Action								
5-C. Code	5-D. Legal Authority	6-C. Code	6-D. Legal Authority								
5-E. Code	5-F. Legal Authority	6-E. Code	6-F. Legal Authority								
7. FROM: Position Title and Number		15. TO: Position Title and Number									
		POSITION TITLE: PD: POSITION NUMBER:									
8. Pay Plan	9. Occ. Code	10. Grade or Level	11. Step or Rate	12. Total Salary	13. Pay Basis	16. Pay Plan	17. Occ. Code	18. Grade or Level	19. Step or Rate	20. Total Salary/Award	21. Pay Basis
12A. Basic Pay	12B. Locality Adj.	12C. Adj. Basic Pay	12D. Other Pay			20A. Basic Pay	20B. Locality Adj.	20C. Adj. Basic Pay	20D. Other Pay		
14. Name and Location of Position's Organization						22. Name and Location of Position's Organization					

EMPLOYEE DATA

23. Veterans Preference <input type="checkbox"/> 1 - None <input type="checkbox"/> 3 - 10-Point/Disability <input type="checkbox"/> 5 - 10-Point/Other <input type="checkbox"/> 2 - 5-Point <input type="checkbox"/> 4 - 10-Point/Compensable <input type="checkbox"/> 6 - 10-Point/Compensable/30%				24. Tenure <input type="checkbox"/> 0 - None <input type="checkbox"/> 2 - Conditional <input type="checkbox"/> 1 - Permanent <input type="checkbox"/> 3 - Indefinite		25. Agency Use <input type="checkbox"/>		26. Veterans Pref for RIF <input type="checkbox"/> YES <input type="checkbox"/> NO					
27. FEGLI <input type="checkbox"/>				28. Annuitant Indicator <input type="checkbox"/>		29. Pay Rate Determinant <input type="checkbox"/>							
30. Retirement Plan <input type="checkbox"/>			31. Service Comp. Date (Leave) <input type="checkbox"/>		32. Work Schedule <input type="checkbox"/>			33. Part-Time Hours Per Biweekly Pay Period <input type="checkbox"/>					
POSITION DATA				35. FLSA Category <input type="checkbox"/> E - Exempt <input type="checkbox"/> N - Nonexempt		36. Appropriation Code		37. Bargaining Unit Status					
34. Position Occupied <input type="checkbox"/> 1 - Competitive Service <input type="checkbox"/> 3 - SES General <input type="checkbox"/> 2 - Excepted Service <input type="checkbox"/> 4 - SES Career				38. Duty Station Code						39. Duty Station (City - County - State or Overseas Location)			
40. Agency Data		41.	42.	43.	44.								
45. Educational Level		46. Year Degree Attained		47. Academic Discipline		48. Functional Class		49. Citizenship <input type="checkbox"/> 1 - USA <input type="checkbox"/> 8 - Other		50. Veterans Status		51. Supervisory Status	

PART C - Reviews and Approvals (Not to be used by requesting office.)

1. Office/Function	Initials/Signature	Date	Office/Function	Initials/Signature	Date
A.			D.		
B.			E.		
C.			F.		

2. Approval: I certify that the information entered on this form is accurate and that the proposed action is in compliance with statutory and regulatory requirements.

Signature	Approval Date
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PART D - Remarks by Requesting Office

(Note to Supervisors: Do you know of additional or conflicting reasons for the employee's resignation/retirement?
If "YES", please state these facts on a separate sheet and attach to SF 52.)

YES NO

SOURCE OF VACANCY:
REASON FOR TEMP HIRE:
SUPERVISOR:
RANK:
ETS:
MOS/DAFSC:

PART E - Employee Resignation/Retirement

Privacy Act Statement

You are requested to furnish a specific reason for your resignation or retirement and a forwarding address. Your reason may be considered in any future decision regarding your re-employment in the Federal service and may also be used to determine your eligibility for unemployment compensation benefits. Your forwarding address will be used primarily to mail you copies of any documents you should have or any pay or compensation to which you are entitled.

and agencies to issue regulations with regard to employment of individuals in the Federal service and their records, while section 8506 requires agencies to furnish the specific reason for termination of Federal service to the Secretary of Labor or a State agency in connection with administration of unemployment compensation programs.

This information is requested under authority of sections 301, 3301, and 8506 of title 5, U.S. Code. Sections 301 and 3301 authorize OPM

The furnishing of this information is voluntary; however, failure to provide it may result in your not receiving: (1) your copies of those documents you should have; (2) pay or other compensation due you; and (3) any unemployment compensation benefits to which you may be entitled.

1. Reasons for Resignation/Retirement (NOTE: Your reasons are used in determining possible unemployment benefits. Please be specific and avoid generalizations. Your resignation/retirement is effective at the end of the day - midnight - unless you specify otherwise.)

2. Effective Date	3. Your Signature	4. Date Signed	5. Forwarding Address (Number, Street, City, State, ZIP Code)
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PART F - Remarks for SF 50

RESUME

Month/ Year—Job Title

Work Experience

Specialized experience

Should demonstrate qualifications for position



Employment Eligibility Verification
Department of Homeland Security
 U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 08/31/2019

▶ **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)
Address (Street Number and Name)		Apt. Number	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's E-mail Address		Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

<input type="checkbox"/> 1. A citizen of the United States	QR Code - Section 1 Do Not Write In This Space
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. <i>(See instructions)</i>	

*Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
 An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.*

1. Alien Registration Number/USCIS Number: _____
OR
 2. Form I-94 Admission Number: _____
OR
 3. Foreign Passport Number: _____
 Country of Issuance: _____

Signature of Employee	Today's Date (mm/dd/yyyy)
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Preparer and/or Translator Certification (check one):

I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code

STOP | Employer Completes Next Page | STOP



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
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List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)
Document Title		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States. *leave blank*

The employee's first day of employment (mm/dd/yyyy): _____ (See instructions for exemptions)

Signature of Employer or Authorized Representative		Today's Date(mm/dd/yyyy)	Title of Employer or Authorized Representative	
Last Name of Employer or Authorized Representative		First Name of Employer or Authorized Representative	Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)		City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name (if applicable)			B. Date of Rehire (if applicable)	
Last Name (Family Name)	First Name (Given Name)	Middle Initial	Date (mm/dd/yyyy)	

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
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I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
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To be completed by HR or Supervisor

on this page...
 * Attach copies of originals *

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	LIST B Documents that Establish Identity	LIST C Documents that Establish Employment Authorization
OR	AND	
1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI	1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <p style="text-align: center;">For persons under age 18 who are unable to present a document listed above:</p> 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record	1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of Birth Abroad issued by the Department of State (Form FS-545) 3. Certification of Report of Birth issued by the Department of State (Form DS-1350) 4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 5. Native American tribal document 6. U.S. Citizen ID Card (Form I-197) 7. Identification Card for Use of Resident Citizen in the United States (Form I-179) 8. Employment authorization document issued by the Department of Homeland Security

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

Refer to the instructions for more information about acceptable receipts.

Attach copies of originals in this page.

Declaration for Federal Employment*

Form Approved:
OMB No. 3206-0182

(*This form may also be used to assess fitness for federal contract employment)

GENERAL INFORMATION

1. **FULL NAME** (Provide your full name. If you have only initials in your name, provide them and indicate "Initial only". If you do not have a middle name, indicate "No Middle Name". If you are a "Jr.," "Sr.," etc. enter this under Suffix. First, Middle, Last, Suffix)

2. **SOCIAL SECURITY NUMBER**

3a. **PLACE OF BIRTH** (Include city and state or country)

3b. **ARE YOU A U.S. CITIZEN?**

YES NO (If "NO", provide country of citizenship)

4. **DATE OF BIRTH** (MM / DD / YYYY)

5. **OTHER NAMES EVER USED** (For example, maiden name, nickname, etc)

6. **PHONE NUMBERS** (Include area codes)

Day

Night

Selective Service Registration

If you are a male born after December 31, 1959, and are at least 18 years of age, civil service employment law (5 U.S.C. 3328) requires that you must register with the Selective Service System, unless you meet certain exemptions.

- 7a. Are you a male born after December 31, 1959? YES NO (If "NO", proceed to 8.)
- 7b. Have you registered with the Selective Service System? YES (If "YES", proceed to 8.) NO (If "NO", proceed to 7c.)
- 7c. If "NO," describe your reason(s) in item 16.

Military Service

8. Have you ever served in the United States military? YES (If "YES", provide information below) NO

If you answered "YES," list the branch, dates, and type of discharge for all active duty.

If your only active duty was training in the Reserves or National Guard, answer "NO."

Branch	From (MM/DD/YYYY)	To (MM/DD/YYYY)	Type of Discharge

Background Information

For all questions, provide all additional requested information under item 16 or on attached sheets. The circumstances of each event you list will be considered. However, in most cases you can still be considered for Federal jobs.

For questions 9, 10, and 11, your answers should include convictions resulting from a plea of *nolo contendere* (no contest), but omit (1) traffic fines of \$300 or less, (2) any violation of law committed before your 16th birthday, (3) any violation of law committed before your 18th birthday if finally decided in juvenile court or under a Youth Offender law, (4) any conviction set aside under the Federal Youth Corrections Act or similar state law, and (5) any conviction for which the record was expunged under Federal or state law.

9. During the last 7 years, have you been convicted, been imprisoned, been on probation, or been on parole? (Includes felonies, firearms or explosives violations, misdemeanors, and all other offenses.) If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved. YES NO
10. Have you been convicted by a military court-martial in the past 7 years? (If no military service, answer "NO.") If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the military authority or court involved. YES NO
11. Are you currently under charges for any violation of law? If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved. YES NO
12. During the last 5 years, have you been fired from any job for any reason, did you quit after being told that you would be fired, did you leave any job by mutual agreement because of specific problems, or were you debarred from Federal employment by the Office of Personnel Management or any other Federal agency? If "YES," use item 16 to provide the date, an explanation of the problem, reason for leaving, and the employer's name and address. YES NO
13. Are you delinquent on any Federal debt? (Includes delinquencies arising from Federal taxes, loans, overpayment of benefits, and other debts to the U.S. Government, plus defaults of Federally guaranteed or insured loans such as student and home mortgage loans.) If "YES," use item 16 to provide the type, length, and amount of the delinquency or default, and steps that you are taking to correct the error or repay the debt. YES NO

Declaration for Federal Employment*

Form Approved:
OMB No. 3206-0182

(*This form may also be used to assess fitness for federal contract employment)

Additional Questions

14. Do any of your relatives work for the agency or government organization to which you are submitting this form? (Include: father, mother, husband, wife, son, daughter, brother, sister, uncle, aunt, first cousin, nephew, niece, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepfather, stepmother, stepson, stepdaughter, stepbrother, stepsister, half brother, and half sister.) If "YES," use item 16 to provide the relative's name, relationship, and the department, agency, or branch of the Armed Forces for which your relative works. YES NO
15. Do you receive, or have you ever applied for, retirement pay, pension, or other retired pay based on military, Federal civilian, or District of Columbia Government service? YES NO

Continuation Space / Agency Optional Questions

16. Provide details requested in items 7 through 15 and 18c in the space below or on attached sheets. Be sure to identify attached sheets with your name, Social Security Number, and item number, and to include ZIP Codes in all addresses. If any questions are printed below, please answer as instructed (these questions are specific to your position and your agency is authorized to ask them).

Certifications / Additional Questions

APPLICANT: If you are applying for a position and have not yet been selected, carefully review your answers on this form and any attached sheets. When this form and all attached materials are accurate, read item 17, and complete 17a.

APPOINTEE: If you are being appointed, carefully review your answers on this form and any attached sheets, including any other application materials that your agency has attached to this form. If any information requires correction to be accurate as of the date you are signing, make changes on this form or the attachments and/or provide updated information on additional sheets, initialing and dating all changes and additions. When this form and all attached materials are accurate, read item 17, complete 17b, read 18, and answer 18a, 18b, and 18c as appropriate.

17. I certify that, to the best of my knowledge and belief, all of the information on and attached to this Declaration for Federal Employment, including any attached application materials, is true, correct, complete, and made in good faith. I understand that a false or fraudulent answer to any question or item on any part of this declaration or its attachments may be grounds for not hiring me, or for firing me after I begin work, and may be punishable by fine or imprisonment. I understand that any information I give may be investigated for purposes of determining eligibility for Federal employment as allowed by law or Presidential order. I consent to the release of information about my ability and fitness for Federal employment by employers, schools, law enforcement agencies, and other individuals and organizations to investigators, personnel specialists, and other authorized employees or representatives of the Federal Government. I understand that for financial or lending institutions, medical institutions, hospitals, health care professionals, and some other sources of information, a separate specific release may be needed, and I may be contacted for such a release at a later date.

- 17a. Applicant's Signature: _____ Date _____
(Sign in ink)
- 17b. Appointee's Signature: _____ Date _____
(Sign in ink)

Appointing Officer:

Enter Date of Appointment or Conversion
MM / DD / YYYY

18. **Appointee (Only respond if you have been employed by the Federal Government before):** Your elections of life insurance during previous Federal employment may affect your eligibility for life insurance during your new appointment. These questions are asked to help your personnel office make a correct determination.

- 18a. When did you leave your last Federal job? _____ DATE: _____
MM / DD / YYYY
- 18b. When you worked for the Federal Government the last time, did you waive Basic Life Insurance or any type of optional life insurance? YES NO DO NOT KNOW
- 18c. If you answered "YES" to item 18b, did you later cancel the waiver(s)? If your answer to item 18c is "NO," use item 16 to identify the type(s) of insurance for which waivers were not canceled. YES NO DO NOT KNOW



Selective Service System

Data Management Center | P.O. Box 94638 Palatine, IL 60094-4638

www.sss.gov

November 17, 2016

MEMORANDUM FOR REGISTRANT

SUBJECT: Online Verification of Your Registration

This document certifies officially that the below named individual is registered on the date shown with the Selective Service System as required by Section 3 of the Military Selective Service Act (MSSA) -- 50 U.S.C. 3802.

Selective Service Number:	##-#####-#
Name:	John Doe
Date of Registration:	11/15/2016

Because you have satisfied the MSSA by registering, you remain eligible for those programs and benefits linked to registration compliance, such as student financial aid, government employment, job training, driver's license in several states, and U.S. citizenship for immigrants, for which you are otherwise qualified.

Thank you for your inquiry. If you have any further questions, please feel free to contact the Data Management Center at the address above. Our telephone number is 847-688-6888 or toll - free: 1-888-655-1825.

A handwritten signature in cursive script that reads "Nicole F. Harris".

Nicole F. Harris
DMC Manager

STATEMENT OF PRIOR FEDERAL SERVICE
To be Completed by Employee

1. Name (Last, First, Middle Initial) <div style="background-color: yellow; height: 15px; width: 100%;"></div>	2. Social Security Number <div style="background-color: yellow; height: 15px; width: 100%;"></div>	3. Date of Birth (Month, Day, Year) <div style="background-color: yellow; height: 15px; width: 100%;"></div>
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4. Does the application or resume that you submitted, for the position to which you are being appointed, list all of your Federal government civilian and uniformed service, including beginning and ending dates, as well as the type of appointment and work schedule for civilian service?
 Yes — If "Yes", check this block and skip to item 8. No — If "No", check this block and complete items 5 - 9.

5. List below your prior civilian service. Include service with the DC Government on appointments made before October 1, 1987.

NAME AND LOCATION OF AGENCY	FROM			TO			TYPE OF APPOINTMENT AND WORK SCHEDULE (Full-Time, Part-Time, or Intermittent)
	Year	Month	Day	Year	Month	Day	
<div style="background-color: yellow; height: 100%; width: 100%;"></div>	<div style="background-color: yellow; height: 100%; width: 100%;"></div>						<p align="center">QS. 5</p> <ul style="list-style-type: none"> List prior civilian service. Include service with the D.C. Government on appointments made before October 1, 1987.

6. During periods of employment shown in item 5, did you have a total of more than 6 months' absence without pay during any one calendar year?
 Yes — If "Yes", list the following information. No — If "No", go to item 7.

TYPE OF ABSENCE, IF KNOWN (LWOP, Furlough, Suspension, AWOL, or Placement in Nonpay Status)	FROM			TO			TOTAL		
	Year	Month	Day	Year	Month	Day	YEARS	MONTHS	DAYS
<div style="background-color: yellow; height: 100%; width: 100%;"></div>	<div style="background-color: yellow; height: 100%; width: 100%;"></div>						<p align="center">QS. 6</p> <p>Select yes or no if you have a total of more than 6 months' absence without pay during any one calendar year.</p> <ul style="list-style-type: none"> ✓ If yes, list the information. ✓ If no, move to the next question. 		

7. List all uniformed service below. List active service in any branch of the Armed Forces of the United States, including active duty as a reservist, and active service in the commissioned corps of the Public Health Service or the National Oceanic and Atmospheric Administration.

BRANCH OF SERVICE	FROM			TO			DISCHARGE (Honorable or Dishonorable)
	Year	Month	Day	Year	Month	Day	
<div style="background-color: yellow; height: 100%; width: 100%;"></div>	<div style="background-color: yellow; height: 100%; width: 100%;"></div>						<p align="center">QS. 7</p> <p>List all uniformed service in any branch of the Armed Forces of the United States, including:</p> <ul style="list-style-type: none"> ✓ Active duty as a reservist, ✓ Active service in the commissioned corps of the Public Health Service, & ✓ Active service in National Oceanic Atmospheric Administration (NOAA).

8. Do you claim any type of veterans' preference which has not been verified?
 No Yes — Check one of the statements, if it applies to you. I claim preference as the:
 Spouse of a disabled veteran Mother of a deceased or disabled veteran Unmarried widow/widower of a veteran

9. **CERTIFICATION:** The prior Federal civilian and uniformed service listed on my application/resume and listed above constitutes my entire record of Federal employment. I have no other Federal service for which I want to claim credit.

Signature Date

ETHNICITY AND RACE IDENTIFICATION

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

Name (Last, First, Middle Initial)

Social Security Number

Birthdate (Month and Year)

Agency Use Only

Privacy Act Statement

Ethnicity and race information is requested under the authority of 42 U.S.C. Section 2000e-16 and in compliance with the Office of Management and Budget's 1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. Providing this information is voluntary and has no impact on your employment status, but in the instance of missing information, your employing agency will attempt to identify your race and ethnicity by visual observation.

This information is used as necessary to plan for equal employment opportunity throughout the Federal government. It is also used by the U. S. Office of Personnel Management or employing agency maintaining the records to locate individuals for personnel research or survey response and in the production of summary descriptive statistics and analytical studies in support of the function for which the records are collected and maintained, or for related workforce studies.

Social Security Number (SSN) is requested under the authority of Executive Order 9397, which requires SSN be used for the purpose of uniform, orderly administration of personnel records. Providing this information is voluntary and failure to do so will have no effect on your employment status. If SSN is not provided, however, other agency sources may be used to obtain it.

Specific Instructions: The two questions below are designed to identify your ethnicity and race. **Regardless of your answer to question 1, go to question 2.**

Question 1. Are You Hispanic or Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Yes No

Question 2. Please select the racial category or categories with which you most closely identify by placing an "X" in the appropriate box. Check as many as apply.

RACIAL CATEGORY (Check as many as apply)	DEFINITION OF CATEGORY
<input type="checkbox"/> American Indian or Alaska Native	A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
<input type="checkbox"/> Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
<input type="checkbox"/> Black or African American	A person having origins in any of the black racial groups of Africa.
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
<input type="checkbox"/> White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

SELF-IDENTIFICATION OF DISABILITY

(See Privacy Act information and additional instructions on reverse)

Last Name, First Name, and MI

Date of Birth (MM/YY)

Social Security Number

Purpose:

Each agency in the Executive Branch of the Federal government has established programs to facilitate the hiring, placement, and advancement of individuals with disabilities. Self-identification of disability status is essential for effective data collection and analysis of the Federal government's efforts. While self-identification is voluntary, your cooperation in providing accurate information is critical to these efforts. Every precaution is taken to ensure that the information provided by each employee is kept in the strictest confidence.

ENTER CODE HERE



Targeted Disabilities or Health Conditions:

- 2- Developmental Disability, for example, autism spectrum disorder
- 3- Traumatic Brain Injury
- 19- Deaf or serious difficulty hearing, benefiting from, for example, American Sign Language, CART, hearing aids, a cochlear implant and/or other supports
- 20- Blind or serious difficulty seeing even when wearing glasses
- 31- Missing extremities (arm, leg, hand and/or foot)
- 40- Significant mobility impairment, benefiting from the utilization of a wheelchair, scooter, walker, leg brace(s) and/or other supports
- 60- Partial or complete paralysis (any cause)
- 82- Epilepsy or other seizure disorders
- 90- Intellectual disability
- 91- Psychiatric disability
- 92- Dwarfism
- 93- Significant disfigurement, for example, disfigurements caused by burns, wounds, accidents, or congenital disorders

Other Options:

- 01 - I do not wish to identify my disability status.
- 05 - I do not have a disability.
- 06 - I have a disability, but it is not listed on this form.

Other Disabilities or Health Conditions:

- 13- Speech impairment
- 41- Spinal abnormalities, for example, spina bifida or scoliosis
- 44- Non-paralytic orthopedic impairments, for example, chronic pain, stiffness, weakness in bones or joints, some loss of ability to use part or parts of the body
- 51- HIV Positive/AIDS
- 52- Morbid obesity
- 59- Nervous system disorder for example, migraine headaches, Parkinson's disease, or multiple sclerosis
- 80- Cardiovascular or heart disease
- 83- Blood diseases, for example, sickle cell anemia, hemophilia
- 84- Diabetes
- 85- Orthopedic impairments or osteoarthritis
- 86- Pulmonary or respiratory conditions, for example, tuberculosis, asthma, emphysema
- 87- Kidney dysfunction
- 88- Cancer (Present or past history)
- 94- Learning disability or attention deficit/hyperactivity disorder (ADD/ADHD)
- 95- Gastrointestinal disorders, for example, Crohn's Disease, irritable bowel syndrome, colitis, celiac disease, dysphexia
- 96- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis
- 97- Liver disease, for example, hepatitis or cirrhosis
- 98- History of alcoholism or history of drug addiction (but not currently using illegal drugs)
- 99- Endocrine disorder, for example, thyroid dysfunction

Designation of Beneficiary

Unpaid Compensation of Deceased Civilian Employee

Important:
Read all instructions before
filling in this form

A. Identification

Name (Last, first, middle) [REDACTED]		Date of birth (mm, dd, yyyy) [REDACTED]	Social Security Number [REDACTED]
Department or agency in which presently employed (or former department or agency):			
Department or agency Dept of Army or Air	Bureau National Guard Bureau	Division HIARNG or HIANG	Location (City, state and ZIP code) Duty Location +

I, the employee named above, canceling any and all previous Designations of Beneficiary heretofore made by me, do now designate the beneficiary or beneficiaries named below to receive any **unpaid compensation** due and payable after my death. I understand that this Designation of Beneficiary relates solely to money due as defined in 5 U.S.C. 5581, 5582, 5583, and in no way will affect the disposition of any benefit which may become payable under the Retirement or Group Life Insurance Acts applicable to my Government service. I further understand that this Designation of Beneficiary will remain in full force and effect until (1) I expressly change or revoke it in writing, (2) I transfer to another agency, or (3) I am reemployed by the same or another department or agency of the Government.

B. Information Concerning The Beneficiaries (See Examples of Designations):

First name, middle initial, and last name of each beneficiary	Address (Including ZIP code) of each beneficiary	Relationship	Share to be paid to each beneficiary
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Date of designation (mm, dd, yyyy) [REDACTED]	Your signature [REDACTED]	Total = 100 %	

C. Witnesses (A witness is not eligible to receive payment as a beneficiary):

We, the undersigned, certify that this statement was signed in our presence.

Signature of witness [REDACTED]	Number and street Sign at unit, anyone can witness	City, state and ZIP code [REDACTED]
Signature of witness [REDACTED]	Number and street Sign at unit, anyone can witness	City, state and ZIP code [REDACTED]

Receiving agency certification

I have reviewed this designation and certify that the designated shares total 100% and that no witnesses are designated as beneficiaries.

Date received	Signature	Date

Type or print your return address to insure return

Enter technician's address here

Insert DD214s

and/or

prior SF-50s

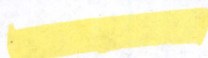
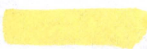
if applicable

EMPLOYEE EDUCATIONAL DATA

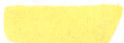
PRIVACY ACT NOTICE: In accordance with the provisions of the Privacy Act of 1974 protecting against unwarranted invasion of individual privacy, this information is not to be reproduced or used for any other purpose and will be adequately protected under lock and key while it is in the recipient's custody. It will be disposed of by burning, shredding, or pulping in such a manner that the above intent is carried out.

INSTRUCTIONS: Please complete this form according to the instructions and return it to the Human Resources Office. In order to keep your education record up-to-date, be sure to notify the personnel office whenever you attain a higher level of education than the level you show on this form. If you have any questions, please contact the **HRO Services Section at 733-4116**.



LAST NAME-FIRST NAME-MIDDLE INITIAL OF EMPLOYEE	SOCIAL SECURITY NUMBER
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




EDUCATION LEVEL: (Refer to Attachment 1) - Insert the code in the box to the right which best represents the **HIGHEST** level of education you have attained.

EDUCATION LEVEL: (Refer to Attachment 1) - Insert the code in the box to the right which best represents the HIGHEST level of education you have attained.	
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YEAR GRADUATED: Insert in the boxes to the right the last two digits of the year in which you attained your highest level of education. (This includes year graduated High School.)





YEAR GRADUATED: Insert in the boxes to the right the last two digits of the year in which you attained your highest level of education. (This includes year graduated High School.)		
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INSTRUCTIONAL PROGRAM: (Refer to Attachment 2) - Insert the six-digit code in the boxes to the right that best describes your major field of study.

INSTRUCTIONAL PROGRAM: (Refer to Attachment 2) - Insert the six-digit code in the boxes to the right that best describes your major field of study.						
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NUMBER OF CREDIT HOURS:

Enter total number of hours.

			
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TYPE OF CREDIT HOURS:

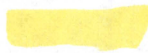
Enter: "1" for Semester Hours, or
"2" for Quarter Hours

NUMBER OF CREDIT HOURS: Enter total number of hours.	TYPE OF CREDIT HOURS: Enter: "1" for Semester Hours, or "2" for Quarter Hours
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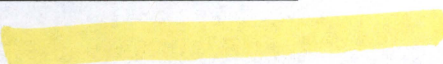
TYPE OF SCHOOL & NAME OF COLLEGE:

Enter in the box to the right ONE of the following codes and the name of the college attended.

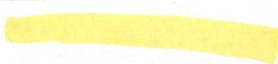
- (B) Junior College
- (C) College or University
- (H) High School
- (S) Secretarial, Business or Commercial School
- (V) Vocational, Trade or Tech School (High School Level)
- (W) Vocational, Trade or Tech School (Above High School)

TYPE OF SCHOOL & NAME OF COLLEGE: Enter in the box to the right ONE of the following codes and the name of the college attended. <ul style="list-style-type: none">(B) Junior College(C) College or University(H) High School(S) Secretarial, Business or Commercial School(V) Vocational, Trade or Tech School (High School Level)(W) Vocational, Trade or Tech School (Above High School)	
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EMPLOYEE'S SIGNATURE:



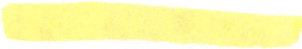
DATE:




CONDITION OF EMPLOYMENT

The regulations that govern the employment of National Guard technicians require membership in an appropriate National Guard unit as a condition of employment. This requirement is derived from Section 709(f)(1), Title 32, United States Code.

This is to certify that I understand that my full-time technician position with the Hawaii Air/Army National Guard is contingent upon my maintaining membership with the Hawaii Air/Army National Guard. Should I lose my membership for any reason, I will be terminated from my full-time technician position.



(Printed Name)



(Signature)



(Date)

MEMORANDUM OF UNDERSTANDING - TEMPORARY APPOINTMENT

(Revised 15 December 2014)

I, the undersigned, understand that **(please initial next to each item below):**

1. This appointment is subject to termination at any time without the use of adverse action or reduction-in-force procedures. Notice will be provided by Standard Form 50 (Notification of Personnel Action). Initial

2. A temporary limited employee:

a. Does not acquire permanent status under a temporary limited appointment or eligibility to be noncompetitively converted to a permanent appointment. Initial

b. Does not serve a probationary or trial period. Initial

c. Is not eligible for coverage under the Civil Service Retirement System (CSRS), the Federal Employees Retirement System (FERS), or the Federal Employees Group Life Insurance (FEGLI) Program--unless the temporary employment follows, without a break in service in excess of three days, employment in a covered position. In addition, temporary service performed on or after 1 January 1989 is not creditable under FERS even if the employee later becomes covered by FERS. Since I am not currently eligible for a federal retirement program, I may be eligible to enroll in a "myRA" (myRetirement Account) savings account with the U.S. Treasury Department (<https://myra.treasury.gov/>). Initial

d. Is eligible for coverage under the Federal Employees Health Benefits (FEHB) Program when the temporary appointment is expected to be for 90 consecutive days or more in a continuous appointment. Employees may also carry over FEHB coverage when they move from a covered position to a temporary appointment without a break in service in excess of three days. Initial

(1) If your initial appointment is less than 90 consecutive days, you will be considered to be in a 90-day waiting period before you will be eligible to enroll. If your appointment is extended without a break in service to 90 or more consecutive days, you will be notified, and information regarding your FEHB eligibility will be provided to you. Initial

(2) Upon eligibility for FEHB, a dual status technician becomes ineligible for TRICARE Reserve Select (TRS) and must contact TRICARE to disenroll in TRS whether or not he/she enrolls in the FEHB. Initial

e. Is not eligible for coverage under the Federal Dental and Vision Program (FEDVIP). However, is eligible to enroll in the Flexible Spending Account (FSA) and the Long Term Care Insurance (FLTCIP) programs. Initial

f. Is not eligible for within-grade increases (WIGI) when serving in a General Schedule (GS) position, even when that temporary limited appointment has been extended beyond one year. An employee serving under a temporary limited appointment in a Federal Wage System (WG/WL/WS) position is eligible for a WIGI when the required waiting periods are met and job performance is fully acceptable or higher. Initial

g. Is eligible to work on a part-time, intermittent, or full-time basis if the agency authorizes such an appointment. Initial

h. Earns leave when appointed to a position with a regularly scheduled tour of duty, either part-time or full-time. All regularly scheduled temporary employees earn sick leave, and those whose temporary appointments are made for 90 consecutive days or more also earn annual leave. Temporary employees serving on temporary limited appointments not to exceed one year are not eligible for military leave. Extensions of or continuous consecutive temporary appointments, which result in more than one year of consecutive service are also not eligible for military leave since each extension or conversion action is considered a new appointment for military leave purposes. Initial

i. Is not covered by adverse action procedures under 5 USC 4303 and 5 USC 7511 even when converted to a new temporary limited appointment with total service extending beyond one year because each temporary appointment is always limited to one year or less. Initial

j. Does not have the protection of reduction-in-force procedures. Initial

3. The regulations that govern the employment of National Guard technicians require membership in an appropriate National Guard unit as a condition of employment. This requirement is derived from Section 709(f)(1), Title 32, United States Code. I certify that I understand that my full-time technician position with the Hawaii Air/Army National Guard is contingent upon my maintaining membership with the Hawaii Air/Army National Guard. Should I lose my membership for any reason, I will be terminated from my full-time technician position. Initial

4. Dual-Status military technicians are required to wear the uniform appropriate for the member's grade and component of the armed services while performing duties. The uniform will be worn in compliance with the regulations issued by the applicable military component. Initial

Please sign and date below to acknowledge receipt of this information. A signed copy of this document will be filed in your Electronic Official Personnel Folder (eOPF).

Signature

Printed Name

Date

TRS AND FEHB ACKNOWLEDGMENT FORM

(Revised 15 December 2014)

The John Warner National Defense Authorization Act for 2007 (P.L. 109-364), signed by President George W. Bush on 17 October 2006, excludes individuals eligible for health insurance under the Federal Employees Health Benefits (FEHB) Program from coverage under TRICARE Reserve Select (TRS).

The following chart reflects eligibility to enroll or continue coverage under TRS:

	Eligible for FEHB	Enrolled In FEHB	Eligible for FEHB through a family member	Enrolled in FEHB through a family member	Enroll In TRS?
Selected Reserve Member	No	No	N/A	N/A	Yes
Selected Reserve Member	Yes	No	N/A	N/A	No (if eligible for FEHB, cannot enroll in TRS)
Selected Reserve Member	Yes	Yes	N/A	N/A	No (if eligible for or enrolled in FEHB, cannot enroll in TRS)
Selected Reserve Member	No	No	Yes	No	Yes (however cannot enroll in both FEHB and TRS)
Selected Reserve Member	No	No	Yes	Yes	No (if enrolled in FEHB, cannot enroll in TRS)
Family Member	Yes	No	N/A	N/A	Yes (however cannot enroll in both FEHB and TRS)
Family Member	Yes	Yes	N/A	N/A	No (if enrolled in FEHB, cannot enroll in TRS)

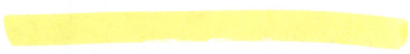
You were recently hired as a permanent or indefinite federal employee. This makes you *eligible* to enroll in the FEHB program. Upon *eligibility* for FEHB, you must contact TRICARE West Region's Contractor, UnitedHealthcare Military & Veterans, Customer Service at 1-877-988-9378 and notify them of your FEHB eligibility and cancel your TRS coverage immediately.

If you are a temporary employee, you will be *eligible* to enroll in the FEHB when the temporary appointment is expected to be for 90 consecutive days or more. If your initial appointment is less than 90 consecutive days, you will be considered to be in a 90-day waiting period before you will be eligible to enroll. If the appointment is extended without a break in service to 90 consecutive days or more, you will be notified, and information regarding your FEHB eligibility will be provided to you. Upon *eligibility*, whether or not you elect to enroll in the FEHB program, you must contact TRICARE West Region's Contractor, UnitedHealthcare Military & Veterans, Customer Service at 1-877-988-9378 and notify them of your FEHB eligibility and cancel your TRS coverage immediately.

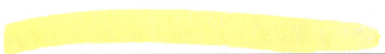
If you have any questions about how to terminate your TRS enrollment, contact UnitedHealthcare Military & Veterans Customer Service at the phone number above or their web site at www.uhcmilitarywest.com.

If you fail to end your TRS coverage as required, TRICARE will terminate your coverage retroactive to when you became eligible for FEHB and you will be responsible for any health care costs after the effective date of termination. You could also face a fine and/or a charge of fraud.

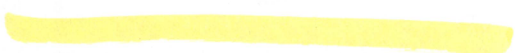
Please sign and date this letter to acknowledge receipt of this information. A signed copy of this document will be filed in your Electronic Official Personnel Folder (eOPF).



(SIGNATURE)



(DATE)



(PRINTED NAME)

**NOTIFICATION TO HIANG/HIARNG TEMPORARY TECHNICIANS
REGARDING ELIGIBILITY FOR FEDERAL EMPLOYEES HEALTH BENEFITS (FEHB)**

(15 December 2014)

1. To further the goal of providing affordable health insurance to Federal employees, the Office of Personnel Management (OPM) issued a final ruling effective 17 November 2014 expanding the eligibility criteria for coverage under the FEHB program to include certain temporary, seasonal, and intermittent employees, who are identified as "full-time" to be eligible for health benefits coverage with the same government contribution towards the premium cost as full-time permanent employees. The government pays approximately 2/3% of the premium cost and the employee pays approximately 1/3% of the premium cost.

2. Under this expanded provision of the FEHB program, a full-time employee is defined as an employee, who is employed on average 130 hours in a calendar month. Therefore, temporary employees, who are expected to work 130 hours or more per month for at least 90 consecutive days in a continuous appointment are eligible to enroll in the FEHB program within 60 days of becoming eligible.

a. Temporary technicians currently enrolled in the FEHB and paying 100% of the premium cost (based on the previous provisions) as of the passage of this ruling, have until 12 February 2015 (60 days from date of this notice), to request a change to the health plan currently enrolled in. Please contact the HRO Services Section for a "hard-copy" Standard Form 2809 (Health Benefits Election Form) to complete, and we will coordinate the processing with the Army Benefits Center-Civilian (ABC-C). If you do not wish to change the plan you are currently enrolled in, you still must reenroll by completing a "hard-copy" SF 2809 in order to receive the government portion of the premium. Action is NOT retroactive. It will be effective the first day of the pay period following the pay period in which HRO receives your request.

b. Temporary technicians currently on board and serving on an appointment of 90 consecutive days or more, have until 12 February 2015 (60 days from date of this notice), to enroll in the FEHB program. You must make your election in the Employee Benefits Information System (EBIS) on the ABC-C web site at: <https://www.ebis.army.mil>. You can also contact an ABC-C counselor at 1-877-276-9287 (Option #3) for assistance. Once you have enrolled in EBIS, it will generate a SF 2809 for your records.

c. Newly hired temporary employees with an initial appointment of 90 consecutive days or more, have 60 days from the effective date of their appointment to enroll in the FEHB program. Once your appointment action has been processed, you must make your election in EBIS or contact an ABC-C counselor at 1-877-276-9287 (Option #3) for assistance. Once you have enrolled in EBIS, it will generate a SF 2809 for your records.

d. Temporary technicians, whose initial appointment was made for less than 90 consecutive days, are currently ineligible to enroll in the FEHB. If your temporary appointment is extended without a break in service past 90 consecutive days, you become eligible to enroll on that 90th day and will have 60 days to enroll in the program. HRO will notify you of your eligibility and you will enroll through EBIS.

e. Enrollments become effective the first day of the pay period following the pay period in which the election form is processed in EBIS, and one that follows a pay period in which you are in a pay and duty status. If you do not enroll during the 60-day eligibility period, you will be deemed to have waived coverage and will not be eligible to enroll in the FEHB until the next open season, unless you experience a Qualifying Life Event (QLE) which allows for enrollment. Be advised, that while coverage begins on the effective date, it may take up to several weeks for the health carrier to process the enrollment and issue the membership cards. You may have to pay out of pocket for health care costs and submit a claim for reimbursement once you are active in the health carrier's system.

f. Once enrolled in the FEHB, the coverage will not be revoked regardless of the actual work schedule or employer expectations in subsequent years. However, if you separate, coverage will terminate. Upon any rehire, the eligibility for FEHB would once again need to be determined.

g. Please be advised that bi-weekly premiums are deducted from your pay on a pre-tax basis, which is known as Premium Conversion (PC). Participation in PC limits your opportunity to cancel or change to a self-only plan until there is an open season or you have a QLE. You have 60 days from the effective date of your temporary appointment in which to waive your participation in this program by completing the attached PC waiver form and forwarding to the HRO Services Section to process.

3. Health plan brochures are currently available online at www.opm.gov/FEHBbrochures. If assistance is needed or you have questions regarding the plans available to you, please contact the Human Resources Office (HRO) Services Section at (808) 672-1006, Option 3.

4. **IMPORTANT:** While this is a great extension of benefits for our temporary employees, you are reminded that, upon eligibility for the FEHB, whether or not you elect to enroll, you are ineligible for TRICARE Reserve Select (TRS). If you are enrolled in TRS, you must contact TRICARE West Region's Contractor, UnitedHealthcare Military & Veterans Customer Service at 1-877-988-9378 and notify them of your FEHB eligibility and cancel your TRS coverage immediately. If you fail to end your TRS coverage as required, TRICARE will terminate your coverage retroactive to when you became eligible for FEHB and you will be responsible for any health care costs after the effective date of termination. You could also face a fine and/or a charge of fraud.

5. This expansion of the FEHB also changed the eligibility for other federal benefits as well. Temporary employees will be eligible for Flexible Spending Accounts (FSA) and Long-Term Care Insurance (FLTCIP). However, they are NOT eligible to enroll in the Federal Employees Dental and Vision Program (FEDVIP) and the Federal Employees Group Life Insurance (FEGLI) program.

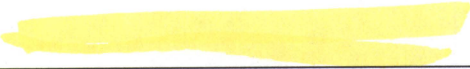
6. The attached documents are provided for your information:

a. DOD Employee Handout – Federal Employees Health Benefits Plan (FEHB) Eligibility Expansion to Certain Employees on Temporary Appointments and Employees on Seasonal and Intermittent Schedules.

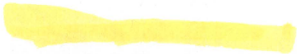
b. OPM Federal Benefits FastFacts for Certain Full-Time Temporary Employees and Certain Full-Time Employees on Intermittent and Seasonal Work Schedules.

7. If you have any questions regarding the above information, please contact the HRO Services Section at (808) 672-1006 (Option 3).

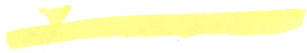
8. Please sign and date below to acknowledge receipt of this information. A signed copy of this document will be filed in your Electronic Official Personnel Folder (eOPF).



(PRINT NAME)



(DATE)



(SIGNATURE)