

## STEP-BY-STEP FOR ONBOARDING FORM

These instructions are provided to guide you in completing your electronic onboarding packet for the Rocky Mountain Regional VA (RMR VA). Onboarding packets that do not meet requirements will not be processed and your rotation start date will be impacted. Read each instruction carefully as you complete your onboarding packet. If you have any questions, please contact RMR Academic Affiliations (AA) Service, [VHAECHAcademicAffiliations@va.gov](mailto:VHAECHAcademicAffiliations@va.gov). It is the Trainee's responsibility to ensure onboarding processes are completed at least 3 weeks prior to his/her rotation start date. PLEASE FOLLOW THE DIRECTIONS LISTED BELOW.

1. **Affiliate Number**- Completed for you.
2. **Program**- Completed for you.
3. **Program Start Date**- Completed for you.
4. **Program End Date**- Completed for you.
5. **Last Name**-Complete Last Name as shown on your government IDs. First letter is capitalized.
6. **First Name**-Complete First Name as shown on your government IDs. First letter is capitalized.
7. **Middle Name**- Complete Middle Name as shown on your government IDs. First letter is capitalized.  
(If you do not have a middle name enter 'NMI')  
*\* If there are any changes to your name during your rotation; you **must** notify AA Service immediately to ensure your records/file is updated and current.*
8. **Date of Birth**- Month Day and Year of birth (i.e. 02/22/1990)
9. **City of Birth**- City you were born in.
10. **State of Birth**- State you were born in.
11. **Country of Birth**- Country you were born in.
12. **Race/ Ethnicity Group**- Race or Ethnicity you are (this information is required and must be provided to have an VA account and Facility Badge issued).
13. **Eye Color**- Color of your *natural* eyes.
14. **Hair Color**- Color of your *natural* hair.
15. **Gender**- Gender that matches your state/federal legal identification.
16. **Height**- According to your legal identification.
17. **Weight**-According to your legal identification.

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18. **SSN-** Complete 9-digit Social Security Number Ex. 111-11-1111.
19. **Foreign National-** Check the box that is applicable to you.
20. **Email Address-** Professional/School email address.
21. **Cell Phone #-** Cell phone which you can be contacted to include area code (i.e. 555-555-1234).
22. **Permanent Address-** Complete address to include zip code (City, state, Country, Zip must be entered on 3<sup>rd</sup> line).
23. **Maiden Last Name-** Complete maiden name(s), if applicable.
24. **Maiden First Name-** Complete maiden name(s), if applicable.
25. **Maiden Middle Name-** Complete maiden name(s), if applicable.
26. **Other Names Used-** Alternate names, nick names, other spellings, or name used; if applicable.
27. **Other Email Address-** Personal email address to contact you; if applicable.
28. **Have you ever had computer access at any VA-** Check the box if applicable to you. If Yes, list the VA in the blank.
29. **What email did you use when creating your TMS account-** You must put the email you used to create TMS account (no filler emails or it will cause delay with your access)
30. **Are you a male born after December 31, 1959-** Check which box is applicable to you.
31. **If yes, have you registered with the Selective Service System-** Check the box that is applicable to you.
32. **Have you ever served in the U.S. Military-** Check the box that is applicable to you.
33. **Are you now in the U.S. Military-** Check Yes if currently in US Military, otherwise check No.
34. **Are you in the Reserves or National Guard-** Check the box that is applicable to you.
35. **Branch of Service-** Place Branch of Service here; if applicable  
Start Date-Month Day and Full Year of start date (MM/DD/YYYY)  
End Date - Month Day and Full Year of end date (MM/DD/YYYY)  
Type of Discharge- (Honorable, General, Other than Honorable Conditions, Bad Conduct, Dishonorable, Officer, or Entry Level Separation)
36. **Are you a U.S. Citizen-** Check the box that is applicable to you.
37. **Check the box applicable to you-** U.S. Citizen by Birth or Naturalized U.S. Citizen.
38. **If not a U.S. Citizen complete the following-**  
“A” Number: Alien Registration Number (eight or nine-digit number) Ex. A012345678  
VISA Type: Nonimmigrant visa or Immigrant visa  
VISA # Likely comprised of eight letters and numbers  
Issue Date: Month Day and Full Year of Date Issued (MM/DD/YYYY)

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Expiration Date Month Day and Full Year of Date expired (MM/DD/YYYY)

Country of Citizenship- Refers to the country in which a person is born and has not renounced or lost citizenship.

Do you have a Valid DS2019? Check the box that is applicable to you.

Date of last validation- Month Day and Full Year of last validation date (MM/DD/YYYY)

39. **Are you now or have you ever been a Licensed Health Professional-** Check the box that is applicable to you (If Yes, Complete Below. If No, Skip to Education).
40. **National Provider Identifier (NPI) #-** A unique 10-digit identification number issue by the Centers for Medicare and Medicaid Services (CMS).
41. **Are you currently licensed-** Check the box that is applicable to you. If Yes, complete the blanks. List all licenses, certifications, and registrations, including the DEA, that you have had as a Health Professional.
42. **If you currently hold an additional License, complete-** Complete the blanks if you have a current license.
43. **Have previously held a license as a Health Professional-** Check the box applicable to you. If yes, fill out license information.
44. **If any additional past licenses complete-** Complete the blanks if you held previous license.
45. **Have you ever had a license revoked-** Check the box that is applicable to you.
46. **Have you ever had your clinical privileges revoked or voluntarily relinquished clinical privileges in lieu of formal action-**Check the box that is applicable to you.
47. **Education** – Enter your current Schools information. Add previous schools as needed on questions 48-49.  
Name of School \_\_\_\_\_  
Address of School \_\_\_\_\_  
Start Date (MM/YY): \_\_\_\_\_ (Expected) Completion Date (MM/YY): \_\_\_\_\_  
Degree or Certificate: \_\_\_\_\_ Major of Study: Area of Study: \_\_\_\_\_
48. Name of School: \_\_\_\_\_  
Address of School: \_\_\_\_\_  
Start Date (MM/YY): \_\_\_\_\_ (Expected) Completion Date (MM/YY): \_\_\_\_\_  
Degree or Certificate: \_\_\_\_\_ Major of Study: \_\_\_\_\_
49. Name of School: \_\_\_\_\_  
Address of School: \_\_\_\_\_  
Start Date (MM/YY): \_\_\_\_\_ (Expected) Completion Date (MM/YY): \_\_\_\_\_  
Degree or Certificate: \_\_\_\_\_ Major of Study: \_\_\_\_\_
50. **Are you a Graduate of an International Medical School-** Check the box applicable to you.
51. **Educational Commission for Foreign Medical Graduates Certificate-** Complete if applicable.

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(ECFMG) Number \_\_\_\_\_ ECFMG Certificate Date \_\_\_\_\_

52. **Have you had any previous internships, residencies, or fellowships-** Check the box that applies to you.
53. **Name of Hospital or Institution-** Fill out if you question fully if you answered ‘Yes’ to question 52.  
Address- only city, state, and zip code needed.  
Specialty- Enter area of focus during the time at the Institution  
Start Date/End Date (MM/YY)- Dates covering your entire time at the Institution  
Number of Months Completed- How many months did you complete at the Institution
54. **Name of Hospital or Institution-** only fill out this section if you had a second Institution to list from question 52.  
Address- only city, state, and zip code needed.  
Specialty- Enter area of focus during the time at the Institution  
Start Date/End Date (MM/YY)- Dates covering your entire time at the Institution  
Number of Months Completed- How many months did you complete at the Institution
55. **As a participant in the Medicare and Medicaid Programs, have you ever been convicted of or investigated for making false, fictitious, or fraudulent statements, representations, writings, or documents regarding the delivery of or payment for health care benefits, items, or services that would be in violation of the Criminal False Claims Act-** Check the box that is applicable to you. If you check Yes; give a detailed statement if what happened.
56. **Are you now, or have you ever been involved in administrative, professional, or judicial proceedings in which malpractice on your part was alleged-** Check the box that is applicable to you. If you check Yes; give a detailed statement if what happened.
57. Questions 55-64- Check the box that is applicable to you. **Failure to disclose or answer information**  
58. **in this section will impact your ability to complete rotations at the agency.**  
59. **\*if you answered Yes on question 56; you must give a detailed statement of the situation.**  
60. **\*if you answered Yes on question 63; you must list the relative and work area on question 65**  
61.  
62.  
63.  
64.
65. **CONTINUATION SECTION**
66. **Have you been employed by the Federal Government before-** Check the box that is applicable to you; if you mark Yes then enter the date you left your last Federal job (i.e. 11/11/2001).

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67. **When you worked for the Federal Government the last time, did you waive Basic Life Insurance or any type of optional insurance-** Complete only if you answered Yes to question 66.

68. **Authorization for Release of Information-** Read and check each statement of understanding.

### AS APPLICABLE FORMS - ATTACHED BELOW

**1. Courtesy Fingerprint Request Form-** If completing fingerprints outside of RMR VA, please complete the attached form. Print and present form to the local VA where you are fingerprinted. This will allow your fingerprints to be sent to RMR VA for badging purposes.

**2. Verification of Certificate of Naturalization** - If applicable, enter nationalization information on the form below. Return form with signed onboarding packet.

**When saving this documents, please use the following nomenclature: Last name, First name, Program / Service.**

**The Appointment Affidavit (page 16) and the WOC Appointment letter (page 17) will ONLY be valid after your onboarding packet has been reviewed and sign and you have been sworn in by the Human Resources Coordinator.**

For any questions feel free to contact RMR VA Academic Affiliations Service at

[VHAECHAcademicAffiliations@va.gov](mailto:VHAECHAcademicAffiliations@va.gov)

# **FINGERPRINT REQUEST FORM**

Bring with you two (2) original IDs (Identity Source Documents) from the list below

[https://www.oit.va.gov/programs/piv/\\_media/docs/IDMatrix.pdf](https://www.oit.va.gov/programs/piv/_media/docs/IDMatrix.pdf)

Complete all fields on this form to the best of your ability

**Applicant Category: Check One**

<b>EMPLOYEE</b>	<b>CONTRACTOR</b>	<b>HEALTH PROFESSIONS TRAINEE (VHA intern, resident, fellow, student)</b>
<b>AFFILIATE</b>	<b>VOLUNTEER</b>	<b>OTHER:</b>

**ENTER YOUR NAME EXACTLY AS IT APPEARS ON IDs**

Name: (Last, First, Middle)		Other Last Names Used
SSN (use of pseudo number is not permitted)	Position Title	Telephone #
Date of Birth: (mm/dd/yyyy)	City/State and Country of Birth	
E-Mail Address (long-term, sustained E-Mail)	Country of Citizenship	Dual Citizen? (Yes/No)
VA Work Location	POC/COTR/Sponsor/Supervisor	POC Phone #
<b>Contractors Only:</b> Company Name		Company Address
		Contract End Date
<b>Health Professions Trainees Only:</b> School/Affiliate Name		Training Program
		Program End Date

FINGERPRINT LOCATION		FINGERPRINT DATE (mm/dd/yyyy)		PREVIOUS PIV CARD HOLDER (Yes/No)	
GENDER (M/F)	HEIGHT (inches)	WEIGHT (US pounds)	HAIR COLOR	EYE COLOR	RACE/ETHNICITY

**Courtesy Prints for another Facility**

Facility Name/Location:	Facility SOI#	Facility SON#
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**Personnel Security Specialist USE ONLY**

Date Cleared	Signature
Comments	

## VERIFICATION OF CERTIFICATE OF NATURALIZATION

Date: \_\_\_\_\_

I personally cited the Certificate of Naturalization for:	
Date of Birth:	
Place of Birth:	
Certificate Number:	
INS Registration Number:	
Issued By:	INS
On:	

\_\_\_\_\_  
HUMAN RESOURCES REPRESENTATIVE