



APPLICATION FOR ASSOCIATED HEALTH OCCUPATIONS

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

INSTRUCTIONS: Please submit this application furnishing all information in sufficient detail to enable the Department of Veterans Affairs to determine your eligibility for appointment in Veterans Health Administration.

Type, or print in ink. If additional space is required, please attach a separate sheet and refer to items being answered by number.

1. OCCUPATION FOR WHICH APPLYING

- A ☐ CERTIFIED RESPIRATORY THERAPY TECHNICIAN
B ☐ REGISTERED RESPIRATORY THERAPIST
C ☐ LICENSED PHYSICAL THERAPIST
D ☐ LICENSED PRACTICAL/VOCATIONAL NURSE

- E ☐ LICENSED PHARMACIST
F ☐ PHYSICIAN ASSISTANT
G ☐ EXPANDED-FUNCTION DENTAL AUXILIARY
H ☐ OCCUPATIONAL THERAPIST

☐ OTHER (Specify)

2. NAME (Last, First, Middle)

3. APPLICATION FOR (Check one)

- ☐ GENERAL PRACTICE ☐ SPECIALTY (Identify Below)

4. PRESENT ADDRESS (Include ZIP Code) STREET ADDRESS 2

APT. NO.

CITY

STATE ZIP CODE

COUNTRY

5. TELEPHONE NUMBER (Include Area Code)

5A. RESIDENCE

5B. BUSINESS

6. DATE OF BIRTH

7. PLACE OF BIRTH (City)

STATE

COUNTRY

8. SOCIAL SECURITY NUMBER

9A. CITIZENSHIP

- ☐ U.S. CITIZEN BY BIRTH ☐ NATURALIZED U.S. CITIZEN ☐ NOT A U.S. CITIZEN (Complete item 9B)

9B. COUNTRY OF WHICH YOU ARE A CITIZEN

10A. HAVE YOU EVER FILED APPLICATION FOR APPOINTMENT IN THE VA

- ☐ YES ☐ NO (If "YES" complete items 10B and 10C)

10B. NAME OF OFFICE WHERE FILED

10C. DATE FILED

11. WHEN MAY INQUIRY BE MADE OF YOUR PRESENT EMPLOYER

12. DATE AVAILABLE FOR EMPLOYMENT

I - ACTIVE MILITARY DUTY

13A. DATE FROM

13B. DATE TO

13C. SERIAL OR SERVICE NO.

13D. BRANCH OF SERVICE

13E. TYPE OF DISCHARGE

- ☐ HONORABLE ☐ OTHER (Explain on separate sheet)

II - LICENSE, DEA CERTIFICATION, REGISTRATION AND CLINICAL PRIVILEGES (As applicable)

14A. LIST ALL STATES/TERRITORIES IN WHICH YOU ARE NOW OR HAVE EVER BEEN LICENSED (If not held now, explain on separate sheet)

14B. LICENSE NO.

14C. CURRENT REGISTRATION (If "NO" explain on separate sheet)

YES

NO

NOT REQUIRED

14D. EXPIRATION DATE

15A. ARE YOU FULLY LICENSED IN EVERY STATE IN WHICH YOU RECEIVED A LICENSE (If restricted, limited or probational in any State(s), explain on separate sheet)

- ☐ YES ☐ NO ☐ NOT APPLICABLE

15B. DO YOU HAVE PENDING OR HAVE YOU EVER HAD A STATE LICENSE TO PRACTICE REVOKED, SUSPENDED, DENIED, RESTRICTED, LIMITED, OR ISSUED/PLACED ON A PROBATIONAL STATUS OR VOLUNTARILY RELINQUISHED

- ☐ YES ☐ NO (If "YES" explain on separate sheet)

15C. HAVE YOU EVER HELD A REGISTRATION TO PRACTICE THAT IS NO LONGER HELD OR CURRENT

- ☐ YES ☐ NO (If "YES" explain on separate sheet)

16A. NAME THE CERTIFYING BODY FOR YOUR HEALTH OCCUPATION

16B. DATE OF MOST RECENT REGISTRATION/CERTIFICATION (Give Month and Year)

16C. WHAT IS YOUR REGISTRY/ CERTIFICATION NUMBER

16D. HAS ACTION EVER BEEN TAKEN AGAINST YOUR CERTIFICATION OR REGISTRATION

- ☐ YES ☐ NO (If "YES" explain on separate sheet)

17A. DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD CLINICAL PRIVILEGES AT ANY HEALTH CARE INSTITUTION, AGENCY OR ORGANIZATION

- ☐ YES ☐ NO (If "YES" complete item 17B)

17B. NAME OF CURRENT OR MOST RECENT INSTITUTION, AGENCY OR ORGANIZATION WHERE HELD

17C. HAVE ANY OF YOUR STAFF APPOINTMENTS OR CLINICAL PRIVILEGES EVER BEEN DENIED, REVOKED, SUSPENDED, REDUCED, LIMITED, OR VOLUNTARILY RELINQUISHED

- ☐ YES ☐ NO (If "YES" explain on separate sheet)

III - THIS SECTION TO BE COMPLETED BY FACILITY DIRECTOR OR DESIGNEE

CERTIFICATION: I certify that I have verified licensure and registration with State boards, and cited visa or evidence of citizenship. Board certification has been verified (if appropriate).

18. EVIDENCE HAS BEEN CITED IN REGARDS TO:

- ☐ CERTIFICATION OR REGISTRATION
☐ NATURALIZED CITIZENSHIP
☐ LICENSURE/REGISTRATION FOR ALL STATES LISTED BY APPLICANT

- ☐ VISA
☐ CURRENT OR MOST RECENT CLINICAL PRIVILEGES
☐ NO CURRENT OR PREVIOUS CLINICAL PRIVILEGES

19A. SIGNATURE OF AUTHORIZED OFFICIAL

19B. TITLE

19C. DATE (MONTH, DAY, YEAR)

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Table of Contents Vawwva Gov Vaforms Medical Vha 2850c Fill

1. Understanding the eBook Vawwva Gov Vaforms Medical Vha 2850c Fill
 - The Rise of Digital Reading Vawwva Gov Vaforms Medical Vha 2850c Fill
 - Advantages of eBooks Over Traditional Books
2. Identifying Vawwva Gov Vaforms Medical Vha 2850c Fill
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Vawwva Gov Vaforms Medical Vha 2850c Fill
 - User-Friendly Interface
4. Exploring eBook Recommendations from Vawwva Gov Vaforms Medical Vha 2850c Fill
 - Personalized Recommendations
 - Vawwva Gov Vaforms Medical Vha 2850c Fill User Reviews and Ratings

- Vawwva Gov Vaforms Medical Vha 2850c Fill and Bestseller Lists
- 5. Accessing Vawwva Gov Vaforms Medical Vha 2850c Fill Free and Paid eBooks
 - Vawwva Gov Vaforms Medical Vha 2850c Fill Public Domain eBooks
 - Vawwva Gov Vaforms Medical Vha 2850c Fill eBook Subscription Services
 - Vawwva Gov Vaforms Medical Vha 2850c Fill Budget-Friendly Options
- 6. Navigating Vawwva Gov Vaforms Medical Vha 2850c Fill eBook Formats
 - ePub, PDF, MOBI, and More
 - Vawwva Gov Vaforms Medical Vha 2850c Fill Compatibility with Devices
 - Vawwva Gov Vaforms Medical Vha 2850c Fill Enhanced eBook Features
- 7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Vawwva Gov Vaforms Medical Vha 2850c Fill
 - Highlighting and Note-Taking Vawwva Gov Vaforms Medical Vha 2850c Fill
 - Interactive Elements Vawwva Gov Vaforms Medical Vha 2850c Fill
- 8. Staying Engaged with Vawwva Gov Vaforms Medical Vha 2850c Fill
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Vawwva Gov Vaforms Medical Vha 2850c Fill
- 9. Balancing eBooks and Physical Books Vawwva Gov Vaforms Medical Vha 2850c Fill
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Vawwva Gov Vaforms Medical Vha 2850c Fill
- 10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
- 11. Cultivating a Reading Routine Vawwva Gov Vaforms Medical Vha 2850c Fill
 - Setting Reading Goals Vawwva Gov Vaforms Medical Vha 2850c Fill
 - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Vawwva Gov Vaforms Medical Vha 2850c Fill
 - Fact-Checking eBook Content of Vawwva Gov Vaforms Medical Vha 2850c Fill
 - Distinguishing Credible Sources

13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development
 - Exploring Educational eBooks
14. Embracing eBook Trends
 - Integration of Multimedia Elements
 - Interactive and Gamified eBooks

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