DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service Commissioned Corps

APPLICATION FOR TRAINING FOR PHS COMMISSIONED PERSONNEL

SECTION I - TO BE COMPLETED BY ALL APPLICANTS

INSTRUCTIONS: Before completing the application, read all the items carefully including the definitions of long-term training and short-term training on page 4. Complete all the items in Sections I and II. PRINT OR TYPE the application and submit the original and 2 photocopies to your immediate supervisor.

TYPE OF TRAINING FOR WHICH YOU ARE APPLYING

Short-Term: See definitions on page 4. Do NOT use this form. Use form HHS-350.

Long-Term: Application should be made for complete period of training.

Specify length below:

☐ Full-Time _____

☐ Part-Time _____

State field of study or specialty: _____

Sub specialty: _____

RESIDENCY APPLICANTS ALSO COMPLETE THE FOLLOWING:

☐ Intramural
☐ Extramural
☐ Will Accept Either

IF TRAINING REQUESTED IS INTRAMURAL, WILL IT INVOLVE ANY EXTRAMURAL TRAINING: _____ HOW MUCH: _____

FULL NAME *(First, Middle, Last)*			SOCIAL SECURITY NO.
PRESENT MAILING ADDRESS *(Official duty station)*	DIVISION	BUREAU	BUSINESS PHONE

PHS SERIAL NO.	DATE OF BIRTH *(mm/dd/yyyy)*	TYPE OF APPT. ☐ Regular ☐ Reserve	GRADE	DATE ENTERED ON DUTY IN PHS *(mm/dd/yyyy)*	OBLIGATED MILITARY SERVICE COMPLETION DATE *(mm/dd/yyyy)*

CATEGORY *(Medical, etc.)*

PRESENT ASSIGNMENT *(Indicate your title and brief description of your duties)*

PLACE TRAINING DESIRED ***(List in order of preference)***

INSTITUTION OR HOSPITAL	CITY and STATE	FROM	TO	APPROX. TUITION FEES	APPROX. TRAVEL COSTS	APPROX. PER DIEM COSTS	OTHER COSTS
1.							
2.							
3.							

DESCRIPTION OF TRAINING DESIRED *(Attach announcement if possible)*

REASONS TRAINING REQUESTED *(Relate to present and future needs of the Commissioned Corps of the U.S. Public Health Service)*

APPLICANT CERTIFICATION ***(Sign appropriate statement)***

A. I understand the Department of Health and Human Services (HHS) policy prohibits acceptance of contributions to salary, from whatever source, by active-duty officers, unless the contributions are accepted to the benefit of the Government and are deposited to the Miscellaneous Receipts of the Treasury of the United States. Further, with regard to the training I receive, I have read and agree to the following:

1. INTRAMURAL TRAINING AGREEMENT:

If HHS-supported intramural training program includes one or more periods of extramural training (i.e., training received in non-HHS facilities), I voluntarily agree to serve on active duty with the Commissioned Corps of the U.S. Public Health Service (Corps) for 6 months or twice the period of training received in non-HHS facilities, whichever is greater, subject to the following limitations: (a) If the total period of training in non-HHS facilities is 30 days or less, I incur no active-duty obligation; (b) Up to 1 year of training in non-HHS facilities, for which no tuition and fees are charged, shall be disregarded in determining the period of myactive-duty obligation. My active-duty obligation shall commence immediately upon cessation of my participation in the training program. Failure to fulfill my active-duty obligation shall subject me to the penalties set forth in Paragraph B, below. *(See CC25.2.3 of the electronic Commissioned Corps Issuance System (eCCIS.))*

2. EXTRAMURAL TRAINING AGREEMENT:

I voluntarily agree to serve on active duty with the Corps for 6 months or twice the period of training, whichever is greater, for any period of HHS-supported extramural training which exceeds 30 days (or part-time equivalent) and which is not part of an HHS intramural training program. My active-duty obligation shall commence immediately upon cessation of my participation in the training program. Failure to fulfill my active-duty obligation shall subject me to the penalties set *forth in Paragraph B, below. (See CC25.2.1 and CC25.2.2 of the eCCIS.)*

B. I understand that if I fail to complete an active-duty obligation with the Corps incurred as a result of my extramural training as set forth in Paragraph A 1 and 2, above, I shall be obligated to pay HHS an amount equal to two (2) times the total amount of tuition, fees, and other training expenses, *and* two (2) times any compensation (to include but not limited to pay, allowances, special pays, travel, transportation, and shipment of household goods) received by or paid to me in connection with the training. *Furthermore*, I understand that if I fail to fulfill an active-duty obligation incurred pursuant to my participation in training under this agreement, HHS will deny lump sum payment of unused annual leave to my credit; divest me of any entitlements to travel and transportation allowances and travel time which are otherwise authorized in connection with separation from the Corps; withhold my final pay and allowances to satisfy any indebtedness to the Government; and deny my request for a commission in the inactive reserve.

SIGNATURE	DATE

SECTION II - TO BE COMPLETED BY APPLICANTS FOR RESIDENCY AND LONG-TERM TRAINING ONLY

EDUCATION AND PROFESSIONAL TRAINING

NAME OF UNIVERSITY, COLLEGE, OR PROFESSIONAL SCHOOL	CITY and STATE	DATES ATTENDED FROM	DATES ATTENDED TO	MAJOR	DEGREE

OTHER SPECIAL TRAINING ***(Such as internships, residencies, etc.)***

INSTITUTION OR HOSPITAL	CITY and STATE	DATES ATTENDED FROM	DATES ATTENDED TO	DESCRIPTION OF TRAINING *(e.g., type of internship)*

ADDITIONAL QUALIFICATIONS

STATES AND DATES OF PROFESSIONAL LICENSURE, INCLUDE TYPE AND LICENSE NUMBER.

HAVE YOU HAD ANY TRAINING WHICH WILL BE ACCEPTED BY THE AMERICAN SPECIALTY BOARD OF YOUR CHOICE? *(If yes, submit evidence from the Board as to the amount with which you will be credited next July 1.)*

☐ Yes *(How much? No. years: _____ No. months: _____)* ☐ *No*

OTHER SKILLS AND QUALIFICATIONS

TITLE OF POSITION	OPERATING DIVISION / STAFF DIVISION / NON-HHS ORGANIZATION	BUREAU	DATES OF ASSIGNMENT FROM	DATES OF ASSIGNMENT TO

REFERENCES *(List the names of four persons with whom you have had professional affiliation and who are in a position to evaluate your qualifications for the training requested. Do not include your immediate superior. If applying for residency, include senior staff members and officers in charge of hospitals where you served as intern or resident.)*

FULL NAME	STREET	CITY	STATE	ZIP CODE

SECTION III - ACTION TAKEN ON APPLICATION

RECOMMENDATION OF IMMEDIATE SUPERVISOR

☐ Approval ☐ Disapproval	TITLE	STATION

REASONS FOR APPROVAL OR DISAPPROVAL *(Use page 4 if additional space is needed and check here* ☐)

SIGNATURE OF IMMEDIATE SUPERVISOR	DATE

RECOMMENDATION OF BRANCH CHIEF

NONDISCRIMINATION CERTIFICATION: It has been duly ascertained that the training institution(s) named in Section I, Item 14, do(es) not discriminate because of race, color, or national origin in the admission or in the subsequent treatment of students. This officer has been recommended for training without regard to race, creed, color, national origin, or gender.

☐ Approval ☐ Disapproval	IS FINANCIAL SUPPORT AVAILABLE AT INITIATING LEVEL? ☐ Yes ☐ No	IS TRAINING JUSTIFIED BY THE NEEDS OF THE SERVICE? ☐ Yes ☐ No	CAN APPLICANT BE RELEASED TO TAKE THIS TRAINING? ☐ Yes ☐ No

HOW WOULD THE TRAINING BENEFIT THE SERVICE?

SIGNATURE OF BRANCH CHIEF	BRANCH	DATE

RECOMMENDATION OF DIVISION OR OFFICE DIRECTOR

☐ Approval ☐ Disapproval	IS FINANCIAL SUPPORT AVAILABLE? ☐ Yes ☐ No	HOW WOULD THE TRAINEE'S SERVICES BE USED?

REASONS FOR APPROVAL OR DISAPPROVAL

SIGNATURE OF DIVISION OR OFFICE DIRECTOR	DIVISION OR OFFICE	DATE

RECOMMENDATION OF CENTER, BUREAU, OR INSTITUTE DIRECTOR

☐ Approval ☐ Disapproval	IS FINANCIAL SUPPORT AVAILABLE? ☐ Yes ☐ No

REASONS FOR APPROVAL OR DISAPPROVAL

SIGNATURE OF BUREAU OR INSTITUTE DIRECTOR	BUREAU OR INSTITUTE	DATE

COMMITTEE ACTION ***(Forward to Division of Commissioned Corps Personnel and Readiness, Assignments and Career Management Branch/ Assignments, 1101 Wootton Parkway, Plaza Level, Suite 100, Rockville, MD 20852).***

☐ Approval ☐ Disapproval	SIGNATURE OF CHAIRPERSON	DATE

REASONS FOR RECOMMENDATION

DCCPR/ACM AND/OR DCCTCD RECOMMENDATION

IMMEDIATE OFFICE OF THE DIRECTOR, DCCPR, ACTION

☐ Approval ☐ Disapproval	SIGNATURE OF DIRECTOR, DCCPR	DATE

DEFINITIONS OF TYPE OF TRAINING

LONG-TERM TRAINING: Long-term training includes all units or courses in a planned educational program leading to an academic degree, whether taken full-time, part-time, continuously, or intermittently. *(If the amount of training to be taken during any one academic term or fiscal year falls within the limits of short-term training but still meets this definition, it will be processed as long-term training.)* Long-term training also includes internship or residency training the period for which exceeds that specified as short-term training (see below).

SHORT-TERM TRAINING: Training outside the Department of Health and Human Services in non-Government institutions and facilities which does not lead to an academic degree. However, such training must be within the following limits: full-time training that does not exceed 30 consecutive days or a total of 90 calendar days in a fiscal year; part-time training that does not exceed 70 hours in attendance within a 30-day period or a total of 210 hours in a fiscal year. Use form HHS-350 for this type of training.

INSTRUCTIONS FOR ROUTING APPLICATION

Applicant - Complete the application. Submit the original and two photocopies to your immediate supervisor.

Supervisor - Complete item 22 on all copies, and forward to the Branch Chief.

Branch Chief - Complete item 23 on all copies and forward as indicated.

REMARKS

PRIVACY ACT STATEMENT FOR FORM PHS-1122-1

This statement is provided pursuant to the Privacy Act of 1974 (5 U.S.C. 552a). Our authority to collect this information from you is 42 U.S.C. 218a.

Principal Purpose and Routine Uses

The information you provide on this form will be used to determine whether the training you request will be sponsored by HHS. This form also serves as a record of the service agreement you willingly incur in return for HHS-sponsored training. This information will be used only as necessary in personnel administration processes carried out in accordance with established regulations and published notices of systems of records. Copies of these systems of records may be obtained by contacting the office where you submitted this form.

Record System

09-40-0001, PHS Commissioned Corps General Personnel Records, HHS/PSC/HRS; 09-40-0003, PHS Commissioned Corps Board Proceedings, HHS/PSC/HRS; 09-40-0004, PHS Commissioned Corps Grievance, Investigatory and Disciplinary Files, HHS/PSC/HRS; 09-40-0006, PHS Commissioned Corps Payroll Records, HHS/PSC/HRS; 09-40-0010, Pay, Leave and Attendance Records, HHS/PSC/HRS; and 09-40-0011, Proceedings of the Board for Correction of PHS Commissioned Corps Records, HHS/PSC/HRS.

Information Regarding Disclosure of Your Social Security Account Number

Disclosure of your Social Security Number (SSN) is mandatory under provisions of Executive Order 9397 to obtain benefits and services as an officer in the Commissioned Corps of the U.S. Public Health Service (Corps). Your SSN is also used to distinguish your record from those of Corps officers who may have similar names and dates of birth.

Effects of Non-Disclosure

You must disclose your SSN as explained above. If you do not provide the information requested on this form, you will not be considered for HHS sponsored training.