STEP-BY-STEP FOR ONBOARDING FORM

These instructions are provided to guide you in completing your electronic onboarding packet for the VA Maryland Health Care System (VAMHCS). 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 VAMHCS Education Service BALEDUHPT@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.

1. **Affiliate Number**- This number will be assigned to you from the VAMHCS Education Service., posted in your onboarding package or on your instruction sheet (whichever is applicable to you).
2. **Program**- Type in the program name assigned to you from the VAMHCS Education Service, posted in your onboarding package or on your instruction sheet (whichever is applicable to you).
3. **Program Start Date**- The date you start your VA clinical rotation. (Residents/MS3/MS4: AY start date; Nursing/Other Trainees: This date is the day you begin your clinical rotation).
4. **Program End Date**- The date you will end **your entire** VA clinical rotation. (this can vary from 1 month to 6 years). Nursing/Other Trainees will enter his/her **anticipated program graduation date**.
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 Education Service immediately to ensure your records/file is updated and current.*
8. **Date of Birth**- Month Day and Year of birth (E.g. 02/22/2022)
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**- 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.

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**- Best email address to contact you (school or personal).
21. **Cell Phone #**- Cell phone which you can be contacted to include area code EX. 555-555-1234.
22. **Permanent Address**- Complete address to include zip code (City, state, Country, Zip must be entered on 3rd 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**-Alternate 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 applicable; 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)

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

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 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.

(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 second Institution to list form 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

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 in this section will impact your ability to complete rotations at the agency.
    * if you answered yes on question 56; you must give a detailed statement of the situation.
    * if you answered yes on question 63; you must list the relative and work area on question 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 Ex. 11/11/2222.

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.

For any questions feel free to contact the OKC VA HCS Education Service at BALEDUHPT@va.gov.