Washington State Guard

Applicant
Forms Package

v19-06

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WASHINGTON STATE GUARD
APPLICATION

Name: *(Last, First, MI)*							**Soc Sec Number:**	
Address:							**Home Phone:**	
							Work Phone:	
Date of Birth:			Place of Birth:				**U.S. Citizen** ***(circle one)***	
							No	**Birth** / **Naturalized***
Marital Status	**Sex**	**Height**	**Weight**	**Hair**	**Eyes**	**Convictions (circle one):**	**Yes**	**No**
						If yes, explain fully on separate sheet.		
Dependents: *(Names, Ages, Relationship)*								
Occupation:							**No of Years:**	
Employer: *(Name and Address)*								

MILITARY SERVICE *(Attach copy of DD Form 214, NGB Form 22 or other documents verifying service)*

Year	Branch	Unit and Location	Grade

MILITARY SKILLS

Skill	MOS/AFSC	Title	Grade
Primary			
Other			
Decorations and Awards:			

MILITARY TRAINING COURSES AND SCHOOLS *(Include Correspondence Courses)*

Year	Duration	Course, School Name	Completed	
			Yes	No

** NOTE: If naturalized citizen, attach certified copy of naturalization papers.*

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Name: *(Last, First, MI)*	Soc Sec Number:

CIVILIAN ACADEMIC EDUCATION

Year	School Name and Location	Major Course/Title	Graduate	
			Yes	No

CIVILIAN TRAINING COURSES, SPECIAL SCHOOLS

Year	School Name	Course Subject	Duration	Complete	
				Yes	No

	Yes	No
Are you a member of a public safety organization (police, fire, etc.)?		
Are you an elected official or legislator?		
Have you ever been rejected for military service or separated under less than honorable conditions?		
Are you a member of any federal military service organization or do you have a service obligation remaining?		

I hereby declare that the information provided in this application is true and correct.

This information is furnished for official use by the Military Department of the State of Washington and is not to be released to others without my permission except when permitted or required by law.

I understand that a background investigation will most likely be conducted to verify the information contained in my application.

I understand that the grade in which I shall be appointed shall be determined by the Washington State Guard Appointment Board based on my prior military experience and the needs of the Military Department of the State of Washington.

I make this application without reservation or inducement.

Applicant's Signature: _____ Date: _____

HEADQUARTERS MILITARY DEPARTMENT
STATE OF WASHINGTON
Office of the Adjutant General
Camp Murray, Tacoma, Washington 98430-5002

PRIVACY ACT NOTICE

Purposes and Uses:
Information provided on this form will be furnished to individuals in connection with an investigation to determine fitness for appointment or advancement in the Washington State Guard, and information obtained may be furnished to third parties as necessary in fulfillment of official responsibilities.

Effect of Nondisclosure:
Furnishing the requested information below is voluntary, but failure to provide all or part of the information may result in a lack of further consideration for appointment or advancement in the Washington State Guard.

AUTHORITY TO RELEASE INFORMATION

To Whom It May Concern:
I hereby authorize an investigator or duly accredited representative of the State of Washington bearing this release, or copy thereof, in person or through official correspondence, to obtain any information from schools, employers, criminal justice agencies, individuals, or other sources, relating to my activities. This information may include, but is not limited to, academic, achievement, performance, attendance, social media, personal history, disciplinary, arrest and conviction records. I hereby direct you to release such information, and I understand that the information released is for official use by the State of Washington Military Department and may be disclosed to such third parties as necessary in fulfillment of official responsibilities.

I hereby release any individual, organization or agency including record custodians, from any and all liability for damages of whatever kind or nature which may at any time result to me on account of compliance, or attempts to comply, with this authorization. Should there be any question as to the validity of this release, you may contact me at the address and/or telephone number shown below.

Full Name: _____

Soc Sec No: _____ Other Names Used: _____

Date of Birth _____ Place of Birth (City & State) _____

Complete Mailing Address: _____

Dates I Have Resided at this Address: From _____ To _____

Telephone Numbers: (Include Area Code) Home _____ Work _____

Signature: _____ Date Signed: _____

I hereby release any individual, organization or agency including record custodians, from any and all liability for damages of whatever kind or nature which may at any time result to me on account of compliance, or attempts to

Return this completed form to you WSG Recruiter or by mail to:

Commander
Washington State Guard
Camp Murray, WA 98430-5002

POLICE RECORD CHECK

1. DATE OF REQUEST *(YYYYMMDD)*

Form Approved
OMB No. 0704-0007
Expires Oct 31, 2006

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO ADDRESS SHOWN AT BOTTOM OF FORM.

SECTION I - *(To be completed by Recruiting Service)*

2. NAME OF APPLICANT *(Last, First, Middle Name(s), Alias)*	3. SEX	4. PLACE OF BIRTH		
	☐ MALE ☐ FEMALE	a. CITY	b. COUNTY	c. STATE

5. DATE OF BIRTH *(YYYYMMDD)*	6.a. RACIAL CATEGORY *(X one or more)*		b. ETHNIC CATEGORY	7. SOCIAL SECURITY NUMBER
	☐ (1) AMERICAN INDIAN/ALASKA NATIVE ☐ (2) ASIAN ☐ (3) BLACK OR AFRICAN AMERICAN	☐ (4) WHITE ☐ (5) NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	☐ (1) HISPANIC OR LATINO ☐ (2) NOT HISPANIC OR LATINO	

8. ADDRESS IN ADDRESSEE'S JURISDICTION *(See "MAIL TO" block)*				9. DATES RESIDED AT THIS ADDRESS	
a. NUMBER AND STREET *(Include apartment no.)*	b. CITY	c. STATE	d. ZIP CODE	a. FROM *(YYYYMMDD)*	b. TO *(YYYYMMDD)*

10. PERSON MAKING THIS REQUEST			
a. NAME *(Last, First, Middle Name(s))*	b. RANK	c. SIGNATURE	d. TITLE

SECTION II - *(To be completed by Applicant)*

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 United States Code, Sections 504, 505, 508, and 12102; E.O. 9397.
PRINCIPAL PURPOSE: To determine eligibility of a prospective enlistee in the Armed Forces of the United States.
ROUTINE USES: Information collected on this form may be released to law enforcement agencies engaged in the investigation or prosecution of a criminal act or the enforcement or implementation of a statute, rule, regulation or order; to any component of the Department of Justice for the purpose of representing the DoD.
DISCLOSURE: Voluntary; however, failure of the applicant to complete Section II may result in refusal of enlistment in the Armed Forces of the United States.

The data are for OFFICIAL USE ONLY and will be maintained and used in strict confidence in accordance with Federal law and regulations. Making a knowing and willful false statement on this DD Form 369 may be punishable by fine or imprisonment or both. All information provided by you, which possibly may reflect adversely on your past conduct and performance, may have an adverse impact on you in your military career in situations such as consideration for special assignment, security clearances, court martial and administrative proceedings, etc.

11. I HEREBY CONSENT TO RELEASE FROM YOUR FILES THE INFORMATION REQUESTED BELOW.	SIGNATURE

SECTION III - *(To be completed by Police or Juvenile Agency)*

The person described above, who claims to have resided at the address shown above, has applied for enlistment in the Armed Forces of the United States. Please furnish from your files the information relative to Section III below. A return envelope is provided for your convenience.

12. HAS THE APPLICANT A POLICE OR JUVENILE RECORD, TO INCLUDE MINOR TRAFFIC VIOLATIONS? ☐ YES ☐ NO
(If YES, what was the offense or charge, date, disposition and sentence?)

13. IS APPLICANT NOW UNDERGOING COURT ACTION OF ANY KIND? *(If YES, give details.)* ☐ YES ☐ NO

THIS IS TO CERTIFY THAT THE ABOVE DATA AS CORRECTED ARE TRUE AND CORRECT ACCORDING TO THE RECORD ON FILE IN THIS OFFICE. THIS INFORMATION IS CONFIDENTIAL AND CANNOT BE USED IN ANY OTHER MANNER EXCEPT FOR OFFICIAL PURPOSES.

14. DATE *(YYYYMMDD)*	15. TITLE	16. VERIFIED BY *(Signature)*

LAW ENFORCEMENT AGENCY MAIL TO:	RECRUITING AGENCY MAIL FROM:

Applicant Instructions for Completing Standard Forms 88 and 93 (v19-06 WSG)

PLEASE PRINT USING UPPERCASE LETTERS ONLY while completing these forms—do not use cursive or lowercase. Complete this form by first printing it out (if you do not already have a hard copy) and then fill it out by hand using the following instructions.

Note: Depending on how these forms are printed, there may be additional questions for you on the back a given sheet. Please check and complete as necessary.

Standard Form 88 (SF 88):

Note 1: Parts 2 and 3 are intentionally missing.
Note 2: Parts 12a and 12b are already filled in for you.

☐ On Page 1 fill out Parts 1-13 ONLY. Leave "DATE OF EXAM" and the rest of the page blank.

☐ On Page 2 fill out "NAME" exactly as you filled in Part 1 on Page 1. Leave the rest of the page blank.

Standard Form 93 (SF 93):

Note 1: Parts 2 and 3 are intentionally missing.
Note 2: Part 6 is already filled in for you.

☐ Fill out Parts 1-24 ONLY. Leave the rest of the form blank. Be sure to sign and date Part 24.

After you have completed your portion of both forms:

☐ Give these two completed forms (SF 88 and SF 93) along with the following Physician Instructions to your physician for him/her to complete.

After your physician has completed their portions of both forms:

☐ Upon receipt of the completed Standard Form 88 from your physician, please check that they checked the appropriate box in Part 46 and has signed and dated Part 48 of the form.

☐ Also check that on the completed Standard Form 93 that your physician signed and dated Part 26 of the form. If either form is not done correctly, your application will be rejected.

☐ Make a copy of these forms (not the instructions) and give/send it to your WSG Recruiter. DO NOT send/give your original forms to your Recruiter. Instead keep those for your records.

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Physician Instructions for Completing Standard Forms 88 and 93 (v19-06 WSG)

PLEASE PRINT USING UPPERCASE LETTERS ONLY while completing these forms—do not use cursive or lowercase. Complete this form by first printing it out (if you do not already have a hard copy) and then fill it out by hand using the following instructions.

Note: Depending on how these forms are printed, there may be additional questions for you on the back a given sheet. Please check and complete as necessary.

Standard Form 88 (SF 88):

Note 1: Parts 2-3, 18-19, 24-41, and 45 are intentionally missing.
Note 2: Parts 1-13 should already be filled out by your patient.

☐ Fill out the "DATE OF EXAM" in the upper right corner of Page 1.

☐ Complete Parts 14-48 as applicable. Be sure to check the appropriate box in Part 46 and sign at Part 48.

☐ If additional documentation is included, note the number of pages for such at "NO. OF SHEETS ATTACHED" located at the top right side of the second page.

Standard Form 93 (SF 93):

Note 1: Parts 2 and 3 are intentionally missing.
Note 2: Parts 1-24 should already be filled out by your patient.

☐ After reviewing your patient's answers to Parts 1-23, note any appropriate comments you may have in Part 25. Be sure to sign and date Part 26.

After you have completed your portion of both forms:

☐ Return both completed forms (four pages) to your patient.

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MEDICAL RECORD	REPORT OF MEDICAL EXAMINATION	DATE OF EXAM

1. LAST NAME - FIRST NAME - MIDDLE			
4. HOME ADDRESS (*Number, street or RFD, city or town, state and ZIP Code*)			5. EMERGENCY CONTACT (*Name and address of contact*)
6. DATE OF BIRTH	7. AGE	8. SEX ☐ FEMALE ☐ MALE	9. RELATIONSHIP OF CONTACT
10. PLACE OF BIRTH		11. RACE ☐ WHITE ☐ BLACK ☐ AMERICAN INDIAN/ ALASKA NATIVE ☐ HISPANIC WHITE ☐ HISPANIC BLACK ☐ ASIAN/PACIFIC ISLANDER	
12a. AGENCY **WASHINGTON MILITARY DEPARTMENT**		12b. ORGANIZATION UNIT **WASHINGTON STATE GUARD (WSG/VSG)**	13. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY / b. CIVILIAN
14. NAME OF EXAMINING FACILITY OR EXAMINER, AND ADDRESS			15. RATING OR SPECIALTY OF EXAMINER 16. PURPOSE OF EXAMINATION **ENLISTMENT**

17. CLINICAL EVALUATION

NOR-MAL	(*Check each item in appropriate column, enter "NE" if not evaluated*)	ABNOR-MAL	NOR-MAL	(*Check each item in appropriate column, enter "NE" if not evaluated*)	ABNOR-MAL
	A. HEAD, FACE, NECK AND SCALP			O. PROSTATE (Over 40 or clinically indicated)	
	B. EARS - GENERAL (INTERNAL CANALS) *(Auditory acuity under items 39 and 40)*			P. TESTICULAR	
				Q. ANUS AND RECTUM *(Hemorrhoids, Fistulae) (Hemocult Results)*	
	C. DRUMS (*Perforation*)			R. ENDOCRINE SYSTEM	
	D. NOSE			S. G-U SYSTEM	
	E. SINUSES			T. UPPER EXTREMITIES *(Except feet) (Strength, range of motion)*	
	F. MOUTH AND THROAT			U. FEET	
	G. EYES - GENERAL (*Visual acuity and refraction under items 28, 29, and 36*)			V. LOWER EXTREMITIES *(Except feet) (Strength, range of motion)*	
	H. OPHTHALMOSCOPIC			W. SPINE, OTHER MUSCULOSKELETAL	
	I. PUPILS *(Equality and reaction)*			X. IDENTIFYING BODY MARKS, SCARS,TATTOOS	
	J. OCULAR MOTILITY *(Associated parallel movements nystagmus)*			Y. SKIN, LYMPHATICS	
	K. LUNGS AND CHEST			Z. NEUROLOGIC *(Equilibrium tests under item 41)*	
	L. HEART *(Thrust, size, rhythm, sounds)*			AA. PSYCHIATRIC *(Specify any personality deviation)*	
	M. VASCULAR SYSTEM *(Varicosities, etc.)*			BB. BREASTS	
	N. ABDOMEN AND VISCERA *(Include hemia)*			CC. PELVIC *(Females only)*	

NOTES: *(Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 42 and use additional sheets if necessary)*

NAME	NO. OF SHEETS ATTACHED

MEASUREMENTS AND OTHER FINDINGS

20. HEIGHT	21. WEIGHT	22. COLOR HAIR	23. COLOR EYES

42. NOTES *(Continued)* AND SIGNIFICANT OR INTERVAL HISTORY

(Use additional sheets if necessary)

43. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers)*

44. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED *(Specify)*

46. EXAMINEE *(Check)*

A ☐ IS QUALIFIED FOR

B ☐ IS NOT QUALIFIED FOR

ADMINISTRATIVE DUTIES

47. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

48. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
	X

NO. OF ATTACHED SHEETS:

MEDICAL RECORD	REPORT OF MEDICAL HISTORY	DATE OF EXAM

NOTE: This information is for official and medically-confidential use only and will not be released to unauthorized persons

1. NAME OF PATIENT (Last , first, middle)		
4a. HOME STREET ADDRESS (Street or RFD; City or Town; State; and ZIP Code)		5. EXAMINING FACILITY
4b. CITY / 4 c. STATE / 4 d. ZIP CODE		

6. PURPOSE OF EXAMINATION

ENLISTMENT

7. STATEMENT OF PATIENT'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Use additional pages if necessary)

a. PRESENT HEALTH	b. CURRENT MEDICATION	REGULAR OR INTERM.
c. ALLERGIES (Include insect bites/stings and common foods)		
	d. HEIGHT	e. WEIGHT
8. PATIENT' S OCCUPATION	9. ARE YOU (Check one) ☐ RIGHT HANDED ☐ LEFT HANDED	

10. PAST/CURRENT MEDICAL HISTORY

CHECK EACH ITEM	YES	NO	DON'T KNOW	CHECK EACH ITEM	YES	NO	DON'T KNOW	CHECK EACH ITEM	YES	NO	DON'T KNOW
Household contact with anyone with tuberculosis				Shortness of breath				Bone, joint or other deformity			
				Pain or pressure in chest				Loss of finger or toe			
Tuberculosis or positive TB test				Chronic cough				Painful or "trick" shoulder or elbow			
Blood in sputum or when coughing				Palpitation or pounding heart							
				Heart trouble				Recurrent back pain or any back injury			
Excessive bleeding after injury or dental work				High or low blood pressure							
				Cramps in your legs				"Trick" or locked knee			
Suicide attempt or plans				Frequent indigestion				Foot trouble			
Sleepwalking				Stomach, liver or intestinal trouble				Nerve Injury			
Wear corrective lenses				Gall bladder trouble or gallstones				Paralysis (including infantile)			
Eye surgery to correct vision								Epilepsy or seizure			
Lack vision in either eye				Jaundice or hepatitis				Car, train, sea or air sickness			
Wear a hearing aid				Broken bones				Frequent trouble sleeping			
Stutter or stammer				Adverse reaction to medication				Depression or excessive worry			
Wear a brace or back support				Skin diseases				Loss of memory or amnesia			
Scarlet fever				Tumor, growth, cyst, cancer				Nervous trouble of any sort			
Rheumatic fever				Hernia				Periods of unconsciousness			
Swollen or painful joints				Hemorrhoids or rectal disease				Parent/sibling with diabetes, cancer, stroke or heart disease			
Frequent or severe headaches				Frequent or painful urination							
Dizziness or fainting spells				Bed wetting since age 12				X-ray or other radiation therapy			
Eye trouble				Kidney stone or blood in urine				Chemotherapy			
Hearing loss				Sugar or albumin in urine				Asbestos or toxic chemical exposure			
Recurrent ear infect ions				Sexually transmitted diseases							
Chronic or frequent colds				Recent gain or loss of w eight				Plate, pin or rod in any bone			
Severe tooth or gum trouble				Eating disorder (anorexia bulimia, etc.)				Easy fatigability			
Sinusitis								Been told to cut down or criticized for alcohol use			
Hay fever or allergic rhinitis				Arthritis, Rheumatism, or Bursitis							
Head injury								Used illegal substances			
Asthma				Thyroid trouble or goiter				Used tobacco			

11. FEMALES ONLY

CHECK EACH ITEM	YES	NO	DON'T KNOW	DATE OF LAST MENSTRUAL PERIOD	DATE OF LAST PAP SMEAR	DATE OF LAST MAMMOGRAM
Treated for a female disorder						
Change in menstrual pattern						

CHECK EACH ITEM. IF "YES" EXPLAIN IN BLANK SPACE TO RIGHT. LIST EXPLANATION BY ITEM NUMBER.

ITEM	YES	NO
12. Have you been refused employment or been unable to hold a job or stay in school because of:		
a. Sensitivity to chemicals, dust , sunlight, etc.		
b. Inability to perform certain motions.		
c. Inability to assume certain positions.		
d. Other medical reasons (If yes, give reasons.)		
13. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details.)		
14. Have you ever been denied life insurance? (If yes, state reason and give details.)		
15. Have you had, or have you been advised to have, any operation. (If yes, describe and give age at which occurred.)		
16. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)		
17. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)		
18. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection.)		
19. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)		
20. Have you ever received, is there pending, or have you ever applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.)		
21. Have you ever been arrested or convicted of a crime, other than minor traffic violations. (If yes, provide details.)		
22. Have you ever been diagnosed with a learning disability? (If yes, give type, where, and how diagnosed.)		

23. LIST ALL IMMUNIZATIONS RECEIVED

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

24a. TYPED OR PRINTED NAME OF EXAMINEE	24b. SIGNATURE X	24 c. DATE

25. PHYSICIAN' S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (Physician shall comment on all positive answers in Items 7 through 11. Physician may develop by interview any additional medical history deemed important, and record any significant findings here.)

26a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	26b. SIGNATURE X	26 c. DATE