



**DEPARTMENT OF THE AIR FORCE
AIR FORCE RESERVE OFFICER TRAINING CORPS
DETACHMENT 290 (AETC)
UNIVERSITY OF KENTUCKY LEXINGTON KY**

Welcome! On behalf of Lt Col Harrop and the University of Kentucky's Air Force ROTC Cadre, we would like to welcome you to Detachment 290, home of the Flying Wildcats.

In order to enroll into the AFROTC program you must complete the following steps no later **7 August 2020**.

1. Register online: <https://wings.holmcenter.com/applyforafrotc> Refer to the AFROTC Online Admissions for Applicants Guide for a step-by-step tutorial ,which was sent to your email address provided.

2. Complete the following documents and upload to WINGS under Supporting Documents.
 - DD Form 2983-Recruit/Trainee Prohibited Activities Form
 - DD Form 2005 – Privacy Act Statement for Health Care Records
 - Drug Demand Reduction Program Statement of Understanding
 - AF Form 2030 – USAF Drug and Alcohol abuse Certificate
 - Request and Consent for Release of Student Records
 - Mail Authorization Release
 - DD Form 93 – Record of Emergency Data
 - Scholarship Statement of Understanding
 - Non Technical Major Statement of Understanding
 - Direct Deposit
 - Servicemembers Group Life Insurance (SGLI)
 - Approved DoDMERB File (or AFROTC Form 28 – Sports Physical if not completed)
 - ACT/SAT Scores
 - web versions acceptable with student's name
 - Transcripts of Completed College Courses, if applicable.
 - Immunizations Record (dates received MMR and Varicella/Chicken Pox)
 - Selective Service Numbers (males only) – this can be obtained at <https://www.sss.gov/>
 - Scholarship Memorandum of Understanding

All documents must be received no later than **3 Aug 20**.

The following tips will be helpful when completing the online forms:

1. Chrome. WINGS and other military websites work best when accessed through Chrome. If you do not already have Chrome installed, it is a free software download that can be found here: <https://www.google.com/chrome/>

2. Adobe Acrobat Pro. This software will allow you to open, view, and manipulate PDFs in the best manner possible. It can be downloaded for free by UK students using your MyUK credentials here: <https://download.uky.edu/index.php>
3. If you have trouble accessing UK downloads, there is a free version of Adobe Acrobat available here: <https://acrobat.adobe.com/us/en/acrobat/pdf-reader.html?promoid=C4SZ2XDR&mv=other>
4. Scanner. If you do not have access to a scanner, you can use your phone. There are many free options in App Store.

What do I need to do now to start prepping for success?

- Start working out! Fitness test standards can be found in the attachment. The first fitness assessment will be late Fall.
- Schedule an appointment to have a sports physical completed by 3 Aug 2020. Print and take the form below to your appointment. Please double check the form is filled out correctly before you leave the appointment. When it's complete, upload to WINGS under Supporting Documents.

Note: do **not** send any documents with Personal Identifiable Information (PII), such as your Social Security Number, to the Detachment or Cadre's personal email address. All documents must be uploaded to your personal WINGS account under Supporting Documents.

Finally, we will have a mandatory New Student Orientation before classes start. Due to COVID-19 requirements, this will be held online and a separate session for cadets stations will be held on 13 Aug. To reduce interaction, all cadets will be scheduled accordingly with an appointment time.

Event: AFROTC New Student Orientation (NSO)

Date: 12 Aug 2020

Who: New cadets (parents are welcomed/encouraged to attend)

Location: Zoom (link will be sent at time of event)

Dress Code: Business Casual (males come clean shaven)

Time: 0900 *those without their forms completed will be notified by cadre of a 0800 start time

Parking: N/A

What to bring to New Student Orientation:

1. Birth Certificate (original copy only)
2. Social Security Card *A certified Birth Certificate and signed Social Security Card. Copies WILL NOT be accepted. Both documents will be returned the same day.
3. Be sure to have your WINGS user name/password and bring a laptop if you have one.
4. If you previously served in the military please bring the Original DD Form 214 (copy 4-member copy) or DD Form 785 (we will make a copy and return to you that day). If you are currently serving in the National Guard, Reserves or other service, you must provide a sign DD Form 368 to acknowledge your conditional release prior to commissioning.

To better assist you, included are some instructions on how to complete the packet that was emailed separately.

Respectfully,

The Detachment 290 Cadre and Staff

Lt Col Richard Harrop, Commander

Maj Lindsey Phillabaum, Operations Flight Commander

Capt Lindsey Colburn, Recruiting Flight Commander

TSgt Benjamin Gonzales, NCOIC, Personnel

SSgt Libby Sheets, NCOIC, Admin Management

Becky Umbrell, Department Academic Administrative Associate

DD Form 2983: Recruit/trainee prohibited activities acknowledgement

RECRUIT/TRAINEE PROHIBITED ACTIVITIES ACKNOWLEDGMENT			
PRIVACY ACT STATEMENT			
<p>AUTHORITY: 10 U.S.C. 136, Under Secretary of Defense for Personnel and Readiness; DoD Instruction 1304.33, Standardized Protection Policies Prohibiting Inappropriate Relations Between Recruiters and Recruits, and Trainers and Trainees.</p> <p>PRINCIPAL PURPOSE(S): To document your understanding of the prohibitions identified in section 7 of this form.</p> <p>ROUTINE USE(S): The DoD Blanket Routine Uses found at http://dpclo.defense.gov/Privacy/SORNs/Index/BlanketRoutineUses.aspx apply to this collection.</p> <p>DISCLOSURE: Voluntary. However, if you fail to provide the requested information or complete this form, you might not be able to complete your enlistment or receive training.</p>			
INSTRUCTIONS			
<p>In accordance with DoDI 1304.33, this form will be read and signed no later than the first visit with a recruiter following a recruit's entry into the Delayed Entry Program or read and signed no later than the first day of entry-level training for a trainee. As a minimum, the signed original will be retained in the recruit's file until they enter active duty or in the trainee's file until they detach from the training command or school they are attending. Please initial beside each entry acknowledging that you have read and understand the statement.</p>			
1. RECRUIT/TRAINEE NAME <i>(Last, First, Middle)</i>	2. PAY GRADE	3. RECRUITING OFFICE/TRAINING COMMAND	
	Cadet	AFROTC Detachment 290	
4. RECRUITING OFFICE/TRAINING COMMAND ADDRESS <i>(City, State, ZIP Code)</i>	5. DATE SIGNED <i>(YYYYMMDD)</i>	6. SIGNATURE	
Lexington, KY 40506			
7. I ACKNOWLEDGE AND UNDERSTAND THAT AS A RECRUIT OR TRAINEE, I WILL NOT:			
<i>(initial)</i> _____	a. Develop, attempt to develop, or conduct a personal, intimate, or sexual relationship with a recruiter or trainer. This includes, but is not limited to, dating, handholding, kissing, embracing, caressing, and engaging in sexual activities. Prohibited personal, intimate, or sexual relationships include those relationships conducted in person or via cards, letters, e-mails, telephone calls, instant messaging, video, photographs, social networking, or any other means of communication.		
_____	b. Establish a common household with a recruiter/trainer, that is, share the same living area in an apartment, house, or other dwelling.		
_____	c. Consume alcohol with a recruiter/trainer on a personal social basis.		
_____	d. Attend social gatherings, clubs, bars, theaters or similar establishments on a personal social basis with a recruiter/trainer.		
_____	e. Allow entry of any recruiter/trainer in my dwelling or privately-owned vehicle except to conduct official business. Exceptions are permitted for official business when the safety or welfare of the recruiter/trainer is at risk.		
_____	f. Gamble with a recruiter/trainer.		
_____	g. Make sexual advances toward, or seek or accept sexual advances or favors from, a recruiter/trainer.		
_____	h. Lend money to, borrow money from, or otherwise become indebted to a recruiter/trainer.		
8. EXCEPTIONS. Exceptions may be granted to accommodate relationships that existed prior to the start of the recruiting process or prior to the trainee starting the formal training process. These relationships include, but are not limited to, family members. Only the Recruit's or Trainee's Commander, O-4 or higher, or higher level authority, has the authority to approve these exceptions. Approved exceptions will be documented below and signed by the Recruit's or Trainee's Commander, O-4 or higher, or a higher-level authority. DESCRIPTION OF EXCEPTION(S):			
<i>(initial)</i> _____	9. VIOLATIONS. Violations of any part of paragraph 7.a. through 7.h., not granted an exception in paragraph 8, may result in disciplinary action.		
10. APPROVED BY			
a. NAME <i>(Last, First, Middle Initial)</i>	b. TITLE	c. DATE SIGNED <i>(YYYYMMDD)</i>	d. SIGNATURE/RANK

Block 1: fill in with your last, first and middle name.

Block 2: During your duration in the program, pay grade will be listed as “Cadet”

Block 3: Recruiting Office: AFROTC Detachment 290

Block 4: Recruiting Office/Training Command Address: City/State/Zip of our Det’s location.
Lexington, KY 40506

Block 5: Date signed. Insert the date you sign this form.

Block 6. Signature. Sign with your signature.

Block 7: Read and acknowledge each prompt. Initial on each line. These are prohibited actions between cadre and trainees/recruits. You will not partake in any of the actions listed with a staff member.

Block 8: Exceptions to Policy: None.

Block 9: Acknowledge with your initials that any violations will result in disciplinary action.

Block 10 a-d. This is for a cadre member to review and sign.

Below is a link to a video from a detachment to assist you.

<https://www.youtube.com/watch?v=DPpTAyqCOzA&t=10s>

DD Form 2005:

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS		
<i>This form is not an authorization or consent to use or disclose your health information.</i>		
1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN): 10 U.S.C. 136, Under Secretary of Defense for Personnel and Readiness; 10 U.S.C. Chapter 55, Medical and Dental Care; 42 U.S.C. Chapter 32, Third Party Liability for Hospital and Medical Care; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); DoDI 6055.05, Occupational and Environmental Health (OEH); and E.O. 9397 (SSN), as amended.		
2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED: Information may be collected from you to provide and document your medical care; determine your eligibility for benefits and entitlements; adjudicate claims; determine whether a third party is responsible for the cost of Military Health System (MHS) provided healthcare and recover that cost; evaluate your fitness for duty and medical concerns which may have resulted from an occupational or environmental hazard; evaluate the MHS and its programs; and perform administrative tasks related to MHS operations and personnel readiness.		
3. ROUTINE USES: Information in your records may be disclosed to: <ul style="list-style-type: none">• Private physicians and Federal agencies, including the Department of Veterans Affairs, Health and Human Services, and Homeland Security (with regard to members of the Coast Guard), in connection with your medical care;• Government agencies to determine your eligibility for benefits and entitlements;• Government and nongovernment third parties to recover the cost of MHS provided care;• Public health authorities to document and review occupational and environmental exposure data; and• Government and nongovernment organizations to perform DoD-approved research. Information in your records may be used for other lawful reasons which may include teaching, compiling statistical data, and evaluating the care rendered. Use and disclosure of your records outside of DoD may also occur in accordance with 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, which incorporates the DoD Blanket Routine Uses published at: http://dpcld.defense.gov/privacy/SORNsIndex/BlanketRoutineUses.aspx . Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD by DoD 6025.18-R. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.		
4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION: Voluntary. If you choose not to provide the requested information, comprehensive health care services may not be possible, you may experience administrative delays, and you may be rejected for service or an assignment. However, care will not be denied. This all inclusive Privacy Act Statement will apply to all requests for personal information made by MHS health care treatment personnel or for medical/dental treatment purposes and is intended to become a permanent part of your health care record. Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.		
5. SIGNATURE OF PATIENT OR SPONSOR	6. SOCIAL SECURITY NUMBER OR DOD IDENTIFICATION NUMBER OF MEMBER OR SPONSOR	7. DATE (YYYYMMDD)

Read each statement in paragraphs 1 to 4. This form is for you to acknowledge that we will be collecting healthcare information from you. Your right to privacy is protected and it will not be disclosed under HIPAA. You may only disclose information about your health to personnel with a need-to-know. Signing this form is your acknowledgement. Below is a link to a video to assist you.

Block 5: Signature

Block 6: Enter your Social Security Number

Block 7: Date of acknowledgement

https://www.youtube.com/watch?v=IOZNGnc_rnI&t=164s

Attachment 5

DRUG DEMAND REDUCTION PROGRAM MOU

Figure A5.1. Drug Demand Reduction Program MOU.

<p>DEPARTMENT OF THE AIR FORCE AIR UNIVERSITY (AETC)</p> <p>MEMORANDUM OF UNDERSTANDING FOR DRUG TESTING POLICY FOR CADETS PARTICIPATING IN RESERVE OFFICER TRAINING CORPS (ROTC)</p> <p>By direction of the Secretary of the Air Force, I understand as an Air Force ROTC cadet participating in a SROTC program, I will be subject to random urinalysis drug testing. I understand that if I am randomly selected, I must provide the requested sample within the specified time limits. I understand failure to report for a mandatory urinalysis test will be considered an Unauthorized Absence (UA) and will result in individual command-directed screening. I understand that any individual refusing to submit a urinalysis sample or testing positive on a urinalysis test will be processed for disenrollment or dismissal from Air Force ROTC or specific officer commissioning program.</p>	
<p>_____</p> <p>Cadet Signature and Date</p>	<p>_____</p> <p>Parent/Guardian Signature and Date (Only for applicants under legal age of majority. Must be notarized if not signed in presence of detachment personnel)</p>
<p>_____</p> <p>Printed Name and Signature Witness (or Notary) and Date</p>	

Read and acknowledge. This form is for you to understand that you are subject to random drug screening. If selected to provide a sample, you will provide it in a timely manner, and the actions that will be taken if a test is refused. Sign and date. If under 18, a parent/legal guardian must sign this form. Cadre will sign once received. Below is a link for a video created by a detachment to assist you.

<https://www.youtube.com/watch?v=PDEHwF1NCkE&t=3s>

Release/Consent of Student Records



**DEPARTMENT OF THE AIR FORCE
AIR FORCE RESERVE OFFICER TRAINING CORPS
DETACHMENT 290 (AETC)
UNIVERSITY OF KENTUCKY LEXINGTON KY**

21 November 2019

MEMORANDUM FOR CADETS

FROM: Air Force Reserve Officer Training Corps (AFROTC) Detachment 290

SUBJECT: Request and Consent for Release of Student Records

1. In compliance with 10 U.S.C. 2102 et seq., your consent is required to permit the educational institution in which you are/were enrolled to release official copies of your transcripts of grades and/or other student records, files, or data that are a part of your student records to AFROTC and Department of Defense (DOD) agencies, as may be required by these agencies.

2. It is mutually understood that the purposes of this request for official copies of student records is necessary for AFROTC screening and evaluation of its present and potential cadet members and those cadets commissioned or disenrolled from the AFROTC program. It is further understood that the privacy of the information collected by means of the request will be maintained in accordance with the Privacy Act of 1974 and the Freedom of Information Act, and the information will be used for official AFROTC purposes only.

X

BENJAMIN M. GONZALES, TSGT, USAF
NCOIC, PERSONNEL ACTIONS

1st Ind, Student _____
(print last name, first name, middle int.)

21 November 2019

MEMORANDUM FOR AFROTC Det 290

I have read and understand your request for official copies of my school records. I hereby voluntarily consent to the release of such official records as you may require in your above-stated request and have signed the attached authorization for appropriate school officials to release to Det 290 personnel or to the appropriate DOD agency any and all official records, files, and data for their use as requested above.

(Student's Signature)

(Parent's Signature if student is under the age of 18)

:

This memo is to give consent and acknowledge all personnel records are required as part of the AFROTC program, and is maintained under the Privacy Act of 1974 and Freedom of Information Act. Your information will not be shared only for official purpose and those with proper clearance.

On page 1, read the prompt and acknowledge with your signature. If you are under 18 years old, you must have a parent/guardian sign the understanding.

Page 2 gives your consent of voluntary release of information. Your information is strictly for ROTC related-requirements business. This release allows school officials to access. Like the first page, sign as the student and have your parent/guardian sign if under the age of 18.

DD Form 93: Record of Emergency Data

RECORD OF EMERGENCY DATA			
PRIVACY ACT STATEMENT			
<p>AUTHORITY: 5 USC 552, 10 USC 655, 1475 to 1480 and 2771, 38 USC 1970, 44 USC 3101, and EO 9397 (SSN).</p> <p>PRINCIPAL PURPOSES: This form is used by military personnel and Department of Defense civilian and contractor personnel, collectively referred to as civilians, when applicable. For military personnel, it is used to designate beneficiaries for certain benefits in the event of the Service member's death. It is also a guide for disposition of that member's pay and allowances if captured, missing or interned. It also shows names and addresses of the person(s) the Service member desires to be notified in case of emergency or death. For civilian personnel, it is used to expedite the notification process in the event of an emergency and/or the death of the member. The purpose of soliciting the SSN is to provide positive identification. All items may not be applicable.</p> <p>ROUTINE USES: None.</p> <p>DISCLOSURE: Voluntary; however, failure to provide accurate personal identifier information and other solicited information will delay notification and the processing of benefits to designated beneficiaries if applicable.</p>			
<p style="text-align: center;">INSTRUCTIONS TO SERVICE MEMBER</p> <p>This extremely important form is to be used by you to show the names and addresses of your spouse, children, parents, and any other person(s) you would like notified if you become a casualty (other family members or fiancé), and, to designate beneficiaries for certain benefits if you die. IT IS YOUR RESPONSIBILITY to keep your Record of Emergency Data up to date to show your desires as to beneficiaries to receive certain death payments, and to show changes in your family or other personnel listed, for example, as a result of marriage, civil court action, death, or address change.</p>		<p style="text-align: center;">INSTRUCTIONS TO CIVILIANS</p> <p>This extremely important form is to be used by you to show the names and addresses of your spouse, children, parents, and any other person(s) you would like notified if you become a casualty. Not every item on this form is applicable to you. This form is used by the Department of Defense (DoD) to expedite notification in the case of emergencies or death. It does not have a legal impact on other forms you may have completed with the DoD or your employer.</p>	
<p>IMPORTANT: This form is divided into two sections: Section 1 - Emergency Contact Information and Section 2 - Benefits Related Information. READ THE INSTRUCTIONS ON PAGES 3 AND 4 BEFORE COMPLETING THIS FORM.</p>			
SECTION 1 - EMERGENCY CONTACT INFORMATION			
1. NAME (Last, First, Middle Initial)		2. SSN	
3a. SERVICE/CIVILIAN CATEGORY <input type="checkbox"/> ARMY <input type="checkbox"/> NAVY <input type="checkbox"/> MARINE CORPS <input checked="" type="checkbox"/> AIR FORCE <input type="checkbox"/> DoD <input type="checkbox"/> CIVILIAN <input type="checkbox"/> CONTRACTOR			b. REPORTING UNIT CODE/DUTY STATION AFROTC DET 290 LEX, KY
4a. SPOUSE NAME (If applicable) (Last, First, Middle Initial) <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		b. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER	
5. CHILDREN a. NAME (Last, First, Middle Initial)		b. RELATIONSHIP	c. DATE OF BIRTH (YYYYMMDD)
			d. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER
6a. FATHER NAME (Last, First, Middle Initial)		b. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER	
7a. MOTHER NAME (Last, First, Middle Initial)		b. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER	
8a. DO NOT NOTIFY DUE TO ILL HEALTH		b. NOTIFY INSTEAD	
9a. DESIGNATED PERSON(S) (Military only)		b. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER	
10. CONTRACTING AGENCY AND TELEPHONE NUMBER (Contractors only)			

This can be updated at any time during your time in the program. This is your emergency contact information to be included in your records. In the event of an emergency, we must have a contact for you available. Below is a link to a video to assist you.

Block 1: Fill in your name (last, first, middle initial)

Block 2: Your entire Social Security Number

Block 3a: Must be marked Air Force, as we are an Air Force program. Block 3b is **AFROTC DET 290, LEX KY**. This is our unit's location.

Only complete blocks 4a to 5 if you have a spouse or child.

Block 6a and 6B: Enter father's information (last, first, middle initial) and a current address/phone number. Leave blank if unknown.

Block 7a and 7b: Enter mother's information (last, first, middle initial) and a current address/phone number. Leave blank if unknown.

Only complete blocks 8a and 8b if you do not wish for one of your contacts to be contacted.

Skip blocks 9a to 14. This is for life insurance information input.

Block 15: Signature

Block 16: Signature of witness (cadre member)

Block 17: Date stamp of your submission.

<https://www.youtube.com/watch?v=Dvxr3qD0FgE>

Mail Authorization Release:

**DEPARTMENT OF THE AIR FORCE
AIR UNIVERSITY (AETC)**

The Detachment Commander (CC), the Personnel NCO (DP), and the Information Management NCO (IM) need to open official US Air Force (USAF) correspondence delivered to the detachment addressed to cadets. Access to these documents is for the verification and accuracy of the contents ONLY. Specific documents we open are: assignment orders for cadets entering active duty, cadet travel summaries, and cadet Leave and Earnings Statements (LES). We must verify these documents when received to ensure accuracy and to immediately correct or report any discrepancies to higher headquarters. In accordance with the Privacy Act, we must have your permission to access this mail. Therefore, request you sign your payroll signature below to consent to our access. Giving consent is strictly voluntary. However, if you do not give your consent, delays may be encountered in processing these vital items. Only OFFICIAL USAF correspondence specifically approved by the detachment commander will be opened. Please sign below if you agree to authorize cadre members to open OFFICIAL USAF mail addressed to you.

Cadet Signature and Date

Parent/Guardian Signature and Date
(Only for applicants under legal age of majority.
Must be notarized if not signed in presence of
detachment personnel)

Printed Name and Signature Witness (or Notary) and Date

The purpose of this memorandum is to allow access to any content that is mailed on your behalf to the detachment. Cadets receive items mailed such as Leave and Earning Statements (LES), cadet travel summaries, and other items. However, we do require your permission as your right to privacy. Consent is strictly voluntary.

Input your signature as the cadet/student. Your signature authorizes consent to access. a parent/guardian must sign if you are under the age of 18.

AF 2030: Drug and Alcohol Abuse Certificate

USAF DRUG AND ALCOHOL ABUSE CERTIFICATE		
PRIVACY ACT STATEMENT		
<p><i>AUTHORITY: Title 10 U.S.C., Chapter 31, Sections 504, 505, 508, 513; Chapter 807, Section 8067; Chapter 833, Section 8258; Chapter 1205, Sec12201, and Executive Order 9397 (SSN), as amended.</i></p> <p><i>PURPOSE: To determine enlistment/commissioning eligibility, and process qualified applicants. To determine classification and assignment actions after enlistment or commissioning. All documents are source documents in determining benefits/entitlements.</i></p> <p><i>ROUTINE USES: Disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act outside the DoD as a routine use. 'Blanket Routine Uses' apply.</i></p> <p><i>DISCLOSURE: Voluntary; however, failure to furnish personal identification information may negate the enlistment/commissioning application.</i></p> <p><i>SORN(s): F036 AF PC H, Air Force Enlistment/Commissioning Records System.</i></p>		
SECTION I. DEFINITION OF TERMS		
<p>ADVERSE ADJUDICATION: An adverse adjudication (<i>adult or juvenile</i>) is a finding, decision, sentence, or judgment, other than unconditionally dropped, dismissed, or acquitted. If the adjudicating authority places a condition or restraint that leads to dismissal, dropped charges, or acquittal, the adjudication is adverse. Suspension of sentence, pardon, not processed, or dismissal after compliance with imposed conditions is adverse adjudication.</p> <p>AIR FORCE: Includes active Air Force, Air Force Reserve, Air National Guard, and Air Force Academy.</p> <p>ALCOHOL ABUSE: Alcohol use confirmed by competent medical authority that the individual is emotionally, mentally, or physically dependent on alcohol.</p> <p>NOTE: When not confirmed by medical authority, self-admitted alcohol use that leads to a person's misconduct or unacceptable behavior; to the impairment of work performance, physical or mental health, financial responsibility or personal relationships; must be reported during the medical examination for determination of alcohol abuse.</p> <p>DRUG ABUSE: The illegal, wrongful, or improper use of marijuana, any narcotic substance, hallucinogens, or any illegal drug.</p> <p>ILLEGAL DRUGS: Any drug or narcotic that is habit forming or has a potential for abuse because of its stimulant, depressant, or hallucinogenic effect. Includes, but not limited to: cocaine, crack, hallucinogens, (<i>to include lysergic acid diethylamide (LSD), phenycyclidine (PCP), tetrahydrocannabinol (THC) in non-marijuana form, and others</i>), opium, morphine, heroin, dilaudid, codeine, Demerol, inhalants (<i>paint, glue, and others</i>), amphetamines (<i>speed</i>), methamphetamines (<i>ice</i>), barbiturates(<i>downers</i>), and anabolic steroids.</p> <p>MARIJUANA: Any intoxicating organic or synthetic cannabis or tetrahydrocannabinol (THC) type substance. Organic forms from the hemp plant include marijuana, hashish and all derivatives of cannabis sativa. Synthetically, in the form of an herbal and chemical product which, when consumed mimics the effects of cannabis, includes salviadinorum or salvinorum or any product known under such names as "Spice", "Genie", "DaScents", "Zohia", "K-2", and "KO Knockout 2" or variant thereof by whatsoever name it may be called.</p>		
SECTION II. CERTIFICATION AT TIME OF APPLICATION		
<p>WARNING: YOU MUST BE TOTALLY HONEST IN COMPLETING THIS FORM. If you are truthful now and are accepted by the Air Force, no punitive action can or will be taken against a civilian applicant as a result of any information you reveal. HOWEVER, YOU ARE CAUTIONED THAT SHOULD YOU CONCEAL DRUG OR ALCOHOL ABUSE INFORMATION AT THIS TIME, AND IT IS DISCOVERED AFTER YOUR ENTRY INTO THE AIR FORCE, PUNITIVE ACTION MAY BE TAKEN AGAINST YOU BASED UPON THE FALSE INFORMATION YOU HAVE PROVIDED. Such action includes, but is not limited to, elimination from training or discharge under less than honorable conditions.</p>		
INITIAL YES/NO BOXES AS APPLICABLE		YES NO
I have read and understand the definition of the terms above.		
Have you ever used or experimented with marijuana? (<i>Prior marijuana use is not disqualifying for enlistment or appointment, unless you are determined to be a chronic user or psychologically dependent, have been convicted or adversely adjudicated for marijuana involvement. Preservice marijuana use may render you ineligible for certain skills.</i>)		
Have you ever experimented with, used, or possessed any illegal drug or narcotic?		
Have you ever been a supplier or distributor of or a trafficker in marijuana, or other illegal drugs or narcotics?		
Have you ever been treated or undergone rehabilitation for drug or alcohol abuse?		
Have you consumed hemp seed oil or any products containing hemp seed oil in the last 45 days?		
SECTION III. STATEMENTS OF UNDERSTANDING		INITIALS
During my medical examination I will be tested and screened for drug and alcohol abuse. I understand that any detection of drug use (<i>including marijuana</i>) or alcohol abuse will render me ineligible for the Air Force. I understand I will undergo further drug and alcohol screening after entry in the Air Force, and I may be discharged based on the results of such screening.		
Service in the United States Air Force places me in a position of special trust and responsibility. Drug or alcohol abuse after this date will be considered evidence of my inability to meet the standards of behavior expected of me as a member of the Air Force. Therefore, any drug use (<i>including marijuana</i>) or any alcohol abuse as described above, FROM THIS DATE FORWARD , renders me ineligible for the Air Force.		
Drug and alcohol abuse by members of the U.S. Air Force violates Air Force standards of behavior and conduct and will not be tolerated. If I am identified as a drug or alcohol abuser while a member of the Air Force, appropriate disciplinary or administrative action may be taken against me, to include trial by court martial or discharge under less than honorable conditions.		
I understand that certain skill areas in the Air Force cannot be performed by persons who have abused drugs or alcohol. My unit commander will have final approval authority regarding my actual assignment to sensitive skill positions. If I am not acceptable for such duties due to information I have revealed on this form, I will be reassigned to another position in my skill or reclassified into another skill. If it is established that I have used any substance beyond that which I have indicated on this form, I understand my enlistment, commissioning, or appointment may be declared fraudulent and I may be discharged.		
<p>KNOWING AND UNDERSTANDING ALL THE INFORMATION ABOVE, AND REALIZING THAT THIS DOCUMENT WILL BE USED ONLY TO DETERMINE MY ELIGIBILITY AND RECORD MY CERTIFICATION OF ELIGIBILITY, I HEREBY STATE THAT THE ABOVE INFORMATION AS TO MY PREVIOUS DRUG OR ALCOHOL INVOLVEMENT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.</p>		
DATE	NAME (<i>Last, First, M.I.</i>) AND SSN OF APPLICANT	SIGNATURE

AF FORM 2030, 20170815
Prescribing Directive AFI36-2002

PREVIOUS EDITIONS ARE OBSOLETE

PRIVACY ACT INFORMATION: The information in this form is FOR OFFICIAL USE ONLY. Protect IAW the Privacy Act of 1974

WITNESS		
I CERTIFY THE ABOVE INDIVIDUAL SIGNED THIS CERTIFICATE OF HIS/HER OWN FREE WILL		
DATE	NAME (<i>Last, First, M.I.</i>) AND GRADE OF WITNESS	SIGNATURE
REMARKS		
SECTION IV. RECERTIFICATION AT TIME OF ENLISTMENT, COMMISSIONING, OR APPOINTMENT		INITIALS
I have read and fully understand all the information on this form.		
I hereby state that there has been no change in my status since I originally provided this information on the date on front of this form.		
I hereby certify that I have not used any drug, including marijuana, and that I have not been in any alcohol related abuse incidents, since I originally completed this form.		
DATE	NAME (<i>Last, First, M.I.</i>) AND SSN OF APPLICANT	SIGNATURE
WITNESS		
I CERTIFY THE ABOVE INDIVIDUAL SIGNED THIS CERTIFICATE OF HIS/HER OWN FREE WILL		
DATE	NAME (<i>Last, First, M.I.</i>) AND GRADE OF WITNESS	SIGNATURE

- Section I: Read each definition of terms.
- Section II: Initial after reading each statement, mark yes/no with your initials.
- Section III: Statements of Understanding. Read each statement and initial in the blank to acknowledge. At the bottom of the form, date, print and sign in the blanks.
- Witness: A cadre member will sign as the witness once the forms has been received.
- Section IV: Recertification. This is only to be signed prior to enlistment/contacting.

Below is a link to assist you. It was created by the US Air Force Academy, but also is applicable to AFROTC.

<https://www.youtube.com/watch?v=iB5nPcVgeJI>

Scholarship Statement of Understanding:

AFROTCI36-2011 22 JUNE 2018

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* Please print, use black ink, take picture or scan and upload to WINGS under Supporting Documents

Attachment 2

SCHOLARSHIP PROGRAM STATEMENT OF UNDERSTANDING

Figure A2.1. Scholarship Program Statement of Understanding.

FOUR-YEAR SCHOLARSHIP SELECTEES (4YR HSSP). I understand I must be enrolled as a full-time student each term and be enrolled and participating in AFROTC courses and Leadership Laboratory each term. I understand that I must pass the FA prior to 31 December of my freshman year or my scholarship will be terminated and I will be disenrolled from AFROTC. I understand I must achieve a Term Grade Point Average (TGPA) of 2.5 or higher during all terms while I am contracted. If I do not, my scholarship eligibility may be impacted. If I am disenrolled from AFROTC as an AS100 cadet, I will not be subject to recoupment of scholarship funding or call to active duty. I have been counseled by an AFROTC representative on the scholarship activation and retention standards prescribed in AFROTC instructions and I understand the activation and retention standards. Even if I achieve GPA standards and my Det/CC does not feel my performance warrants scholarship retention, I understand my scholarship can be terminated immediately. In such case, I may, at the discretion of my Det/CC, continue in AFROTC on a non-scholarship basis.

THREE-YEAR SELECTEES (3YR HSSP). I understand that I must be enrolled as a full-time student through the entire freshman year at the school where I will activate my scholarship and that I must be enrolled in and attending AFROTC classes and Leadership Laboratory each term. I understand that I must have a TGPA of 2.5 during my spring term of my freshman year and have a Cumulative Grade Point Average (CGPA) of 2.5 or higher by the end of spring term of my freshman year to activate my scholarship in the fall of my sophomore year. I understand I must achieve a TGPA of 2.5 or higher during all terms while I am contracted. I have been counseled by an AFROTC representative on the scholarship activation and fitness and retention standards prescribed in AFROTC instructions. I understand the activation and retention standards and that I must pass the FA NLT the fall term of my AS200 year. If I fail to meet any of these standards, my scholarship offer will be withdrawn. In such case, even if I achieve these standards and my Det/CC does not feel my performance warrants scholarship retention, I understand my scholarship offer can be withdrawn immediately.

ALL SCHOLARSHIP SELECTEES. I understand that I must complete a **minimum of 24 semester/36 quarter hours of Math/Physics/Chemistry/ Engineering or four semesters/six quarters of the same foreign language before I commission.** I understand that if I fail to complete this requirement, or appear to not be on-track to complete this requirement, then I will lose my scholarship and may be disenrolled from the program. In such situations, I understand that I may be required to repay the scholarship funds or be called to serve on active duty for a period of 2 years. I understand that being a scholarship cadet does not guarantee me a POC enrollment allocation. I understand that failure to compete favorably for an enrollment allocation will result in loss of scholarship, disenrollment from AFROTC, and could result in recoupment of scholarship funds. **This does not apply to 1-2-year scholarship winners.**

Signature

Cadet Signature / Date

Printed Name Witness Date

Signature

Parent/Guardian Signature / Date
(Only for Applicants Under Min Enlistment Age)

Signature

Witness Signature

- This form is for any scholarship recipient to understand the standard they must meet in order to keep the scholarship active. In this instance, the HSSP program is a 4 year commitment and there is a certain requirement to keep the scholarship active.
- Cadet will read and sign in the first line.
- Parent is only required for cadets under 18.
- Cadre will sign as witness.

Foreign Language/Technical Statement of Understanding

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AFROTCI36-2011 22 JUNE 2018

Print, fill out in pencil, take a picture or scan, and upload to WINGS under Supporting Documents

Attachment 3

ACADEMIC PLAN FOR FOREIGN LANGUAGE OR TECHNICAL REQUIREMENT FOR NON-TECHNICAL SCHOLARSHIP CADETS

Figure A3.1. Academic Plan.

I understand that as a scholarship recipient I am required to take and pass a minimum of 4 semesters /6 quarters of the same foreign language or 24 semester/36 quarter hours of Math/Physics/Chemistry/Engineering. I understand that I must maintain at least a "C-" or the institutional equivalent in each course. I also understand that failure to accomplish this requirement prior to commissioning could result in loss of my scholarship and/or disenrollment from the AFROTC program. If disenrolled, I may have to repay my scholarship or be called to serve on active duty in my enlisted grade for a period of two years. In order to fulfill this requirement, I plan to take the following courses:

Course #	Course Title	Hours	Term Schedule	Term Complete	Cadet Initial	Cadre Initial
Total:						

Cadet Signature _____ Date _____

Cadre Signature _____ Date _____

Typed/Printed Cadet Name _____

Typed/Printed Cadre Name _____

I reviewed the completed course work for Cadet _____ and verify that he/she has completed a minimum of 4 semesters /6 quarters of the same foreign language or 24 semester/36 quarter hours of Math/Physics/Chemistry/Engineering, or will complete this requirement prior to commissioning (Except Nurses and 1-2-year scholarship winners).

AS Instructor _____

Date _____

- This is only for any cadet entering a scholarship who is **not** in a technical major. You must take and pass a minimum of 4 semesters of the **same** foreign language **or** 24 semester hours of math/physics/chemistry/engineering.
- In the table given, list the course number, title, number of hours, scheduled term. Initial under “Cadet Initial”
- Cadet sign in first blank
- Parent is only required for cadets under 18.
- Cadre will sign as witness. This must also be verified by an AS instructor.
-

- Direct Deposit

FAST START
DIRECT DEPOSIT

INSTRUCTIONS FOR PROCESSING FEDERAL EMPLOYEE PAYMENTS

Use: For processing Federal employee net salary, allotments, and other agency - approved payments associated with Federal employment (i.e. travel reimbursement, uniform allowance, etc). Employee must complete items 1,2,3 and 5. Complete item 4 only if you want to start, cancel or change the amount of a savings or discretionary allotment - see instructions on back of form.

1. EMPLOYEE INFORMATION <input style="width: 100%;" type="text"/> (SSN) EMPLOYEE PAYROLL IDENTIFICATION NUMBER EMPLOYEE NAME (as on payroll records) <input style="width: 90%;" type="text"/> (Last, First, Initial's) TELEPHONE NUMBER (WORK) <input style="width: 150px;" type="text"/> (HOME) <input style="width: 150px;" type="text"/>			
2. TYPE OF ACCOUNT <input checked="" type="checkbox"/> Checking <input type="checkbox"/> Savings TYPE OF PAYMENT <input type="checkbox"/> Net Pay <input type="checkbox"/> Travel <input checked="" type="checkbox"/> Other Federal employment related payments	3. DIRECT DEPOSIT ACCOUNT INFORMATION - NET PAY/TRAVEL/OTHER (Use Sec. 4 for allotments) A voided personal check/sharedraft may be attached in lieu of completing this section. See instructions on back of this form. ROUTING TRANSIT NUMBER <input style="width: 150px;" type="text"/> <input type="checkbox"/> Check Digit ACCOUNT NUMBER <input style="width: 200px;" type="text"/> ACCOUNT TITLE <input style="width: 300px;" type="text"/> (Account Holder's Name) FINANCIAL INSTITUTION NAME <input style="width: 300px;" type="text"/>		
4. ALLOTMENT INFORMATION Complete this section only if you want to start, cancel or change the amount of a savings or discretionary allotment - see instructions on back of form.			
TYPE OF ALLOTMENT (Check One) <input type="checkbox"/> Savings (whole dollar amounts only) <input type="checkbox"/> Discretionary or Third Party	TYPE OF ACCOUNT (Check One) <input type="checkbox"/> SAVINGS <input type="checkbox"/> CHECKING	ACTION (Check One) <input type="checkbox"/> START <input type="checkbox"/> CANCEL <input type="checkbox"/> CHANGE	AMOUNT (Check One) <input type="checkbox"/> INCREASE TO: <input type="checkbox"/> DECREASE TO: New Total \$ <input style="width: 100px;" type="text"/>
ALLOTTEE NAME (person/company who will receive allotment) <input style="width: 250px;" type="text"/> ALLOTTEE'S ROUTING NUMBER <input style="width: 150px;" type="text"/> <input type="checkbox"/> Check Digit ALLOTTEE'S ACCOUNT NUMBER <input style="width: 200px;" type="text"/> ALLOTTEE'S ACCOUNT TITLE <input style="width: 300px;" type="text"/> (Account Holder's Name) FINANCIAL INSTITUTION NAME <input style="width: 300px;" type="text"/>			
5. AUTHORIZATION * <input style="width: 400px;" type="text"/> EMPLOYEE'S SIGNATURE <input style="width: 100px;" type="text"/> DATE			
6. AGENCY USE:			

Direct Deposit:

Every contracted cadet will receive a stipend.

- As a contracted cadet, you are authorized to be paid as part of your contract with AFROTC. In order to start a pay record on you, you must provide your bank information to be processed.

-

Section 1: Employee information

Enter your name and a phone number to reach you at.

Section 2: Type of account

Checking or savings

Do not change the type of payments. This is to determine which kind of payments are to be sent to you.

Section 3: Direct Deposit Information. Input your bank details here:

- Routing number
- Account number
- Account title
- Name of the bank you'll be using

Section 4:

Skip this section.

Section 5: Authorization

Sign and date.

- Below is a link to a video:

<https://www.youtube.com/watch?v=pVFvXoZvf3E>

Service Members Group Life Insurance: (SGLI)



Servicemembers' Group Life Insurance Election and Certificate

The SGLI Online Enrollment System (SOES) is the official system of record for Servicemembers' Group Life Insurance for the United States Navy, the United States Army and the United States Air Force. All coverage and beneficiary elections for members of the Navy, the Army and the Air Force should be made in SOES. This form should only be used in special circumstances as defined by the United States Navy, the United States Army and the United States Air Force.

1. About You

<input type="text"/>	Cadet	<input type="text"/>
First Name (First, Middle, Last)	Rank, title or grade	Social Security Number
AFROTC Det 290 , Lexington KY	USAF	<input type="text"/>
Duty location	Branch of Service	Current Amount of SGLI
<input type="checkbox"/> Married <input type="checkbox"/> Single	<input type="text"/>	<input type="text"/>
If married, spouse's name		Spouse's Date of Birth

2. About Your Coverage *This form replaces all prior designations.*

I am completing this form to: (Check all that apply)

- Name or update my SGLI beneficiary. You must complete sections 3 & 5.
- Increase or restore my SGLI coverage to \$ _____. You must complete sections 3, 4, & 5. (Increasing SGLI does not automatically increase FSGLI, if FSGLI was < \$100,000.)
- Reduce my SGLI coverage to \$ _____. You must complete sections 3 & 5.
- Decline or cancel SGLI coverage. Write below "I do not want insurance at this time." You must complete section 5 only.
" _____ "

SGLI coverage is available in increments of \$50,000 up to a maximum of \$400,000. Traumatic Injury Protection (TISGLI) coverage is automatic with SGLI coverage.

3. About Your Beneficiaries *Please always complete this section unless you are declining coverage. If you do not specifically name beneficiaries, your insurance will be paid by law. Please read the information on page 3 before selecting your beneficiaries.*

Primary Name and Address	Social Security Number (if available)	Relationship to you	Share to each (%) – The sum of shares must equal 100%. Each share must be greater than 0%.	Payment Option (Lump sum* or 36 equal monthly payments)
1.	<input type="text"/>			
2.	<input type="text"/>			
3.	<input type="text"/>			
4.	<input type="text"/>			

Secondary Name and Address	Social Security Number (if available)	Relationship to you	Share to each (%) – The sum of shares must equal 100%. Each share must be greater than 0%.	Payment Option (Lump sum* or 36 equal monthly payments)
1.	<input type="text"/>			
2.	<input type="text"/>			
3.	<input type="text"/>			
4.	<input type="text"/>			

Have more beneficiaries? Check this box if 1) You have additional beneficiaries and are completing the Supplemental SGLI Beneficiary Form, SGLV 8286S or, 2) You are attaching additional documentation to complete your beneficiary designation noted above.

*If the insured member elects a lump sum payment, the beneficiary(ies) will be given the option of receiving the lump sum payment through the Prudential Alliance Account®, by check, or Electronic Funds Transfer (EFT). Alliance Account is not available for payments less than \$5,000, payments to individuals residing outside the United States and its territories, and certain other payments. These will be paid by check.

The Bank of New York Mellon is the Administrator of the Prudential Alliance Account Settlement Option, a contractual obligation of The Prudential Insurance Company of America, located at 751 Broad Street, Newark, NJ 07102-0777. Draft clearing and processing support is provided by The Bank of New York Mellon. **Alliance Account balances are not insured by the Federal Deposit Insurance Corporation (FDIC).** The Bank of New York Mellon is not a Prudential Financial company.

4. About Your Health Complete this section *ONLY* if you are restoring or increasing coverage.

Your date of birth (MM, DD, YYYY)

Your weight

Your height

Your gender Female
 Male

Have you had, been treated for, or had known indications of:

- | | Yes | No |
|--|--------------------------|--------------------------|
| a. A heart condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. High blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. A neurological disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Cancer or tumors? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Have you ever been diagnosed as having a disease of the immune system? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Do you have any known physical impairments, deformities, or ill health not covered above? | <input type="checkbox"/> | <input type="checkbox"/> |

Did you answer "YES" to any question? If so, reference the question by letter and list date, duration and details below. Please attach additional documentation if necessary.

If you answered "yes" to any question above, a request to increase coverage does not take effect until approved by the Office of Servicemembers' Group Life Insurance (OSGLI). If you answered "no" to all the questions above, your request for increased coverage takes effect immediately.

5. Your Signature *You must complete this section.*

I have read the information on page 3 and instructions on page 4 and understand that:

- This form replaces any prior beneficiary or payment instructions.
- I can have SGLI and Veterans' Group Life Insurance (VGLI) at the same time, but the combined amount cannot be more than \$400,000. VGLI is lifetime renewable post-separation coverage available to Service Members who separate with SGLI coverage.
- Reducing SGLI coverage can affect the amount of my family coverage (FSGLI) and VGLI coverage (see instructions on page 4).
- By declining or canceling SGLI coverage, I am also declining family coverage (FSGLI) and Traumatic Injury Protection (TSGLI). I am also not eligible for any post-separation coverage (see instructions on page 4).

Please take note:

If my spouse is...	and...	then...
also a member of the uniform services	we married on or after January 2, 2013	spouse SGLI coverage is not automatic, but I may apply for spouse coverage by completing SGLV 3036A.
not a member of the uniformed services	I am married, or get married after completing this form, and have not declined SGLI.	spouse SGLI automatically covers my spouse. I must register my spouse in DEERS so my branch of service can deduct premiums from my pay. Failure to do so will result in a debt for unpaid premiums. I can decline spouse coverage by completing SGLV 3036A.

- I am free to name anyone I want as my beneficiary. I understand if I am married and have designated someone other than my spouse or child as my beneficiary, the person I have named is the person I intend to receive my insurance proceeds. I also understand that my spouse may be notified that he/she (or my child) is not my designated beneficiary.

I certify that, to the best of my knowledge and belief, the above statements are complete and true. Any deception or false statement, either by reference, omission, or otherwise can result in loss of coverage or denial of a claim for benefits. If declining or reducing SGLI coverage, I have received the appropriate general information concerning life insurance from my Unit Personnel Clerk.

Service Member Signature	Social Security Number	Date Signed (MM, DD, YYYY)

Address

Submit this form to your Unit Personnel Clerk. By completing this section the Unit Personnel Clerk acknowledges that they have counseled the Service Member in regards to the information provided on page 4 of this form.

For Branch of Service Use Only		For OSGLI Use Only	
Name of Personnel Clerk	Benjamin M. Gonzales	Representative	
Rank, title or grade	TSgt/NCOIC, Personnel	Approve <input type="checkbox"/>	
Contact telephone/email	859-257-1986	Disapprove <input type="checkbox"/>	
Date		Date	
Address	408 Administration Dr, Lexington KY 40506		

- If you are electing to take the SGLI, fill out sections 1,2,4 and 5.
- If you decline, fill out sections 1,3,5. In section 3, please write in the statement “I do not want insurance at this time”
- Section 1: fill in your personal information in the highlighted portion and the amount you are electing to take.
- Section 2: mark what action you are taking – decline, increase, reduce coverage.
- Section 3 is only if you are taking coverage. Identify a beneficiary to receive.
- Section 4 is for you to mark your health information.
- Section 5: input your signature, Social Security Number, date and sign.

- W-4 – Employee Withholding

Form W-4 Department of the Treasury Internal Revenue Service		Employee's Withholding Certificate ▶ Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. ▶ Give Form W-4 to your employer. ▶ Your withholding is subject to review by the IRS.		OMB No. 1545-0074 2020
Step 1: Enter Personal Information	(a) First name and middle initial		Last name	
	Address			
	City or town, state, and ZIP code			
	(c) <input type="checkbox"/> Single or Married filing separately			
		<input type="checkbox"/> Married filing jointly (or Qualifying widow(er))		
		<input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		
<p>Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the online estimator, and privacy.</p>				
<p>Step 2: Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.</p> <p>Multiple Jobs or Spouse Works Do only one of the following.</p> <p>(a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4); or</p> <p>(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; or</p> <p>(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld ▶ <input type="checkbox"/></p> <p>TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.</p>				
<p>Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)</p>				
Step 3: Claim Dependents		If your income will be \$200,000 or less (\$400,000 or less if married filing jointly):		
		Multiply the number of qualifying children under age 17 by \$2,000 ▶ \$ _____		
		Multiply the number of other dependents by \$500 ▶ \$ _____		
		Add the amounts above and enter the total here 3 \$ _____		
Step 4 (optional): Other		(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income 4(a) \$ _____		

- The form W-4 is a US government form used for any withholdings on income earned. You will only complete steps 1 and 5, unless you have additional income or dependents to claim. Below is a link to better assist you.
- <https://www.youtube.com/watch?v=IOsKZyIWGwQ>

DoDMERB is your DoDMERB is your official medical file. It is a Department of Defense Agency responsible for the determination of medical qualification of applicants for appointment to a United States Service Academy, the Uniformed Services University of the Health Sciences, the Reserve Officer Training Corps (ROTC) Programs of the United States Armed Forces, and other programs as assigned by the Assistant Secretary of Defense for Health Affairs.

AFROTC Detachments coordinate with this office for all medical actions until cadets are contracted. Once contracted, any waivers and medical actions are coordinated with AETC/Surgeon General at JBSA-Randolph, TX.

It is critical for cadets to report any medical changes within 72 hours. Below is an example of what your form should look like.

Prescribed by: DoDI 1304.2

REPORT OF MEDICAL EXAMINATION		1. DATE OF EXAMINATION (YYYY/MM/DD)	2a. SOCIAL SECURITY NUMBER	2b. DoD ID NUMBER (if applicable)
PRIVACY ACT STATEMENT				
<p>AUTHORITY: 10 U.S.C. 504, Persons not qualified; 10 U.S.C. 505, Regular components: qualifications, term, grade; 10 U.S.C. 507, Extension of enlistment for members needing medical care or hospitalization; 10 U.S.C. 532, Qualifications for original appointment as a commissioned officer; 10 U.S.C. 978, Drug and alcohol abuse and dependency; testing of new entrants; 10 U.S.C. 1201, Regulars and members on active duty for more than 30 days: retirement; 10 U.S.C. 1202, Regulars and members on active duty for more than 30 days: temporary disability retired list; 10 U.S.C. 4346, Cadets: requirements for admission; DoD Directive 1145.2, United States Military Entrance Processing Command; E.O. 9397 (SSN) and 10 U.S.C. 1204, Members on Active Duty for 30 Days or Less or on Inactive Duty Training: Retirement, as amended.</p> <p>PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.</p> <p>ROUTINE USE(S): The Routine Uses are listed in the applicable system of records notice found at: http://dpcid.defense.gov/Privacy/SORN/index/DOOD-wide-SORN-Article-View/Article/570661/a0601-270-usmepcom-dod/</p> <p>DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.</p>				
3. LAST NAME - FIRST NAME - MIDDLE NAME (Suffix)		4. HOME ADDRESS (Street, Apartment Number, City, State and Zip Code)		6a. HOME TELEPHONE NUMBER (Include Area Code)
				6b. E-MAIL ADDRESS
6. GRADE/RANK	7. DATE OF BIRTH (YYYY/MM/DD)	8. AGE	9a. BIRTH SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	9b. PREFERRED GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female
				10a. ETHNIC CATEGORY <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non Hispanic/Latino
				10b. RACIAL CATEGORY (Select one) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander
11. TOTAL YEARS GOVERNMENT SERVICE		12. AGENCY (Non-Service Members Only)		13. ORGANIZATION UNIT AND UIC/ICD
a. MILITARY		b. CIVILIAN		
14a. RATING OR SPECIALTY (Aviators Only)		14b. TOTAL FLYING TIME		14c. LAST SIX MONTHS
16a. SERVICE <input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Marine Corps <input type="checkbox"/> Navy <input type="checkbox"/> Coast Guard	16b. COMPONENT <input type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	16c. PURPOSE OF EXAMINATION <input type="checkbox"/> Enlistment <input type="checkbox"/> Commission <input type="checkbox"/> Retention <input type="checkbox"/> Separation <input type="checkbox"/> Other _____		<input type="checkbox"/> Retirement <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> ROTC Scholarship Program <input type="checkbox"/> Medical Board
				18. NAME OF EXAMINING LOCATION, AND ADDRESS (Include Zip Code)
MEDICAL EVALUATION (Check each item in appropriate column. Enter "NE" if not evaluated.)				43. DENTAL DEFECTS AND DISEASE Acceptable <input type="checkbox"/> (Please explain. Use dental form if completed by dentist. If abnormality noted, explain in item 44.) Not Acceptable <input type="checkbox"/> Class _____
		Normal	Abnormal	NE
17. Head, face, neck and scalp				
18. Nose				
19. Sinuses				
20. Mouth and throat				
21. Ears - General (int. and ext. canals/Auditory acuity under item 71)				
22. Tympanic Membranes (Perforation)				
23. Eyes - General				
24. Ophthalmoscopic				
25. Pupils (Equality and reaction)				
26. Ocular motility (Associated parallel movements, nystagmus)				
27. Heart (Thrust, size, rhythm, sounds)				
28. Lungs and chest (include breasts)				
29. Vascular system (Varicosities, etc.)				
30. Anus and rectum (Hemorrhoids, Fistulae) (Prostate if indicated)				
31. Abdomen and viscera (include hernia)				
32. External genitalia (Genitourinary)				
33. Upper extremities				
34. Lower extremities (Except feet)				
35. Feet (Check category)				
35a. <input type="checkbox"/> Normal Arch <input type="checkbox"/> Pes Planus <input type="checkbox"/> Pes Cavus				
35b. <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe				
35c. <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic <input type="checkbox"/> Rigid				
36. Spine, other musculoskeletal				
37. Body marks, scars, tattoos				
38. Skin, lymphatics				
39. Neurologic				
40. Psychiatric (Specify any personality disorder)				
41. Pelvic (Females only)				
42. Endocrine				