In-Processing Documents

(Items 9-11 must be signed with Cadre Present)

1) Contact Sheet

2) Out-of-State Tution Waiver

3) AFROTC Degree Plan

4) AFROTC Form 28 (Sports Physical)

5) DD Form 2005 (Privacy Act – Healthcare Records)

6) Consent for Student Records Release (Academic)

7) DD Form 2983 (Recruit/Trainee Activities)

8) AF Form 4428 (Tattoo Screener)

9) DD Form 93 (Record of Emergency Data)

10) Memorandum of Understanding for Drug Testing Policy

11) AF Form 2030 (Drug and Alcohol Abuse Certificate)

Contact Information

Full Legal Name and (preferred name):

_____

Personal email address (not MSU or .MIL):

_____

Cell Phone Number (for contact and GroupMe):

_____

Driver's License State and Number:

_____

Permanent Address, City, State, Zip:

_____

Mississippi State University NET ID **AND** ID NUMBER:

_____

Please fill out and return.

DEPARTMENT OF THE AIR FORCE
AIR UNIVERSITY (AETC)

_____

MEMORANDUM FOR CENTER FOR AMERICA'S VETERANS

FROM: AFROTC Detachment 425/CC
Mississippi State University
202 Middleton Hall
Mississippi State, MS 39762-5531

SUBJECT: Request Non-resident Tuition Waiver for Cadet _____

1. Request to have the non-resident tuition fee waiver for Cadet _____ (MSU ID# _____). The cadet is presently enrolled in our ROTC program and is in good standing.

2. If there are any questions, please contact our detachment at (662) 325-3810.

Alayna Stevens
ALAYNA STEVENS
Administrative Assistant, Det 425

Veteran, Service-Member, Dependent, Spouse Non-Resident Tuition Waiver Request Form

Name of Student: _____ MSU ID#:_____

Date of Birth: _____/____/_____ Entry Term: Fall 20 20

Address: _____

_____

City: _____State: _____ Zip: _____

Relationship to Veteran/Service Member:

☑ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Step Son

☐ Step Daughter ☐ Adopted Son ☐ Adopted Daughter

Name of Veteran/Service-Member: Self

Branch of Service: Air Force ROTC Dates of Service: Fall 2020-Present

Type of Discharge (if applicable): N/A

ONE OF THE FOLLOWING FORMS OF DOCUMENTATION MUST ACCOMPANY APPLICATION

Honorably Discharged or Retiree:

☐ DD214 (Member 4 Copy)

☐ NGB22

☐ Copy of Military ID (Service Member or Dependent)

☐ Dependent Status Verification (if applicable)

☐ Certificate of Discharge

Active Duty:

☐ Current Orders/Unit of Assignment

☑ Other documentation (as required)

☐ Copy of Military ID (Service Member or Dependent)

☐ Dependent Status Verification (if applicable)

SIGNATURES (Please Print Your Name then Sign)

_____

Student **Date**

_____

Veteran/Service Member **Date**

_____

Center for America's Veterans **Date**

Please return to: Ronnie White, 126 Magruder Street, P. O. Drawer 6283, Mississippi State, MS 39762
Phone: 662-325-6719, FAX: (662) 325-6723, e-mail: rwhite@saffairs.msstate.edu
Visit us: veterans.msstate.edu

Degree Plan

Name *(Last, First, MI)*_____ Major & Graduation Month/Year_____

University Advisor Initial Plan Verification: (Print) _____ (Sign/Date)_____

First Year

Term: Fall 20___ **Course Number/Course Title**	**Credit Hours** **Att / Earned**
	/
	/
	/
	/
	/
	/
	/
	/
	/
Total Hours	/
Term: Spring 20___ **Course Number/Course Title**	**Credit Hours** **Att / Earned**
	/
	/
	/
	/
	/
	/
	/
	/
	/
Total Hours	/
Term: Summer 20___ **Course Number/Course Title**	**Credit Hours** **Att / Earned**
	/
	/
	/
	/
Total Hours	/

Remarks:

Fall Verification

University Advisor Signature/Date: _____

AS Instructor Signature/Date: _____

Student Signature/Date:_____

Second Year

Term: Fall 20___ **Course Number/Course Title**	**Credit Hours** **Att / Earned**
	/
	/
	/
	/
	/
	/
	/
	/
	/
Total Hours	/
Term: Spring 20___ **Course Number/Course Title**	**Credit Hours** **Att / Earned**
	/
	/
	/
	/
	/
	/
	/
	/
	/
Total Hours	/
Term: Summer 20___ **Course Number/Course Title**	**Credit Hours** **Att / Earned**
	/
	/
	/
	/
Total Hours	/

Remarks:

Fall Verification

University Advisor Signature/Date: _____

AS Instructor Signature/Date: _____

Student Signature/Date:_____

Third Year

Term: Fall 20___ Course Number/Course Title	Credit Hours Att / Earned
	/
	/
	/
	/
	/
	/
	/
	/
	/
Total Hours	/
Term: Spring 20___ Course Number/Course Title	**Credit Hours Att / Earned**
	/
	/
	/
	/
	/
	/
	/
	/
	/
Total Hours	/
Term: Summer 20___ Course Number/Course Title	**Credit Hours Att / Earned**
	/
	/
	/
	/
Total Hours	/

Remarks:

Fall Verification

University Advisor Signature/Date: _____

AS Instructor Signature/Date: _____

Student Signature/Date: _____

Fourth Year

Term: Fall 20___ Course Number/Course Title	Credit Hours Att / Earned
	/
	/
	/
	/
	/
	/
	/
	/
	/
Total Hours	/
Term: Spring 20___ Course Number/Course Title	**Credit Hours Att / Earned**
	/
	/
	/
	/
	/
	/
	/
	/
	/
Total Hours	/
Term: Summer 20___ Course Number/Course Title	**Credit Hours Att / Earned**
	/
	/
	/
	/
Total Hours	/

Remarks:

Fall Verification

University Advisor Signature/Date: _____

AS Instructor Signature/Date: _____

Student Signature/Date: _____

Fifth Year

Term: Fall 20___ **Course Number/Course Title**	**Credit Hours** **Att / Earned**
	/
	/
	/
	/
	/
	/
	/
	/
	/
Total Hours	/
Term: Spring 20___ **Course Number/Course Title**	**Credit Hours** **Att / Earned**
	/
	/
	/
	/
	/
	/
	/
	/
	/
Total Hours	/
Term: Summer 20___ **Course Number/Course Title**	**Credit Hours** **Att / Earned**
	/
	/
	/
	/
Total Hours	/

Remarks:

Fall Verification

University Advisor Signature/Date: _____

AS Instructor Signature/Date: _____

Student Signature/Date:_____

College Credits Earned Prior to AFROTC Enrollment

Term: HS/College Name	Course Title	Credit Hours
		/
		/
		/
		/
		/
		/
		/
		/
		/
		/
		/
		/
		/
		/
		/
		/
		/
		/
		/
		/
		/
	Total Hours	/

Remarks:

AIR FORCE ROTC PRE-PARTICIPATORY SPORTS PHYSICAL

1. CADET/APPLICANT NAME	2. AFROTC DETACHMENT

MEDICAL AUTHORITY: Measure height and weight of cadet/applicant. Compare results to AF standards listed on reverse, check block 7 and certify as requested below.

AFROTC CADRE: If cadet/applicant exceeds AF weight standards, conduct a Body Fat Measurement IAW DoDI 1308.3.

3. CADET/APPLICANT MEASUREMENTS	HEIGHT	WEIGHT
4. AIR FORCE WEIGHT STANDARDS (found on reverse)	MINIMUM	MAXIMUM

5. BODY FAT MEASUREMENT	6. BODY FAT STANDARDS:	7. CHECK APPLICABLE BOX	
	FEMALE - 26% MALE - 18%		☐ IS WITHIN AIR FORCE WEIGHT STANDARDS ☐ EXCEEDS AIR FORCE WEIGHT STANDARDS ☐ IS BELOW AIR FORCE WEIGHT STANDARDS

8. MEDICAL AUTHORITY: PLEASE REVIEW THE ABOVE INFORMATION. CONDUCT COUNSELING BELOW IN APPLICABLE AREAS, AND SIGN.

I, *(print name)* _____, HAVE EXAMINED THIS CADET/APPLICANT AND REVIEWED HIS/HER MEDICAL HISTORY. THE FOLLOWING ARE THE RESULTS:

9. (IF CADET/APPLICANT IS BELOW AIR FORCE WEIGHT STANDARDS)

I CERTIFY THIS CADET/APPLICANT'S LEAN BODY MASS POSES NO HEALTH RISK; NO SIGNS OF EATING DISORDERS EXIST. I HAVE DISCUSSED THE IMPORTANCE OF NUTRITION AND WEIGHT MANAGEMENT. _____ (Medical Authority Initials)

10. **(IF CADET/APPLICANT EXCEEDS AIR FORCE WEIGHT STANDARDS)**

I HAVE DISCUSSED APPROPRIATE AND SAFE WEIGHT LOSS WITH THE CADET/APPLICANT. _____ (Medical Authority Initials)

11. **(FOR ALL CADETS/APPLICANTS)**

I **DID / DID NOT** (please circle) FIND MEDICAL CONDITION(S) OR PHYSICAL IMPAIRMENT(S) THAT WOULD PRECLUDE THIS CADET/APPLICANT FROM PARTICIPATING IN A RIGOROUS PHYSICAL TRAINING PROGRAM. IF A MEDICAL CONDITION/PHYSICAL IMPAIRMENT EXISTS THAT MAY PRECLUDE THE INDIVIDUAL FROM PARTICIPATING, PLEASE EXPLAIN:

EXAMINATION DATE	PHYSICIAN OR MEDICAL AUTHORITY SIGNATURE

AFROTC CADRE: REVIEW THE INFORMATION ENTERED ABOVE AND SIGN BELOW:

DATE	AFROTC CADRE SIGNATURE

ACCESSION HEIGHT AND WEIGHT STANDARDS & BODY FAT MEASUREMENT (BFM) STANDARDS

(Per DoDI 1308.3, *DoD Physical Fitness and Body Fat Programs Procedures)*

HEIGHT (INCHES)	POUNDS	
	MINIMUM (BMI = 19 kg/m)	MAXIMUM (BMI = 25.0 kg/m)
58	91	119
59	94	124
60	97	128
61	100	132
62	104	136
63	107	141
64	110	145
65	114	150
66	117	155
67	121	159
68	125	164
69	128	169
70	132	174
71	136	179
72	140	184
73	144	189
74	148	194
75	152	200
76	156	205
77	160	210
78	164	216
79	168	221
80	173	227

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

This form is not an authorization or consent to use or disclose your health information.

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:

- 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)*

DEPARTMENT OF THE AIR FORCE
AIR UNIVERSITY (AETC)

DATE:_____

MEMORANDUM FOR MISSISSIPPI STATE UNIVERSITY STUDENT RECORDS OFFICE

FROM: AFROTC Detachment 425
Mississippi State University
202 Middleton Hall
Mississippi State, MS 39762-5531

SUBJECT: Consent for Release of Student Records

1. In compliance with 10 U.S.C. 2102 et seq., I hereby voluntarily consent to the release of such official records as may be required by Air Force Reserve Officer Training Corps (AFROTC) Headquarters and AFROTC Detachment (Det) 425 to conduct official AFROTC business. I therefore authorize appropriate school officials to release to Det 425 personnel or to the appropriate DOD agency any and all official records, files, and data for their use in official AFROTC business.

2. If there are any questions, please contact our detachment at (662) 325-3810.

_____ _____

Student's Printed Name/Signature (Parent's signature if student is under 18 years of age)

RECRUIT/TRAINEE PROHIBITED ACTIVITIES ACKNOWLEDGMENT

PRIVACY ACT STATEMENT

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.
PRINCIPAL PURPOSE(S): To document your understanding of the prohibitions identified in section 7 of this form.
ROUTINE USE(S): The DoD Blanket Routine Uses found at http://dpclo.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx apply to this collection.
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.

INSTRUCTIONS

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.

1. RECRUIT/TRAINEE NAME *(Last, First, Middle)*	2. PAY GRADE	3. RECRUITING OFFICE/TRAINING COMMAND
	Cadet	Det 425/AFROTC (AETC)
4. RECRUITING OFFICE/TRAINING COMMAND ADDRESS *(City, State, ZIP Code)*	**5. DATE SIGNED** *(YYYYMMDD)*	**6. SIGNATURE**
Mississippi State, MS 39762		

7. I ACKNOWLEDGE AND UNDERSTAND THAT AS A RECRUIT OR TRAINEE, I WILL NOT:

(Initial)	
_____	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):

(Initial)	
_____	**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 *(Last, First, Middle Initial)*	b. TITLE	c. DATE SIGNED *(YYYYMMDD)*	d. SIGNATURE/RANK

TATTOO/BRAND/BODY MARKING SCREENING/VERIFICATION

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 8013, Secretary of the Air Force, Executive Order 9397 (SSN), as amended.
PURPOSE: To provide personnel management support to commanders and supervisors.
ROUTINE USE: Disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act. DoD 'Blanket Routine Uses' apply.
DISCLOSURE: Voluntary, failure to provide SSN may impede proper placement in member's military personnel file.

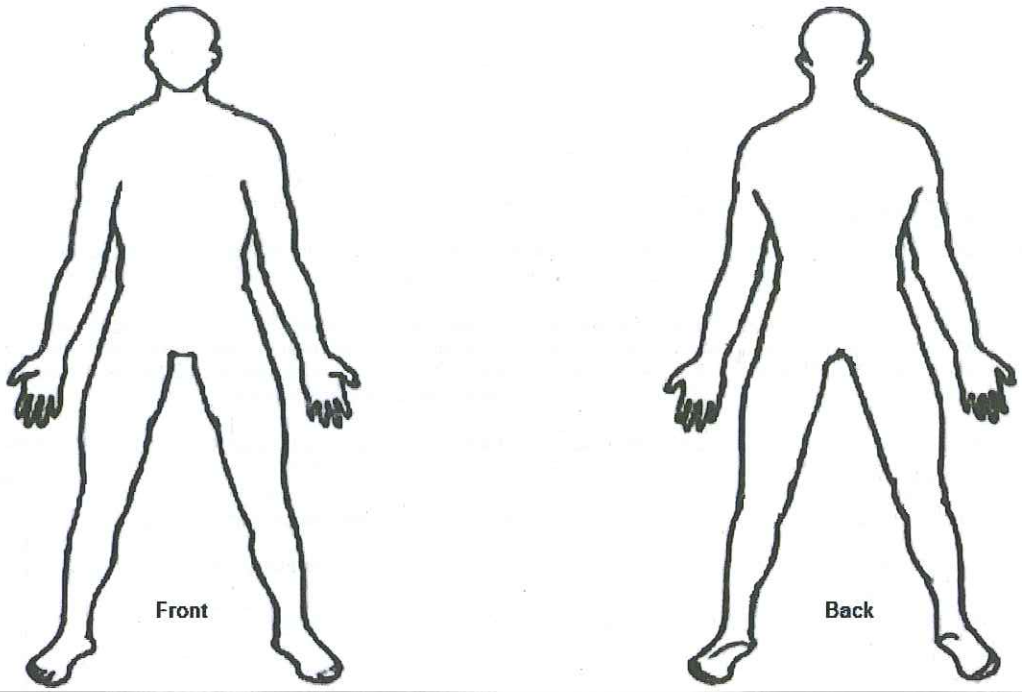
WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a $10,000 fine or both), to anyone making a false statement. If you knowingly and willingly provide a false statement you can be tried by military courts - martial or meet an administrative board for discharge and could receive a less than honorable service characterization.

SECTION I. AIRMAN

a. LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	b. DATE OF BIRTH *(YYYY MM DD)*	c. SOCIAL SECURITY NUMBER

SECTION II. IDENTIFICATION

- Commander marks all tattoo/brand/body markings with a number and Airman initials
- Commander describes tattoo/brand/body marking information below and Airman initials



Number on Body Diagram	Location	Description, Size, Shape and Meaning	Initials

SECTION II. TATTOO/BRAND/BODY MARKING IDENTIFICATION OVERFLOW

There is no additional tattoo/brand/body marking information for this section. Airman Initials: _____

In accordance with the Air Force Policy Memorandum for Appearance and Accession Standards Review dated 9 January 2017; SECTION III. AIR FORCE TATTOO/BRAND/BODY MARKING POLICY is now changed as follows:
- Unauthorized content remains unchanged.
- Effective immediately; there are no size or area: limitations for authorized tattoos on the chest, back, arms, and legs. Tattoos, brands, and body markings will not be on the head, neck, face, tongue, lips, and scalp. Hand tattoos are limited to one single-band ring tattoo, on one finger, on one hand. Ring tattoos are limited to a single band of no more than 3/8 of an inch in width, below the knuckle and above the finger joint (portion closest to the palm).

SECTION III. AIR FORCE TATTOO/BRAND/BODY MARKING POLICY

Unauthorized (content): Tattoos/brands/body markings anywhere on the body that are obscene, commonly associated with gangs, extremist, and/or supremacist organizations, or that advocate sexual, racial, ethnic, or religious discrimination are prohibited in and out of uniform.

Excessive tattoos/brands/body markings will not be exposed or visible (includes visible through the uniform) while wearing any/all uniform combination(s) except the PTU. This includes any combination of short sleeve, long sleeve, open collar uniform, utility uniform sleeves rolled up or worn down, flight duty uniform, etc. This policy does not apply when wearing the PTU. Excessive is defined as any tattoos/brands/body markings that exceed 1/4 (25%) of the exposed body part and are readily visible when wearing any/all uniform combination(s).

The exposed body part is defined as the total area, to include front, sides and back of limb or other body part protruding from a uniform item.

SECTION IV. INITIAL CERTIFICATION			**INITIALS**
I hereby certify that the markings in section II are a true and accurate representation of all tattoos/brands/body markings.			
I have read and fully understand the information contained on this form and have been briefed on Air Force tattoo/brand/body marking policy.			
DATE	Airman NAME *(Last, First, M.I.)* RANK/GRADE	SIGNATURE	
SUPERVISOR			
I CERTIFY THE ABOVE INDIVIDUAL SIGNED THIS CERTIFICATE			
DATE	NAME *(Last, First, M.I.)* RANK/GRADE	SIGNATURE	
FIRST SERGEANT			
I CERTIFY THE ABOVE INDIVIDUAL SIGNED THIS CERTIFICATE			
DATE	NAME *(Last, First, M.I.)* RANK/GRADE	SIGNATURE	

SECTION V. COMMANDER'S ACTION			**INITIALS**
The tattoo/brand/body marking complies with policy and is approved.			
The tattoo/brand/body marking does not comply with policy and requires further action IAW AFI 36-2903.			
DATE	NAME *(Last, First, M.I.)* RANK/GRADE	SIGNATURE	
AIRMAN ACKNOWLEDGEMENT			
DATE	NAME *(Last, First, M.I.)* RANK/GRADE	SIGNATURE	

USAF STATEMENT OF UNDERSTANDING FOR DEPENDENT CARE RESPONSIBILITY

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C.; Chapter 31, Enlistments; AFI 36-2002, Enlisted Accessions; AFI 36-2013, Officer Training School (OTS) and Enlisted Commissioning Programs (ECPS); Executive Order 9397 (SSN), as amended.

PURPOSE: To determine enlistment/commissioning eligibility or process qualified applicants; classification and assignment actions after enlistment or commissioning.

ROUTINE USES: In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, these records contained therein may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. 552a(b)(3). DoD 'Blanket Routine Uses' published at the beginning of the Air Force's compilation of system of records notices apply.

DISCLOSURE: Voluntary. However failure to furnish personal identification information may negate the enlistment/commissioning application.

SORN(s): F036 AF PC H, Air Force Enlistment/Commissioning Records System.

I. MARITAL STATUS

☐ SINGLE	☐ MARRIED *(Civilian)*	☐ MARRIED *(Military)*	☐ SEPARATED	☐ DIVORCED	☐ WIDOWED

II. STATEMENT OF UNDERSTANDING

I understand:

My eligibility is based on my marital and dependency status and failure to claim all my dependents may result in my involuntary separation from the Air Force. I have read and understand the following definitions the Air Force considers a dependent for accession purposes. 1. A spouse. 2. Any person under the age of 18 for whom the applicant or spouse has legal or physical custody, control, care, maintenance, or support. includes children from a previous marriage, a relative by blood or marriage and stepchildren or adopted children of the applicant or spouse. 3. Any unmarried natural children of the applicant or spouse regardless of current residence. For male applicants, the term natural child includes those born out of wedlock. 4. Any person who is dependent upon the applicant or spouse for their care, maintenance, or support regardless of age. (5) FOR MALE APPLICANTS ONLY. An unborn child of the spouse or one claimed by or a court order determines is his. ( )

It is my responsibility to provide legal documents (marriage certificate, birth certificate, etc.) to substantiate my dependent(s) and it is my responsibility to support myself and my dependent(s) on the pay and allowances I receive. I also understand arrangements for care of my dependent(s) is my personal responsibility and will not interfere with my assigned Air Force duties, including shift work, weekend duty, temporary duty away from my assigned duty station and short notice deployments and evacuations. I further understand my dependent(s) will not prevent me from being available for worldwide assignment and failure to perform my military dependent(s) may result in disciplinary action, to include involuntary discharge. ( )

If applying for an enlisted program, my dependent(s) are not permitted to accompany me during basic training, and it is recommended they not accompany me during any technical training. If applying for an officer program, it is strongly recommended my dependent(s) not accompany me while attending training. I also understand government family quarters are assigned based on application date, grade, date of grade, number of dependents, and availability. ( )

Military couples with dependent(s) are required to make dependent care arrangements that allow both members to meet all military obligations and duties. I also understand each member is considered to be serving in his or her own right and must be available for worldwide assignment regardless of marital or dependent status. Additionally, I understand married Air Force couples may apply for a join spouse assignment, but there is no guarantee they will be assigned together.
( )

III. REMARKS

IV. APPLICANT CERTIFICATION

I have read the information on this form and understand how it applies to me and my dependent(s). I also understand the needs of the Air Force come first and I may be involuntarily discharged should I violate any of these provisions. I certify the information on this form is of my personal knowledge and is true and correct and my recruiter did not advise me to conceal any dependency information.

DATE	NAME *(Last, First, Middle Initial)*	SSN	SIGNATURE

V. RECRUITER CERTIFICATION

I certify the information on this form was explained to the applicant and I verified the applicant's dependent(s) and marital status from appropriate source documents.

DATE	RECRUITER'S NAME/GRADE	SIGNATURE

VI. APPLICANT FINAL CERTIFICATION

On the date of enlistment or commissioning or appointment and prior to signing the oath, I reviewed the information on this form and hereby reaffirm complete knowledge and understanding of the statements contained herein. I further certify all changes to my marital or dependent status since initiation of this form are are explained in Section III.

DATE	SIGNATURE

VII. AIR FORCE REPRESENTATIVE FINAL CERTIFICATION

I have verified all known changes to the applicant's marital or dependent status since initiation of this form and certify they are explained in Section III.

DATE	NAME/GRADE OF AIR FORCE REPRESENTATIVE	SIGNATURE

AIR FORCE DEPENDENCY POLICY STATEMENT OF UNDERSTANDING

Air Force Dependency Policy Statement of Understanding.

I, , have been briefed on the Air Force policies concerning family care responsibility and family care responsibility as an AFROTC retention standard. (A family member is any person over whom I have legal or physical custody or control, or who relies primarily upon me for their care, maintenance, or support regardless of age). In particular, I understand the following:

a. **(Non-contract Cadet**) If I am/become unmarried or marry (to include a common-law spouse) a military member (including another AFROTC cadet), and become responsible for any family member incapable of self-care I must acquire and maintain an approved Family Care Plan IAW AFI 36-2908, *Family Care Plans,* that will adequately cover my time in AFROTC. If I am unable or unwilling to create or maintain such a family care plan, I will no longer meet AFROTC retention standards. In such a case, I would then be subject to disenrollment from AFROTC for failure to maintain military retention standards. If I am disenrolled, I will also be subject to recoupment of my scholarship benefits.

b. **(Contract Cadet)** If I am disenrolled from AFROTC after becoming a contract cadet I am subject to call to EAD in my enlisted grade, recoupment of scholarship benefits or release. If I have more than two (three with an approved waiver) dependents incapable of self-care I do not meet enlisted accession standards and cannot be subject to EAD in my enlisted grade. I can only be subject to recoupment or release.

1st Ind, Application

Cadet Signature / Date Cadre Signature

2nd Ind, Enlistment

Cadet Signature / Date Cadre Signature

NOTE: Cadet and detachment representative must sign statement at time of application. Statement must be recertified by the cadet and detachment representative at time of enlistment.

IMPORTANT

All of the items after this page require an AFROTC Cadre member present to witness you sign

RECORD OF EMERGENCY DATA

PRIVACY ACT STATEMENT

AUTHORITY: 5 USC 552, 10 USC 655, 1475 to 1480 and 2771, 38 USC 1970, 44 USC 3101, and EO 9397 (SSN).
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.
ROUTINE USES: None.
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.

INSTRUCTIONS TO SERVICE MEMBER

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 fiance), 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.

INSTRUCTIONS TO CIVILIANS

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.

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.

SECTION 1 - EMERGENCY CONTACT INFORMATION

1. NAME *(Last, First, Middle Initial)*	2. SSN

3a. SERVICE/CIVILIAN CATEGORY	b. REPORTING UNIT CODE/DUTY STATION
☐ ARMY ☐ NAVY ☐ MARINE CORPS ☐ AIR FORCE ☐ DoD ☐ CIVILIAN ☐ CONTRACTOR	

4a. SPOUSE NAME *(If applicable) (Last, First, Middle Initial)*	b. ADDRESS *(Include ZIP Code)* AND TELEPHONE NUMBER
☐ SINGLE ☐ DIVORCED ☐ WIDOWED	

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)*

SECTION 2 - BENEFITS RELATED INFORMATION

11a. BENEFICIARY(IES) FOR DEATH GRATUITY *(Military only)*	b. RELATIONSHIP	c. ADDRESS *(Include ZIP Code)* AND TELEPHONE NUMBER	d. PERCENTAGE

12a. BENEFICIARY(IES) FOR UNPAID PAY/ALLOWANCES *(Military only)* NAME AND RELATIONSHIP	b. ADDRESS *(Include ZIP Code)* AND TELEPHONE NUMBER	c. PERCENTAGE

13a. PERSON AUTHORIZED TO DIRECT DISPOSITION (PADD) *(Military only)* NAME AND RELATIONSHIP	b. ADDRESS *(Include ZIP Code)* AND TELEPHONE NUMBER

14. CONTINUATION/REMARKS

15. SIGNATURE OF SERVICE MEMBER/CIVILIAN *(Include rank, rate, or grade if applicable)*	16. SIGNATURE OF WITNESS *(Include rank, rate, or grade as appropriate)*	17. DATE SIGNED *(YYYYMMDD)*

DEPARTMENT OF THE AIR FORCE
AIR UNIVERSITY (AETC)

MEMORANDUM OF UNDERSTANDING FOR DRUG TESTING POLICY FOR CADETS PARTICIPATING IN SENIOR RESERVE OFFICER TRAINING CORPS (SROTC)

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.

_____//_____ _____

Cadet Signature and Date

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

_____

Printed Name and Signature Witness (or Notary) and Date

USAF DRUG AND ALCOHOL ABUSE CERTIFICATE

PRIVACY ACT STATEMENT

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.

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.

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.

DISCLOSURE: Voluntary; however, failure to furnish personal identification information my negate the enlistment/commissioning application.

SORN(s): F036 AF PC H, Air Force Enlistment/Commissioning Records System.

SECTION I. DEFINITION OF TERMS

ADVERSE ADJUDICATION: An adverse adjudication *(adult or juvenile)* 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.

AIR FORCE: Includes active Air Force, Air Force Reserve, Air National Guard, and Air Force Academy.

ALCOHOL ABUSE: Alcohol use confirmed by competent medical authority that the individual is emotionally, mentally, or physically dependent on alcohol. 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.

DRUG ABUSE: The illegal, wrongful, or improper use of marijuana, any narcotic substance, hallucinogens, or any illegal drug.

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, *(to include lysergic acid diethyamide (LSD), phencyclidine (PCP), tetrahydrocannabinal (THC) in non-marijuana form, and others), opium, morphine, heroin, dilaudid, codeine, Demerol, inhalants (paint, glue, and others), amphetamines (speed),* methamphetamines *(ice),* barbiturates*(downers),* and anabolic steroids.

MARIJUANA: Any intoxicating organic or synthetic cannabis or tetrahydrocannabinal (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 salviadivinorum or salvinorum or any product known under such names as "Spice", "Genie", "DaScents", "Zohia", "K-2", and "KO Knockout 2" or variant thereof by whatsover name it may be called.

SECTION II. CERTIFICATION AT TIME OF APPLICATION

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.

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? *(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.)*		
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 *(including marijuana) 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 *(including marijuana)* 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.	

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.

DATE	NAME *(Last, First, M.I.)* AND SSN OF APPLICANT	SIGNATURE

WITNESS		
I CERTIFY THE ABOVE INDIVIDUAL SIGNED THIS CERTIFICATE OF HIS/HER OWN FREE WILL		
DATE	NAME *(Last, First, M.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 *(Last, First, M.I.)* AND SSN OF APPLICANT	SIGNATURE

WITNESS		
I CERTIFY THE ABOVE INDIVIDUAL SIGNED THIS CERTIFICATE OF HIS/HER OWN FREE WILL		
DATE	NAME *(Last, First, M.I.)* AND GRADE OF WITNESS	SIGNATURE

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)
REPORT OF MEDICAL HISTORY

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

OMB No. 0704-0396
OMB approval expires Nov 30, 2009

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO DODMERB/DR, 8034 EDGERTON DRIVE, SUITE 132, USAF ACADEMY CO 80840-2200.

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, USC 133, 3012, 5031, 8013, and Executive Order 9397.

PRINCIPAL PURPOSE: To determine medical acceptability or update a medical file as part of the application process to a United States Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Program, or the Uniformed Services University of the Health Sciences (USUHS).

ROUTINE USES: This information may be disclosed to the Coast Guard Academy and Merchant Marine Academy for applications to their Academies.

DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy. Use of the Social Security Number (SSN) is used for positive identification of records.

1. NAME *(Last, First, Middle Initial)*	2. SOCIAL SECURITY NUMBER	3. TELEPHONE NO. *(Include area code)*

4. PURPOSE OF EXAMINATION	5. EXAMINATION FACILITY OR EXAMINER AND ADDRESS *(Include ZIP Code)*	6. DATE OF EXAMINATION *(YYYYMMDD)*

Mark each item "Yes" or "No". **EVERY QUESTION MUST BE ANSWERED, OR PROCESSING DELAYS WILL OCCUR.** Every "Yes" must be explained in Block 83, REMARKS, on the back of the form. Mark and explain each item to the best of your ability. Be perfectly honest! Your medical records may be requested to clarify your medical history.

7. HAVE YOU EVER OR DO YOU NOW USE ANY OF THE FOLLOWING:	YES	NO
Amphetamines		
Barbiturates		
Cocaine		
Narcotic Drugs		
Marijuana		
Alcohol *(Amount, frequency, treatment, if any)*		
Chemical Inhalants		
Hallucinogens		

DO YOU	YES	NO
8. Wear glasses		
9. Wear contact lenses or corneal eye retainers *(If Yes, complete 9a.)*		
10. HAVE YOU EVER HAD YOUR VISION IMPROVED BY METHODS OTHER THAN STATED IN QUESTIONS 8 OR 9?		

9a. If you wear contact lenses, how many days have they been removed prior to this examination?

Less than 3	3 - 20	21 or over

Type lens: Hard Soft

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
11. Eye trouble *(exclude glasses, contact lenses)*		
12. Have fluctuating vision or double vision		
13. Have any allergies		
14. Take any medications regularly		
15. Stutter or stammer		
16. Frequent, severe, or migraine headaches		
17. Fainting or dizzy spells		
18. Periods of unconsciousness		
19. Head injury or skull fracture		
20. Epilepsy, seizures or convulsions		
21. Loss of memory *(amnesia)*		
22. Depression, anxiety, excessive worry, or nervousness		
23. Any mental condition or illness		
24. Frequent trouble sleeping		
25. Hearing loss		
26. Ear, nose, or throat trouble		
27. Sinusitis or sinus trouble		
28. Hay fever or allergic rhinitis		
29. Tooth/gum trouble, or current orthodontics		
30. Thyroid trouble		
31. Chronic cough or lung disease		
32. Asthma or wheezing		
33. Unusual shortness of breath		
34. Pain or pressure in chest		
35. Palpitation or pounding heart		
36. Heart trouble or heart murmur		
37. High blood pressure		
38. Coughed up or vomited blood		
39. Stomach, liver, or intestinal trouble		
40. Gallbladder trouble or gallstones		
41. Hepatitis *(yellow jaundice)*		
42. Hemorrhoids or rectal disease		
43. Black or bloody stools		
44. Frequent or painful urination		
45. Bed wetting after age 12		
46. Blood, protein, or sugar in urine		
47. History of diabetes		
48. Kidney stone		
49. Hernia or rupture		
50. Any bone or joint problem, injuries, surgery or medical treatment		
51. Steel pins, plates, or staples in any bones		
52. Wear a bone or joint brace or support		
53. Back pain or trouble		
54. Paralysis or weakness		
55. Foot trouble/use orthotics		
56. Rheumatic fever		
57. Tuberculosis or positive TB test		
58. Sexually transmitted disease *(syphilis, gonorrhea, herpes)*		
59. Skin conditions such as acne, psoriasis, hand or foot rashes, eczema, or dry skin		
60. Adverse reaction to vaccines, drugs, medicines, foods, insect bites or stings		
61. Eating disorder		
62. Recent gain or loss of weight		
63. Excessive bleeding or easy bruising		
64. Tumor, growth, cyst, or cancer		
65. Considered or attempted suicide		

HAVE YOU EVER	YES	NO
66. Sleepwalking episodes after age 12		
67. Easily fatigued		
68. Motion sickness *(car, train, sea, or air)*		
69. X-ray or other radiation therapy		
70. Sensitivity to chemicals, dust, sunlight, etc.		
71. Learning disabilities or speech problems		
72. Been refused employment or been unable to hold a job or stay in school because of:		
a. Inability to perform certain movements?		
b. Inability to assume certain positions?		
c. Other medical reasons?		
73. Been rejected for or discharged from military service because of physical, mental or other reasons?		
74. Been denied or rated up for life insurance?		
75. Received or applied for pension or compensation for existing disability?		
76. Had or been advised to have, any surgical operations?		
77. Consulted, or been treated by clinics, hospitals, physicians, healers, or other practitioners for other than minor illnesses?		
78. Had any injury or illness other than those already noted?		

FEMALES ONLY *(Complete Items 79 - 82)*	YES	NO
79. Been treated for a female disorder, painful periods, or cramps		
80. Had a change in menstrual pattern		
81. Are you now pregnant?		
82. Date of last menstrual period *(YYYYMMDD)*		

83. REMARKS. Applicant use only. Every "yes" response in items 7 through 81 must be explained in the space provided. Give specific dates and details including names of physicians and hospitals or clinics and the current status of the condition. If additional space is required, continue on a separate sheet and attach to this form.

84. CERTIFICATION. 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 physicians, 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.

TYPED OR PRINTED NAME OF EXAMINEE/APPLICANT	SIGNATURE OF EXAMINEE/APPLICANT	DATE SIGNED *(YYYYMMDD)*

85. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA. Examiner shall comment on all "Yes" and blank answers, indicating the item number before each comment. Develop by interview any additional medical history deemed important, and record significant findings here. If additional space is required, continue on a separate sheet and attach to this form.

86. EXAMINER			87. NUMBER OF ATTACHED SHEETS
TYPED OR PRINTED NAME OF EXAMINER	SIGNATURE OF EXAMINER	DATE SIGNED *(YYYYMMDD)*	

Reset