CCHQ USE ONLY: Date Avail: _____ **Cat:** _____ **Trn Code:** _____ **Appt Type:** _____ **Age:** _____ **Grad Date:** _____

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service Commissioned Corps

OMB No. 0937-0025
Expiration: 12/31/2019

APPLICATION FOR APPOINTMENT AS A COMMISSIONED OFFICER IN THE COMMISSIONED CORPS OF THE U.S. PUBLIC HEALTH SERVICE

BEFORE COMPLETING THE APPLICATION, READ ATTACHED INSTRUCTIONS CAREFULLY. GIVE COMPLETE ANSWERS TO ALL ITEMS.

TYPE OR PRINT IN INK. If additional space is needed, attach an 8 ½ x 11 inch sheet of paper. Include your name, present mailing address, social security number, and the pertinent item numbers on each sheet so used. All material submitted becomes the property of the Federal Government and will not be returned. Part of the information will be used for a suitability/background investigation. **YOU MUST SIGN THIS APPLICATION ON PAGE 6 OR YOUR APPLICATION WILL NOT BE PROCESSED**. The Public Health Service Commissioned Corps.

Submit signed original and a clearly readable copy (photocopy acceptable) with **ORIGINAL SIGNATURE** to: Commissioned Corps Headquarters (CCHQ), 1101 Wootton Parkway, 3rd Floor,Suite 300, Rockville, MD 20852. Facsimiles will not be accepted. *(If you print, make sure you print legibly.)*

1a. FULL NAME *(Last, First, Middle)* *(Maiden, if any)*

2. SOCIAL SECURITY NUMBER __ __ __ – __ __ – __ __ __ __

3a. DATE OF BIRTH *(MM/DD/YYYY)* __ __ / __ __ / __ __ __ __

1b. OTHER NAMES USED *(Continue in Item 35 if needed)* From: *(MM/YYYY)* Through: *(MM/YYYY)*

_____ __ __ / __ __ __ __ __ __ / __ __ __ __

_____ __ __ / __ __ __ __ __ __ / __ __ __ __

3b. PLACE OF BIRTH *(City and State, or Foreign City and Country)*

4. PROFESSION OR INTENDED PROFESSION *(e.g., Chemist, Nurse, Physician)*

1c. GENDER ☐ MALE ☐ FEMALE

5. CITIZENSHIP *(Only United States citizens may be appointed to the Public Health Service Commissioned Corps)*

☐ NATIVE* ☐ If NATURALIZED *(Answer A, B, C, D)*

A. Entered: Month _____ Day _____ Year _____
B. Naturalized: Month _____ Day _____ Year _____
C. Naturalization Number: _____
D. Person to whom number was issued: _____
Place Naturalized: _____

** If U.S. citizen born abroad, provide Consulate Report of Birth or other proof of U.S. citizenship.*

6. TYPES OF DUTY(IES) FOR WHICH YOU ARE APPLYING
(Indicate all that are applicable and appropriate, Dates MM/YYYY)

☐ General Duty (extended Active Duty • Full-time)
Available for Active Duty:
__ __ / __ __ __ __

☐ Junior COSTEP *(Applicant must be a full-time student)*
From: __ __ / __ __ __ __
To: __ __ / __ __ __ __

☐ Senior COSTEP *(Applicant must be a full-time student)*
From: __ __ / __ __ __ __
To: __ __ / __ __ __ __

7. CURRENT INFORMATION FOR CONTACTING YOU *(YOU MUST NOTIFY THE CCHQ) IMMEDIATELY OF ANY CHANGES)*
Applicant MUST complete the following:

Mail: Contact Name: _____
Street: _____
City: _____
State: __ __ ZIP: __ __ __ __ __ + __ __ __ __

Telephone (Incl. Area Code): Current: (__ __ __) __ __ __ – __ __ __ __
Cell: (__ __ __) __ __ __ – __ __ __ __
Business: (__ __ __) __ __ __ – __ __ __ __ Ext. _____
E-Mail: _____

8. "PERMANENT" INFORMATION FOR CONTACTING YOU

Mail: Contact Name: _____
Street: _____
City: _____
State: __ __ ZIP: __ __ __ __ __ + __ __ __ __

Telephone (Include Area Code):
Current: (__ __ __) __ __ __ – __ __ __ __
Business: (__ __ __) __ __ __ – __ __ __ __ Ext. _____

Any additional information should be listed in Item 35.

9. BASIC EDUCATION AND PROFESSIONAL TRAINING *(Include below, all degrees you have earned or training you will have completed by the time you are available for appointment. Foreign medical graduates must submit a copy of ECFMG with application. Official transcripts to include final or latest grading period for all college, graduate, and professional training **MUST BE SUBMITTED BEFORE YOU CAN BE APPOINTED**.)*

COLLEGE, UNIVERSITY, OR OTHER INSTITUTION *List chronologically • latest first* *(Include City, State, and ZIP)*	DATES ATTENDED FROM *(MM/DD/YYYY)*	DATES ATTENDED TO *(MM/DD/YYYY)*	TOTAL HOURS CREDIT *(Specify)* Qtr. or Sem.	MAJOR	DEGREE	OFFICIAL NUMBER YEARS IN PROGRAM	DEGREE REQUIREMENTS FULFILLED *(MM/YYYY)*	DEGREE CONFERRED OR WILL BE CONFERRED *(MM/YYYY)*

INTERNSHIP OR RESIDENCY COMPLETED (MUST PROVIDE CERTIFICATE), CURRENTLY SERVING, OR SCHEDULED TO COMMENCE

HOSPITAL OR INSTITUTION *(Include City, State, and ZIP)*	FROM *(MM/YYYY)*	TO *(MM/YYYY)*	SPECIFY TYPE AND SPECIALTY *(if applicable)* *(e.g. Rotating, Mixed, or Straight, Categorical, Surgery, Family Practice)*

10. UNIFORMED SERVICE - List below in chronological order all service you have had in the ARMY, NAVY, AIR FORCE, MARINE CORPS, COAST GUARD, COMMISSIONED CORPS OF THE NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION, and PUBLIC HEALTH SERVICE COMMISSIONED CORPS. **NOTE**: If U.S. Public Health Service, include PHS Serial Number. Include any present Uniformed Services affiliations: PHS, Reserve Unit, ROTC commitment, etc. **Except for PHS affiliation, you will soon be asked to initiate a request for inter-service transfer, conditional release, or to provide proof of discharge, as may be applicable to your situation. No immediate action is required. Total active service time includes full-time active duty plus short tours. Do not add in reserve time when not on active reserve duty.**

BRANCH OF SERVICE Example: Army, Navy, etc.	REGULAR OR RESERVE COMPONENT	HIGHEST RANK HELD	DUTY FROM: *(MM/DD/YYYY)*	DUTY TO: *(MM/DD/YYYY)*	ACTIVE OR INACTIVE DUTY	TOTAL *ACTIVE* NON-PUBLIC HEALTH SERVICE TIME *(In years and months)*

11. Were you ever rejected for duty in any branch of a Uniformed Service?
☐ Yes ☐ No If "Yes," state when and where rejected and cause: _____

12. DEPENDENTS INFORMATION (Full name of spouse and full name(s) and date(s) of birth of child(ren) and/or other dependent(s)): *(Continue in Item 35 if needed)*

(Name)	*(Relationship)*	*(Date of Birth: MM/DD/YYY)*
	SPOUSE	__ __ / __ __ / __ __ __ __
		__ __ / __ __ / __ __ __ __
		__ __ / __ __ / __ __ __ __

Indicate Answers by Placing an "X" in the Appropriate Column.	YES	NO
13. Have you ever received a Federal Government scholarship? If Yes, check appropriately: ☐ Indian Health Service ☐ National Health Service Corps ☐ Other *Describe:* _____ Length of Service obligation: _____ Years Has obligation been fulfilled? ☐ Yes ☐ No	☐	☐
14. Have you EVER been fired from a job or quit a job after being told you would be fired? *(If "Yes," explain in item 35.)*	☐	☐
15. Have you EVER received a military discharge that was not honorable? *(If "Yes," explain in item 35.)*	☐	☐
16. Have you EVER been arrested and/or convicted for any offense, by any police officer, sheriff, marshal, or any other type of law enforcement officer? Please include any arrests that did not result in a conviction or may have been dropped or expunged. *(If "Yes," explain in item 35.)*	☐	☐
17. Have you EVER been charged with any felony offense? *(If "Yes," explain in item 35.)*	☐	☐
18. Have you EVER been charged with an offense (misdemeanor or felony) that involved violence including assault, battery, domestic violence, or threats against persons? *(If "Yes," explain in item 35.)*	☐	☐
19. Have you EVER been charged with a firearms or explosives offense? *(If "Yes," explain in item 35.)*	☐	☐
20. Have you EVER been charged with any offense(s) related to alcohol or drugs? *(If "Yes," explain in item 35.)*	☐	☐
21. Have you EVER illegally used a controlled substance (i.e., marijuana, cocaine, crack cocaine, narcotics, stimulants, hallucinogens, steroids, depressants, inhalants, or prescription drugs? *(If "Yes," explain in item 35.)*	☐	☐
22. Are you delinquent on the repayment of any Federal debt(s)? *(If "Yes," explain in item 35.)* (Examples of Federal debt include delinquent taxes, audit disallowances, guaranteed or direct student loans, FHA loans, and other miscellaneous administrative debts. The definition of delinquency for the purposes of direct and guaranteed loans are any loan more than 31 days past due on a scheduled payment. Deferred loans are not considered delinquent.)	☐	☐
23. Are you a conscientious objector to military service? (If "No," go to Item 25.)	☐	☐
24. If you are a conscientious objector, are you willing to serve in a noncombatant position? (**NOTE:** By Executive Order, the PHS Commissioned Corps may be militarized during times of national emergency and does have officers serving in support roles at all times. If in this Item (24) you state an objection, you will be precluded from appointment in the Commissioned Corps of the U.S. Public Health Service.)	☐	☐

25. REFERENCES: List the names of four individuals who have knowledge of your "knowledge, skills, and abilities," including your most recent employer/supervisor, with whom you have had professional affiliation or training at some time during the past 7 years. Include, where applicable, Dean of College; Dean of Graduate or Professional school; Director of Intern Training Program; Director of Graduate, Post-Graduate, Residency, or Specialty training; chairperson of departments in which graduate or professional work was taken; or employment supervisors. Forward to these individuals form PHS-1813, "Reference Request for Applicants to the PHS Commissioned Corps."

FULL NAME	PROFESSIONAL RELATIONSHIP TO APPLICANT	BUSINESS ADDRESS *(Organization and Street, City, State, ZIP, Telephone)*
1)		E-mail address: Phone:
2)		E-mail address: Phone:
3)		E-mail address: Phone:
4)		E-mail address: Phone:

26. LIST STATES GRANTING FULL/UNRESTRICTED PROFESSIONAL LICENSES/CERTIFICATES/REGISTRATIONS *(Include license or registry number and expiration date and **provide a copy of the license/certificate/registration**.) NOTE: Nurses must provide a photocopy of NCLEX certificate or other proof that this was the licensure examination taken.*

LICENSE TYPE/NUMBER	STATE	STATUS *(e.g., Active, Expired, Suspended, etc.)*	EXPIRATION DATE *(If applicable)*

27. DRUG ENFORCEMENT ADMINISTRATION (DEA) CONTROLLED SUBSTANCE REGISTRATION INFORMATION ***(If you were never registered, so state.)***

A. List all jurisdictions (past and present) where you are or were registered under Title 21, U.S. Controlled Substances Act, and provide your DEA controlled substance registration number for each jurisdiction.

(Explain all "Yes" answers in Item 35.)	YES	NO
B. Has your registration under this Act ever been denied, suspended, revoked, refused renewal, or voluntarily surrendered?	☐	☐
C. Have you ever been charged with, or are currently facing charges of, a violation of the Controlled Substance Act?	☐	☐

28. STATUS IN PROFESSIONAL U.S. BOARDS *(Indicate date and type of board, and whether Board Eligible, Board Certified, or Board Examination has been taken. **Submit copy of ECFMG Certificate and Board Certification, if any.**)*

29. PROFESSIONAL PRACTICE QUESTIONS - If your answer to any of the following is "Yes," provide full details in item 35 but do not disclose specific medical information. *(Questions must be answered even if not in a field where licensure is required.)*	YES	NO
A. Have you EVER been denied membership or renewal thereof, or been subject to disciplinary proceedings by any medical or professional organization?	☐	☐
B. Have you EVER lost or had your professional practice license in any jurisdiction denied, restricted, limited, suspended, revoked, cancelled or placed on probation?	☐	☐
C. Have liability claims been filed against you, or against a hospital, corporation, or government based on a case under your care?	☐	☐
D. Have judgments or settlements been made against you, or against a hospital, corporation, or government based on a case directly under your care?	☐	☐
E. Have you EVER had, or are you about to have, your professional liability insurance declined, canceled, issued on special terms, or refused renewal?	☐	☐
F. Has your license EVER been subjected to probation either voluntarily or involuntarily?	☐	☐
G. Have any disciplinary actions or investigations been initiated against you by any State licensure board?	☐	☐
H. Have you EVER been cautioned, reprimanded, disciplined, censured and/or fined, by any local, State or Federal agency, licensing board, hospital medical board/staff, any institution, or any other professional organization/national professional society or regulatory agency?	☐	☐
I. Have you EVER voluntarily or involuntarily withdrawn your application for clinical privileges or terminated request for clinical privileges before a hospital or health facility's governing board made a decision?	☐	☐
J. Have any or all of your privileges at any health care facility EVER been, or are about to be limited, suspended, revoked, refused renewal, or voluntarily surrendered?	☐	☐
K. Have you EVER been reprimanded, censured, excluded, suspended and/or disqualified from participating in or voluntarily withdrawn to avoid an investigation by Medicare, Medicaid, TRICARE, and/or any other governmental health related programs?	☐	☐
L. Has any information pertaining to you, including malpractice judgments and or disciplinary action EVER been reported to the National Practitioner Data Bank or any other practitioner data bank?	☐	☐
M. Has your Federal DEA number and/or state controlled substance license EVER been suspended revoked, restricted, limited, or relinquished either voluntarily or involuntarily?	☐	☐
N. Have you EVER withdrawn from, or been suspended, dismissed, or expelled from a professional school or postgraduate training program or has any third party ever attempted to have you withdrawn, suspended, dismissed or expelled from a professional school or postgraduate training program?	☐	☐
O. Have you EVER been placed on probation or taken a leave of absence from a medical, dental, or other graduate school or postgraduate training program?	☐	☐
P. Do you have, or has it been suggested to you that you have, a history including the present, of any physical, mental, or emotional impairment that either you or an objective third party might think would limit your ability to meet the duties associated with clinical staff membership and which could require an accommodation for you to exercise your clinical privileges and clinical staff duties completely and safely? *(if yes, please describe the accommodation needed.)*	☐	☐
Q. Are you currently engaged in illegal use of any legal or illegal substances?	☐	☐
R. Are you currently participating in a supervised rehabilitation program and/or professional assistance program, which monitors you for alcohol and/or substance abuse?	☐	☐

30. Provide the names and addresses (past and present) of all of your professional liability insurers and your policy numbers.

31. EMPLOYMENT HISTORY

Begin with current or most recent work or volunteer experience and work backward in time. Account for any periods of unemployment on the last line of the experience blocks in order of occurrence. Do not list any employment prior to commencing undergraduate school. For your PROFESSIONAL EXPERIENCE AND WORK RECORD, include professional training positions not reflected in Item 9. Include assistantships, apprenticeships, and fellowships. Describe your duties, including: (a) professional skills involved; (b) degree of responsibility; (c) complexity of duties; (d) extent of supervision received and exercised; (e) extent of public contact; and (f) extent of influence on policy. Provide ***all*** work experience - use photocopies of this page 4 to continue. **Important: No part of this application may be completed by writing "See CV." All parts of the application must be completed. Missing information will adversely affect your rank, pay, and future promotions.**

DATES EMPLOYED *(MM/YYYY)* From: __ __ / __ __ __ __ To: __ __ / __ __ __ __	EMPLOYER / VERIFIER NAME / MILITARY DUTY LOCATION		YOUR POSITION TITLE / MILITARY RANK	
EMPLOYER 'S / VERIFIER'S STREET ADDRESS	CITY *(Country)*	STATE	ZIP *(+4)* __ __ __ __ __ + __ __ __ __	TELEPHONE NUMBER ( )
STREET ADDRESS OF JOB LOCATION	CITY *(Country)*	STATE	ZIP *(+4)* __ __ __ __ __ + __ __ __ __	TELEPHONE NUMBER ( )
SUPERVISOR'S NAME & STREET ADDRESS *(If different than Job Location)*	CITY *(Country)*	STATE	ZIP *(+4)* __ __ __ __ __ + __ __ __ __	TELEPHONE NUMBER ( )
AVERAGE NUMBER OF HOURS PER WEEK (*Indicate full or part-time*)	KIND OF BUSINESS OR ORGANIZATION *(e.g., education, health, social services, etc.)*			

REASON FOR LEAVING OR WISHING TO LEAVE

DESCRIPTION OF WORK *(Describe your specific duties, responsibilities, and accomplishments in this job.)*

DATES EMPLOYED *(MM/YYYY)* From: __ __ / __ __ __ __ To: __ __ / __ __ __ __	EMPLOYER / VERIFIER NAME / MILITARY DUTY LOCATION		YOUR POSITION TITLE / MILITARY RANK	
EMPLOYER 'S / VERIFIER'S STREET ADDRESS	CITY *(Country)*	STATE	ZIP *(+4)* __ __ __ __ __ + __ __ __ __	TELEPHONE NUMBER ( )
STREET ADDRESS OF JOB LOCATION	CITY *(Country)*	STATE	ZIP *(+4)* __ __ __ __ __ + __ __ __ __	TELEPHONE NUMBER ( )
SUPERVISOR'S NAME & STREET ADDRESS *(If different than Job Location)*	CITY *(Country)*	STATE	ZIP *(+4)* __ __ __ __ __ + __ __ __ __	TELEPHONE NUMBER ( )
AVERAGE NUMBER OF HOURS PER WEEK (*Indicate full or part-time*)	KIND OF BUSINESS OR ORGANIZATION *(e.g., education, health, social services, etc.)*			

REASON FOR LEAVING OR WISHING TO LEAVE

DESCRIPTION OF WORK *(Describe your specific duties, responsibilities, and accomplishments in this job.)*

31. EMPLOYMENT HISTORY *(Continued)*

DATES EMPLOYED *(MM/YYYY)* From: __ __ / __ __ __ __ To: __ __ / __ __ __ __	EMPLOYER / VERIFIER NAME / MILITARY DUTY LOCATION			YOUR POSITION TITLE / MILITARY RANK
EMPLOYER 'S / VERIFIER'S STREET ADDRESS	CITY *(Country)*	STATE	ZIP *(+4)* __ __ __ __ __ + __ __ __ __	TELEPHONE NUMBER ( )
STREET ADDRESS OF JOB LOCATION	CITY *(Country)*	STATE	ZIP *(+4)* __ __ __ __ __ + __ __ __ __	TELEPHONE NUMBER ( )
SUPERVISOR'S NAME & STREET ADDRESS *(If different than Job Location)*	CITY *(Country)*	STATE	ZIP *(+4)* __ __ __ __ __ + __ __ __ __	TELEPHONE NUMBER ( )
AVERAGE NUMBER OF HOURS PER WEEK (*Indicate full or part-time*)	KIND OF BUSINESS OR ORGANIZATION *(e.g., education, health, social services, etc.)*			

REASON FOR LEAVING OR WISHING TO LEAVE

DESCRIPTION OF WORK *(Describe your specific duties, responsibilities, and accomplishments in this job.)*

32. ADDITIONAL SKILLS AND QUALIFICATIONS

FOREIGN LANGUAGE: Do you have adequate competency to use any language(s) in performance of duty? ☐ YES ☐ NO If "Yes," specify language and proficiency level. **1** = Elementary Proficiency, **2** = General Professional Proficiency, **3** = Functionally Native Proficiency

Language	Proficiency	Language	Proficiency

HONORS AND AWARDS (Acquired by academic or non-academic experience.)

NONDEGREE RELATED TRAINING (e.g., computer skills, public speaking, leadership recognition, American Council of Learned Societies (ACLS) fellowship program, Basic Life Support (BLS), Cardiopulmonary Resuscitation (CPR), Emergency Medical Services, etc.)

LIST CURRENT OR FORMER MEMBERSHIP IN PROFESSIONAL ASSOCIATIONS (Also indicate office(s) held and committee membership(s).)

33. TYPES OF ASSIGNMENTS IN WHICH YOU ARE INTERESTED

Officers are required to serve in any area or climate or wherever the needs of the Public Health Service Commissioned Corps may require.

Do you have a preference for assignment to a particular program? ☐ YES ☐ NO If "Yes," which program? (e.g., Indian Health Service, Federal Bureau of Prisons, etc.)

GEOGRAPHIC AREAS IN WHICH YOU PREFER TO SERVE *(i.e., Department of Health and Human Services Regional Areas are as follows: Region I: CT, MA,NH,RI,VT,ME; Region II: NY,NJ,PR,VI; Region III: DE,MD,PA,VA,WV,DC; Region IV: AL,FL,GA,KY,MS,NC,SC,TN; Region V: IL,IN,MI,MN,OH,WI; Region VI: AR,LA,NM,OK,TX; Region VII: IA,KS,MO,NE; Region VIII: CO,MT,ND,SD,WY,UT; Region IX: AZ,CA,HI,NV,GU,AP,AS; Region X: AK,ID,OR,WA.)*

34. Do you have any personal objection to complying with Public Health Service Commissioned Corps uniform and grooming standards?

☐ YES ☐ NO

35. SPACE FOR DETAILED ANSWERS

(Indicate item numbers to which the answers apply. If more space is required, attach an 8 ½ x 11 inch sheet of paper. **Write your name, present mailing address, and social security number on each sheet. NOTE: Specific personal medical information should not be disclosed.)**

ATTENTION - THIS STATEMENT MUST BE SIGNED BY ALL APPLICANTS
Read the following paragraphs carefully before signing this Statement.

A false answer to any question in this Statement may be grounds for not appointing you, or for dismissing you after appointment, and may be punishable by fine or imprisonment (U.S. Code, Title, 18, Section 1001). All the information you give will be considered in reviewing your application.

AUTHORITY FOR RELEASE OF INFORMATION

I have completed this Statement with the knowledge and understanding that any or all items contained herein may be subject to investigation prescribed by law or Presidential directive and I consent to the release of information concerning my capacity and fitness by employers, educational institutions, law enforcement agencies, and other individuals and agencies, to duly accredited investigators, Personnel Staffing Specialists, and other authorized employees of the Federal Government for that purpose. I hereby release from liability all representatives of the Federal Government for their acts performed in good faith and without malice in connection with evaluating my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to these representatives in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for appointment in the Commissioned Corps of the United States Public Health Service.

CERTIFICATION

I certify that all of the statements made by me are true, complete, and correct to the best of my knowledge and belief and are made in good faith. I am willing to serve in any area or climate or wherever the needs of the Commissioned Corps of the U.S. Public Health Service may require.

PRINT OR TYPE NAME AND SIGN IN INK	DATE

Privacy Act Notice

This statement is provided pursuant to the Privacy Act of 1974 (5 U.S.C. 552a). Our authority to collect this information is 42 U.S.C. 202 et seq.; and Executive Order 9397, "Numbering System for Federal Accounts Relating to Individuals Persons."

The information provided on this form will become part of record systems 09-40-0001, "Public Health Service (PHS) Commissioned Corps General Personnel Records", "HHS/PSC/HRS." This information is collected in order to assess the qualifications of each applicant and make a determination whether the applicant meets the requirements to receive a commission. The information is used to make determinations on candidates/applicants seeking appointment to the Corps to assess whether they are suitable for life in the uniformed services based upon a review of a variety of assessment factors including, but not limited to: employment history, character, suitability investigation clearance, and a candidate's prior history of service in one of the uniformed services. Their potential for leadership as a commissioned officer and their ability to deal effectively with people is evaluated. Copies of these systems of records may be obtained by contacting the Commissioned Corps Headquarters, ATTN: Records Manager, Suite 300, 1101 Wootton Parkway, Rockville, MD 20852 This information will be used only as necessary in personnel administration processes carried out in accordance with established regulations and published notices of systems of records.

Effects of Nondisclosure

Completion of this form is mandatory. Failure to provide requested information will result in non-consideration for employment. Disclosure of the Social Security Number (SSN) is mandatory under provisions of Executive Order 9397 to obtain benefits and services as a commissioned officer inasmuch as the SSN is used to distinguish a record from those of commissioned officers who may have similar names and dates of birth. All statements are subject to verification.