



READJUSTMENT COUNSELING SERVICE SCHOLARSHIP PROGRAM (RCSSP) REQUEST FOR DEFERMENT

A participant may request a deferment of obligated service to complete an approved program of advanced clinical training. This document represents a request from you to delay the start of your Department of Veterans Affairs service obligation.

**Return the completed form to:
 RCSSP**

Readjustment Counseling Service (10RCS)
 Department of Veterans Affairs
 810 Vermont Ave., NW
 Washington, DC 20420.

THE PAPERWORK REDUCTION ACT OF 1995: This information is collected in accordance with section 3507 of the Paperwork Reduction Act of 1995. Therefore, we may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who complete this form will average 10 minutes. This includes the time it will take to follow instructions, gather the necessary facts, and fill out the form.

PRIVACY ACT NOTICE: The VA is asking you to provide the information on this form under the authority of 38 CFR, sections 17.545 through 17.553 (RCSSP) in order for VA to determine the applicant's eligibility to receive a scholarship award. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information for: civil or criminal law enforcement; congressional communications; the collection of money owed to the United States; litigation in which the United States is a party or has interest; the administration of VA training and scholarship programs, including verification of the applicant's eligibility to participate; and personnel administration. You do not have to provide this information to VA but, if you do not, VA may be unable to process the applicant's request for a scholarship. If you give VA a social security number, VA will use it to obtain information relevant to determining whether to grant a scholarship, and to administer the applicant's scholarship, if awarded. It also may be used for other purposes authorized or required by law.

RCSSP

Participant's Name (<i>Last, First, Middle</i>):		Social Security Number:	
Address (<i>Include Street Address, City, State, and ZIP Code</i>):		Phone Number:	
		Email Address:	
Type of Residency/Fellowship/Clinical Program you Wish to Attend:	Length of Program:	Program Start Date (<i>MM/DD/YYYY</i>):	Anticipated Date Available for Service Obligation (<i>MM/DD/YYYY</i>):
Is your selection for this residency/fellowship/clinical program through a national match program? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Title of the Match Program:		What is the Notification Date (<i>MM/DD/YYYY</i>)?
Are all match sites/locations that you have applied to accredited by the nationally recognized accrediting body? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Accrediting Body:		
Name and Location of Residency/Fellowship/Clinical Site if Known:			

Name, Address and Telephone Number (*other than your own*) of a Person Through Whom you may Always be Reached:

Name of Secondary Contact (<i>Last, First, Middle</i>):	Phone Number:
Address (<i>Include Street Address, City, State, and ZIP Code</i>):	

If you have any questions please contact the Department of Veterans Affairs, Readjustment Counseling Service Clinical Team at
VHARCSClinicalOversight@va.gov

Signature _____ Date (*MM/DD/YYYY*) _____