

VOLUNTEER ROTATIONS
 CIVILIAN STUDENTS, RESIDENTS, FELLOWS
 MADIGAN ARMY MEDICAL CENTER

PRIVACY ACT STATEMENT

AUTHORITY : 5 U.S.C. 301, Departmental Regulations and E.O. 9397 (SSN).
PRINCIPLE PURPOSE : Telephone number and home address will be used to contact trainee regarding changes to rotations and to request additional information, if needed.
ROUTINE USES : In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, these records or information contained therein may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows: The Blanket Routine Uses' set forth at the beginning of the Army's compilation of systems notices also apply to this system.
DISCLOSURE : Disclosure of information is voluntary; however, failure to provide the requested information may delay information on the trainee rotation.

The following must be completed by the student or affiliated institution and submitted to the Graduate Medical Education Office at least 90 days prior to the rotation.

LAST NAME		FIRST NAME	MIDDLE NAME	DATE OF BIRTH
PLACE OF BIRTH (City & State)		SSN	U.S. CITIZEN *Non-U.S. Citizens are not accepted. <input type="checkbox"/> Yes <input type="checkbox"/> No	
SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	PHONE NUMBER (Include area code)		E-MAIL ADDRESS (Please provide 2 emails)	
ADDRESS				
NAME OF AFFILIATED INSTITUTION			NAME OF PROGRAM	
TYPE OF STUDENT (i.e., Family Practice Resident, PA, Pharmacy)		YEAR LEVEL (if applicable)	YEAR OF GRADUATION	
ROTATION BEGIN DATE	ROTATION END DATE		SERVICE ROTATING ON	

I certify that all statements made on this form are true, complete and correct to the best of my knowledge and belief, and are made in good faith.

SIGNATURE	DATE
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