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)*

AIR FORCE RESERVE OFFICER TRAINING CORPS
220TH CADET WING (PURDUE UNIVERSITY)

_____
(Date)

MEMORANDUM FOR _____
(Student)

FROM: AFROTC Det 220

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 Air Force Reserve officer Training Corps (AFROTC) and Department of Defense (DoD) agencies, as may be required by these agencies.

2. It is mutually understood that the purpose of this request for official copies of student records is necessary for AFROTC screening and evaluation of its present and potential cadet members, as well as, those cadets commissioned or disenrolled from the AFROTC program. It is further understood that the privacy of the information collected by means of 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.

_____
AFROTC Det 220 Representative

1st Ind, _____ _____
(Student) *(Date)*

MEMORANDUM FOR AFROTC Det 220

I have read and understand your request for official copies of my school records. I hereby voluntarily consent to the release of such records as you may require in your above stated request and have signed the authorization for appropriate school officials to release to Detachment 220 personnel or to the appropriate DoD agency any and all official records, files and data for their use as requested above.

_____
Student's signature OR Parent's signature
(if student is under 18 years of age)

AIR FORCE RESERVE OFFICER TRAINING CORPS
220TH CADET WING (PURDUE UNIVERSITY)

_____
(Date)

MEMORANDUM FOR PURDUE UNIVERSITY

FROM: _____
(Student)

SUBJECT: Request and Consent for Release of Student Records

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 220 to conduct official AFROTC business. I therefore authorize appropriate school officials to release to Detachment 220 personnel or to the appropriate Department of Defense agencies any and all official records, files and data for their use in official AFROTC business.

_____
Student's signature OR Parent's signature
(if student is under 18 years of age)

RECORD OF EMERGENCY DATA

OMB No. 0704-0649
Expires 02/28/2026

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE ABOVE ORGANIZATION.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, Under Secretary of Defense for Personnel and Readiness; 10 U.S.C. 655, Designation of persons having interest in status of a missing member; 10 U.S.C. 1475, Death gratuity: death of members on active duty or inactive duty training and of certain other persons; 10 U.S.C. 1476, Death gratuity: death after discharge or release from duty or training; 10 U.S.C. 1477, Death gratuity: eligible survivors; 10 U.S.C. 1478, Death gratuity: amount; 10 U.S.C.1479, Death gratuity: delegation of determinations, payments; 10 U.S.C.1480, Death gratuity: miscellaneous provisions; 10 U.S.C. 1481, Recovery, care, and disposition of remains: decedents covered, 10 U.S.C.1482, Expenses incident to death ; 10 U.S.C. 2771, Final settlement of accounts: deceased members; 38 U.S.C. 1970, Beneficiaries; payment of insurance; DoDI 1304.02, Accession Processing Data Collection Forms; and DoDI 1300.18, DoD Personnel Casualty Matters, Policies, and Procedures.

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, mission 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.

ROUTINE USES: Disclosure of records are generally permitted under 5 U.S.C. 522a(b) of the Privacy Act of 1974, as amended. To federal, state, local, and foreign (within Status of Forces agreements) law enforcement agencies or their authorized representatives in connection with litigation, law enforcement, or other matters under the jurisdiction of such agencies. Additional Routine uses are listed in the following applicable system of records notices:
Army: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570051/a0600-8-104b-ahrc/; https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570052/a0600-8-104b-ngb/
Navy: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570310/n01070-3/
Marine Corp: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570626/m01070-6/
Air Force: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-Component-Article-View/Article/569821/f036-af-pc-c/
Coast Guard: https://www.federalregister.gov/documents/2008/12/19/E8-29793/privacy-act-of-1974-united-states-coast-guard-014-military-pay-and-personnel-system-of-records
DoD-wide: https://www.federalregister.gov/documents/2022/12/16/2022-27145/privacy-act-of-1974-system-of-records

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 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.

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. DOD IDENTIFICATION NUMBER or SSN

3a. SERVICE/CIVILIAN CATEGORY
☐ ARMY ☐ NAVY ☐ MARINE CORPS ☐ DoD ☐ CIVILIAN ☐ CONTRACTOR
☒ AIR FORCE ☐ SPACE FORCE

b. REPORTING UNIT CODE/DUTY STATION
AFROTC Det 220

3c. MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

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

c. PHONE NUMBERS *(Home, Mobile, Other)*	d. PREFERRED LANGUAGE	e. DoD AFFILIATION

5. CHILDREN a. NAME *(Last, First, Middle Initial)*	b. RELATIONSHIP	c. DATE OF BIRTH *(YYYYMMDD)*	d. ADDRESS *(Include ZIP Code)* AND TELEPHONE NUMBER

6a. PARENT ONE NAME *(Last, First, Middle Initial)*	b. ADDRESS *(Include ZIP Code)* AND TELEPHONE NUMBERS *(Home, Mobile, Other)*

7a. PARENT TWO NAME *(Last, First, Middle Initial)*	b. ADDRESS *(Include ZIP Code)* AND TELEPHONE NUMBERS *(Home, Mobile, Other)*

8a. STEP PARENT ONE *(Last, First, Middle Initial)*	b. ADDRESS *(Include ZIP Code)* AND TELEPHONE NUMBERS *(Home, Mobile, Other)*

9a. STEP PARENT TWO *(Last, First, Middle Initial)*	b. ADDRESS *(Include ZIP Code)* AND TELEPHONE NUMBERS *(Home, Mobile, Other)*
10a. DO NOT NOTIFY PERSON DUE TO THEIR ILL HEALTH	b. NOTIFY INSTEAD
11a. DESIGNATED PERSON(S) *(Military: Duty Status - Whereabouts Unknown Civilian: Excused Absence-Whereabouts Unknown)*	b. ADDRESS *(Include ZIP Code)* AND TELEPHONE NUMBER
12. CONTRACTING AGENCY AND TELEPHONE NUMBER *(Contractors only)*	

SECTION 2 - BENEFITS RELATED INFORMATION

13a. BENEFICIARY(IES) FOR DEATH GRATUITY *(Military only)*	b. RELATIONSHIP	c. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER	d. PERCENTAGE
14a. BENEFICIARY(IES) FOR UNPAID PAY/ALLOWANCES *(Military only)* NAME AND RELATIONSHIP		b. ADDRESS *(Include ZIP Code)* AND TELEPHONE NUMBER	c. PERCENTAGE
15a. PERSON AUTHORIZED TO DIRECT DISPOSITION (PADD) *(Military only)* NAME AND RELATIONSHIP		b. ADDRESS *(Include ZIP Code)* AND TELEPHONE NUMBER	

16. CONTINUATION/REMARKS

17. SIGNATURE OF SERVICE MEMBER/CIVILIAN *(Include rank, rate, or grade if applicable)*	18. SIGNATURE OF WITNESS *(Include rank, rate, or grade as appropriate)*	19. DATE SIGNED *(YYYYMMDD)*

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

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
	N/A	AFROTC Det 220
4. RECRUITING OFFICE/TRAINING COMMAND ADDRESS *(City, State, ZIP Code)*	**5. DATE SIGNED** *(YYYYMMDD)*	**6. SIGNATURE**
West Lafayette, IN 47907		

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

10. APPROVED BY

(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.

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

AIR FORCE RESERVE OFFICER TRAINING CORPS
220TH CADET WING (PURDUE UNIVERSITY)

_____
(Date)

MEMORANDUM FOR _____
(Student)

FROM: AFROTC Det 220/CC

SUBJECT: Mail Access Authorization

From time to time, official United States Air Force (USAF) correspondence delivered to Detachment 220 addressed to cadets needs to be opened by the Commander or unit personnel. Access is for the verification and accuracy of contents only. Specific documents include commissioning assignments, cadet travel summaries and all Leave and Earning statements. These documents must be verified upon receipt to ensure their accuracy and to correct/report any discrepancies to Higher Headquarters. In accordance with the Privacy Act of 1974, cadets' permission for cadre members to access these records is needed. Therefore, cadets are asked to provide their payroll signature to serve as consent to access mail. Giving consent is strictly voluntary; however, cadets who do not consent to access will delay processing of critical documents essential to AFROTC matters. Only official USAF correspondence that is specifically approved by the Commander will be opened.

_____
Commander, AFROTC Det 220

1st Ind, _____ _____
(Student) *(Date)*

MEMORANDUM FOR AFROTC Det 220

I do/do not consent for AFROTC Detachemnt 220 cadre to access my official mail.

_____
Student's signature <u>OR</u> Parent's signature
(if student is under 18 years of age)

Attachment 4

DRUG DEMAND REDUCTION PROGRAM MOU

Figure A4.1. Drug Demand Reduction Program MOU.

DEPARTMENT OF THE AIR FORCE
AIR UNIVERSITY (AETC)

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

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 majority. Must be notarized if not signed in presence of detachment personnel)

_____
Printed Name and Signature Witness (or Notary) and Date

FASTSTART

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

(SSN) EMPLOYEE PAYROLL IDENTIFICATION NUMBER

EMPLOYEE NAME
(as on payroll records)
(Last, First, Initials)

TELEPHONE NUMBER (WORK) (HOME)

2. TYPE OF ACCOUNT

- ☐ Checking
- ☐ Savings

TYPE OF PAYMENT

- ☑ Net Pay
- ☐ Travel
- ☐ 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 Check Digit

ACCOUNT NUMBER

ACCOUNT TITLE
(Account Holder's Name)

FINANCIAL INSTITUTION NAME

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)
- ☐ Savings (whole dollar amounts only)
- ☐ Discretionary or Third Party

TYPE OF ACCOUNT (Check One)
- ☐ SAVINGS
- ☐ CHECKING

ACTION (Check One)
- ☐ START
- ☐ CANCEL
- ☐ CHANGE

AMOUNT (Check One)
- ☐ INCREASE TO:
- ☐ DECREASE TO:

New Total $

ALLOTTEE NAME
(person/company who will receive allotment)

ALLOTTEE'S ROUTING NUMBER Check Digit

ALLOTTEE'S ACCOUNT NUMBER

ALLOTTEE'S ACCOUNT TITLE
(Account Holder's Name)

FINANCIAL INSTITUTION NAME

5. AUTHORIZATION

* EMPLOYEE'S SIGNATURE DATE

6. AGENCY USE:

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

2024

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **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.)

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, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

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.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(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 generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

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.)

Step 3: Claim Dependent and Other Credits

If your total 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 for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . 3 $

Step 4 (optional): Other Adjustments

(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) $

(b) **Deductions.** If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . 4(b) $

(c) **Extra withholding.** Enter any additional tax you want withheld each **pay period** . . 4(c) $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) _____ **Date** _____

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

STATE OF LEGAL RESIDENCE CERTIFICATE

PRIVACY ACT STATEMENT

AUTHORITY: 50 U.S.C 571, Residence for tax purposes and 37 U.S.C., Pay and Allowances of the Uniformed Services.
PURPOSE: Information is required for determining the correct State of legal residence for purposes of withholding State income taxes from military pay.
ROUTINE USES: Additional routine uses are listed in the applicable system of records notices, T7340, Defense Joint Military Pay System-Active Component, and T7344, Defense Joint Military Pay System-Reserve Component are located at: http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-Component-Notices/DFAS-Article-List/. M01040-3, Marine Corps Manpower Management Information System Records, located at http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-Component-Notices/.
DISCLOSURE: Voluntary, however, if not provided, State income taxes will be withheld based on the tax laws of the applicable State, based on your home of record.

1. NAME (Last, First, Middle Initial)	**2. DOD ID NUMBER**

3. LEGAL RESIDENCE/DOMICILE (City or county and State)

INSTRUCTIONS FOR CERTIFICATION OF STATE OF LEGAL RESIDENCE

The purpose of this certificate is to obtain information with respect to your legal residence/domicile for the purpose of determining the State for which income taxes are to be withheld from your "wages" as defined by Section 3401(a) of the Internal Revenue Code of 1954. PLEASE READ INSTRUCTIONS CAREFULLY BEFORE SIGNING.

The terms "legal residence" and "domicile" are essentially interchangeable. In brief, they are used to denote that place where you have your permanent home and to which, whenever you are absent, you have the intention of returning. The Soldiers' and Sailors' Civil Relief Act protects your military pay from the income taxes of the State in which you reside by reason of military orders unless that is also your legal residence/domicile. The Act further provides that no change in your State of legal residence/domicile will occur solely as a result of your being ordered to a new duty station.

You should not confuse the State which is your "home of record" with your State of legal residence/domicile. Your "home of record" is used for fixing travel and transportation allowances. A "home of record" must be changed if it was erroneously or fraudulently recorded initially.

Enlisted members may change their "home of record" at the time they sign a new enlistment contract. Officers may not change their "home of record" except to correct an error, or after a break in service. The State which is your "home of record" may be your State of legal residence/domicile only if it meets certain criteria.

The formula for changing your State of legal residence/domicile is simply stated as follows: physical presence in the new State with the simultaneous intent of making it your permanent home and abandonment of the old State of legal residence/domicile. In most cases, you must actually reside in the new State at the time you form the intent to make it your permanent home. Such intent must be clearly indicated. Your intent to make the new State your permanent home may be indicated by certain actions such as: (1) registering to vote; (2) purchasing residential property or an unimproved residential lot; (3) titling and registering your automobile(s); (4) notifying the State of your previous legal residence/domicile of the change in your State of legal residence/domicile; and (5) preparing a new last will and testament which indicates your new State of legal residence/domicile. Finally, you must comply with the applicable tax laws of the State which is your new legal residence/domicile.

Generally, unless these steps have been taken, it is doubtful that your State of legal residence/domicile has changed. Failure to resolve any doubts as to your State of legal residence/domicile may adversely impact on certain legal privileges which depend on legal residence/domicile including among others, eligibility for resident tuition rates at State universities, eligibility to vote or be a candidate for public office, and eligibility for various welfare benefits. If you have any doubt with regard to your State of legal residence/domicile, you are advised to see your Legal Assistance Officer (JAG Representative) for advice prior to completing this form.

I certify that to the best of my knowledge and belief, I have met all the requirements for legal residence/domicile in the State claimed above and that the information provided is correct.

I understand that the tax authorities of my former State of legal residence/domicile will be notified of this certificate.

4. SIGNATURE OF APPLICANT	**5.CURRENT MAILING ADDRESS** (Include Zip Code)	**6. DATE** (YYMMDD)

Prudential

Office of Servicemembers' Group Life Insurance

Servicemembers' Group Life Insurance Election and Certificate

The SGLI Online Enrollment System (SOES) is the official system of record for Servicemembers' Group Life Insurance (SGLI) for the Uniformed Services of the United States. All coverage and beneficiary elections for members with full-time SGLI coverage should be maintained in SOES. This form should only be used in special circumstances as defined by the Uniformed Services.

1. About You

	N/A	
Print Name (First, Middle, Last)	Rank, title or grade	Social Security Number
AFROTC Det 220	Air Force (ORS)	$0
Duty Location	Branch of Service	Current Amount of SGLI

☐ Married ☐ Single

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.*

" I do not want insurance at this time "

SGLI coverage is available in increments of $50,000 up to a maximum of $500,000. Traumatic Injury Protection (TSGLI) 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.				
2.				
3.				
4.				

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.	☐☐☐ ☐☐ ☐☐☐☐			
2.	☐☐☐ ☐☐ ☐☐☐☐			
3.	☐☐☐ ☐☐ ☐☐☐☐			
4.	☐☐☐ ☐☐ ☐☐☐☐			

☐ **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 07102-3777. 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?	☐	☐
b. High blood pressure?	☐	☐
c. A neurological disorder?	☐	☐
d. Diabetes?	☐	☐
e. Cancer or tumors?	☐	☐
f. Have you ever been diagnosed as having a disease of the immune system?	☐	☐
g. Do you have any known physical impairments, deformities, or ill health not covered above?	☐	☐

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 $500,000. VGLI is 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 8286A.
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 8286A.

- 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	Representative
Rank, title or grade	Approve ☐
Contact telephone/email	Disapprove ☐
Date	Date
Address	