

FTNGDOS CHECKLIST for OPERATION GUARDIAN SUPPORT

FULL TIME NATIONAL GUARD DUTY FOR OPERATIONAL SUPPORT

(FTNGDOS 32 USC §502(F) (2) IAW NGB POLICY MEMORANDUM #13-020 (FTNGDOS))

Name: _____ SSN: _____

E-Mail: _____ Duty Location: _____

REQUIRED ITEMS – Initial each box below to indicate compliance

- Completed OGS application
- Commanders Certification (**provide copy**)
- Certified MEDPROS/IMR Printout (**provide copy**)
- Retirement Points Accounting Statement (RPAS) (ARMY ONLY)/ Point Credit Accounting and Reporting System
- DA 705 along with DA Form 5500/5501 **must be within 6 months prior to orders start date** (please provide copy - located in DTMS)
- Individual Government Travel Card. If you do not have one, please provide status: _____
- DD Form 93 Updated: _____ (**provide copy**)
- Family Care Plan: Needed? **Yes** or **No**
(**If Soldier circled yes, please provide proper documentation**)
- ID Tags

DA 5960 _____
Readiness NCO Print & Sign

SGLV 8286

Drill Schedule / Drill Dates

Operation Guardian Support Personnel Information

For Official Use Only

Privacy Act 1974

The U.S. Government conducts background investigations to establish that applicants employed by or working for the government are suitable for the job and/or eligible for a public trust or sensitive position. Information from this form is used primarily as the basis for this investigation.

Giving us the information we ask for is voluntary. However, we may not be able to complete your investigation or complete it in a timely manner, if you don't give us each item of information we request. This may affect your placement or employment prospects.

Your social security number is needed to keep records accurate, because other people may have the same name and birth date. Executive order 9397 also asks Federal agencies to use this number to help identify individuals in agency records.

Operation Guardian Support Personnel Information

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Last Name

First Name

Date of Birth

Rank

Grade

SSN

Gender

Driver's License State /
Number

Place of Birth

Country/
Citizenship

Phone Number

E-mail

Home Address

Emergency Contact Info

Date Moved to Home Address

Mother's Maiden Name (Last, First, MI)

Father's Name (Last, First, MI)

OPERATION GUARDIAN SUPPORT

Application for Full Time National Guard Duty

For use of this form see NGR 500-2 / ANGI 10-801

Last Name		First Name		Middle Name
Present Address				
City		State		Zip Code
Home Phone Number		Work Phone Number		Cell Phone Number

Rank	Branch	Social Security Number	Number of Dependents
		Sex:	Marital Status

Unit/Section of Assignment	Unit Phone Number	Unit Location (City)	PEBD(Army)/Pay Date(Air)
Primary MOS/AFSC	MOS/AFSC Description	Security Clearance Type	Security Clearance Date

Receiving VA Disability?	Open LOD?	ETS Date:	
Location of Most Recent Military Physical Examination		Date of Most Recent Military Physical Examination	
Total Years of Active Federal Service	Current Status (AGR/DSG/MDAY/TECH)	Last set of orders start date:	Last order end date:

Can member stay on until 30SEP19? **YES** **NO**

Available Start and End Dates _____

Projected school or other training dates that may effect OGS orders _____

If you are a Technician, have you informed your supervisor that you are applying for OGS? **YES** **NO**

Are you currently employed by the Department of Homeland Security (CBP) ? **YES** **NO**

Last Name	First Name	Middle Name
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1. Do you currently have a valid Arizona driver's license? _____

2. Have you ever had your license suspended? _____

If yes, explain and list dates _____

3. Have you ever been convicted of a felony? _____

If yes, explain and list dates: _____

4. Are you a US Citizen? _____

If you are not a US Citizen, please provide the following.

Place you entered the United States _____

Country of Citizenship _____

Alien Registration Number _____

You must sign this application. Read the following carefully before you sign:

Personnel Data Privacy Act of 1974 (5 USC 552). This information is used to determine the qualification of persons applying to voluntarily participate in OPERATION GUARDIAN SHIELD. Disclosure is voluntary, however, failure to disclose the requested information may result in the application being rejected.

I certify by my signature that to the **best of my knowledge and belief, all of the information on this application is true and complete. I understand any false statements made on this application could lead to non-selection or dismissal from OPERATION GUARDIAN SUPPORT.**

Signature of Applicant: _____

Date: _____

Commander's Recommendation

OPERATION GUARDIAN SUPPORT

For use of this form see NGR 500-2 / ANGI 10-801

1. Please take the time to thoroughly evaluate the following individual for entry on FTNGS, OPERATION GUARDIAN SUPPORT.

Name _____ Rank _____ Unit _____ Unit/Wing Phone Number _____

2. Service members must meet physical fitness and weight control standards, have no disciplinary flags (or unfavorable information file) and receive the unreserved recommendation of their unit commander. Please personally certify the following requirements individually:

a. Data for last two (2) APFT/ Fitness Tests:

1. APFT Date: _____ Test Result: _____

2. APFT Date: _____ Test Result: _____

3. HT/WT Data: _____

If APFT not current, provide an explanation
(Commander may waive this requirement):

b. Service member IS / IS NOT (circle one) on a weight control program.

c. Service member DOES / DOES NOT (circle one) have negative disciplinary actions pending.

d. Service member's current ETS date: _____

e. Service member's last PHA, Physical: _____

f. Service member IS / IS NOT (circle one) flagged in SIDPERS

3. Extended Active Duty (EAD) is a privilege, not a right. By endorsing below, you are verifying that the individual is a member in good standing of your unit/wing and consistently participates in drills and annual training. You are giving the member your personal recommendation for extended active duty.

I do recommend this member for EAD

I do not recommend this member for EAD

4. For further questions, I can be reached at _____.

Company/Squadron CDR Signature / Date

PRINT Name, Rank and Title

AUTHORIZATION TO START, STOP, OR CHANGE BASIC ALLOWANCE FOR QUARTERS (BAQ), AND/OR VARIABLE HOUSING ALLOWANCE (VHA) <small>For use of this form, see AR 37-104-4; the proponent agency is ASA(FM)</small>				PRIVACY ACT STATEMENT			
1. NAME (Last, First, MI)				AUTHORITY: 37 USC 403; Public Law 96-343; EO 9397.			
2. SOCIAL SECURITY NUMBER		3. GRADE		PRINCIPLE PURPOSE: To start, adjust or terminate military member's entitlement to basic allowance for quarters (BAQ) and/or variable housing allowance (VHA).			
4. TYPE OF ACTION				ROUTINE USE: To adjust member's military pay record, information may be disclosed to Army components, such as USAFAC, major commands, and other Army installations; to other DOD components; other federal agencies such as IRS, Social Security Administration and VA, GAO, members of Congress; State and local government; US and State courts, and various law enforcement agencies. Social Security Number (SSN) is used for positive identification.			
<input type="checkbox"/> START <input type="checkbox"/> CANCEL <input type="checkbox"/> CHANGE <input type="checkbox"/> REPORT		<input type="checkbox"/> CORRECT <input type="checkbox"/> STOP <input type="checkbox"/> RECERTIFICATION		DISCLOSURE IS VOLUNTARY: Nondisclosure may result in nonpayment of BAQ and/or VHA. Disclosure of your SSN is voluntary. However, this form will not be processed without your SSN because the Army identifies you for pay purposes by your SSN.			
5. DUTY LOCATION (Include Station, Name, City, State, and Zip Code)				6. DATE/ACTION (YYYYMMDD)	7. BAQ TYPE		
				<input type="checkbox"/> WITH DEPENDENTS	<input type="checkbox"/> PARTIAL		
				<input type="checkbox"/> WITHOUT DEPENDENTS			
8. MARITAL/DEPENDENCY STATUS				9. QUARTERS ASSIGNMENT/AVAILABILITY			
<input type="checkbox"/> a. SINGLE	<input type="checkbox"/> b. MARRIED (see blocks (1), (2) & (3))	<input type="checkbox"/> c. DIVORCED (see blocks (1), (2) & (3))	<input type="checkbox"/> a. ADEQUATE (see block (1))	<input type="checkbox"/> b. INADEQUATE (see blocks (1), (2) & (4))			
<input type="checkbox"/> d. LEGALLY SEPARATED (see blocks (1), (2) & (3))		<input type="checkbox"/> e. DEPENDENT CHILD (see blocks (4), (5) & (6))	<input type="checkbox"/> c. TRANSIENT (see block (3))	<input type="checkbox"/> d. NOT AVAILABLE			
(1) Spouse/Former Spouse SSN	(2) Spouse/Former Spouse Duty Station	(3) Date of Marriage, Divorce/Separation	(1) QUARTERS NO. _____	(2) FAIR RENTAL VALUE \$ _____			
(4) Child in Custody of: <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Former Spouse <input type="checkbox"/> Other			(3) FROM: _____	TO: _____			
(5) If you check "OTHER" above, prepare DD Form 137 to establish dependency.			(4) <input type="checkbox"/> MEMBER ELECTION	<input type="checkbox"/> COMMANDER DETERMINATION (Attached)			
(6) If child support received from another military member, complete (1), (2) & (3).			(Member in grade E7 and above)				
10. DEPENDENTS/SHARERS (Continue on back if required)							
NAME OF DEPENDENT/SHARER		COMPLETE CURRENT ADDRESS (Include ZIP Code)		RELATIONSHIP	DOB OF CHILDREN		
11. CERTIFICATION OF DEPENDENT SUPPORT							
<input type="checkbox"/> I certify that I can provide, or willing to provide, adequate support for the above named dependents. I am aware that failure to support the above named dependents may result in stopping BAQ and recouping BAQ for any prior periods/nonsupport.							
<input type="checkbox"/> IAW service regulations. I certify that the dependency status of my primary dependents, on whose behalf I am receiving BAQ, has not changed so as to affect my entitlement thereto for the period.							
12. EXPENSES, IF AUTHORIZED, I AM REQUESTING VHA BASED ON							
My permanent duty station:		My dependent's location:		Both my permanent duty station and dependent's location.			
a. Monthly Expenses:	Member	Dependent	b. Sharer/Lease Information	c. Address Information			
(1) Mortgage (PITI) or Rent			(1) Rental/Residential Address:	(1) Landlord's Name and Address:			
(2) Insurance							
(3) Other			(2) Effective Date:	(3) Expiration Date:	(2) Landlord's Phone No.		
TOTALS							
(4) Number of Sharers (show name(s) and address in block 10.)							
I certify ALL information regarding this authorization is correct. I will immediately notify the FAO/HRO of any changes in the information above, due to divorce, marriage, death, living in government quarters etc, which could affect by BAQ or VHA entitlement. IMPORTANT: Making a false statement or claim against the US Government is punishable by courts-martial. The penalty for willfully making a false claim or a false statement in connection with claims is a maximum fine of \$10,000 or imprisonment for 5 years, or both.							
13. MEMBER'S SIGNATURE			14. DATE	15. CERTIFYING OFFICER'S SIGNATURE			
				16. DATE			

Servicemembers' Group Life Insurance Election and Certificate

Office of Servicemembers'
Group Life Insurance

1. About You

<input type="text"/>	<input type="text"/>	<input type="text"/>
Print Name (First, Middle, Last)	Rank, title or grade	Social Security Number
<input type="text"/>	<input type="text"/>	<input type="text"/>
Duty Location	Branch of Service	Current Amount of SGLI

2. About Your Coverage

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.*
- 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.*
" _____ "

Coverage is available in increments of \$50,000 up to a maximum of \$400,000

3. About Your Beneficiaries *Complete this section unless you are declining coverage*

Primary Name and Address	Social Security Number (If available)	Relationship to you	Share to each (% or \$ amounts)	Payment Option (Lump sum* or 36 equal monthly payments)
1.	<input type="text"/>			
2.	<input type="text"/>			
3.	<input type="text"/>			
4.	<input type="text"/>			
Secondary				
1.	<input type="text"/>			
2.	<input type="text"/>			
3.	<input type="text"/>			
4.	<input type="text"/>			

Have more beneficiaries? Check the box and complete Supplemental SGLI Beneficiary Form, SGLV 8286S.

If you do not name beneficiaries above, your insurance will be paid by law (see page 3).

* 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.

Open Solutions Inc. is the Service Provider 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 UMB Bank, N.A. **Alliance Account balances are not insured by the Federal Deposit Insurance Corporation (FDIC).** Open Solutions Inc. and UMB Bank, N.A. are not Prudential Financial companies.

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? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. High blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. A neurological disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Cancer or tumors? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Have you ever been diagnosed as having a disease of the immune system? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Do you have any known physical impairments, deformities, or ill health not covered above? | <input type="checkbox"/> | <input type="checkbox"/> |

Did you answer "YES" to any question? If so, reference the question by letter and list date, duration and details below.

Any request to increase coverage does not take effect until approved by the Office of Servicemembers' Group Life Insurance (OSGLI).

5. Your Signature You must complete this section.

I have read the instructions and understand that:

- This form cancels any prior beneficiary or payment instructions.
- I can have SGLI and Veterans' Group Life Insurance (VGLI) coverage at the same time, but the combined amount cannot be more than \$400,000.
- Reducing or declining SGLI coverage can affect the amount of my family coverage, traumatic injury coverage and post-separation coverage (see instructions for details).
- If I am married or get married after completing this form and have not declined SGLI, spouse SGLI automatically covers my spouse. If my spouse is also a member of the uniformed services and we were married on or after January 2, 2013, spouse SGLI coverage is not automatic, but I may apply for spouse coverage by completing SGLV 8286A. I must register my spouse in DEERS so my branch of service can deduct premiums from my pay. *Failure to register my spouse in DEERS will result in my owing debts for unpaid premiums.* I can decline spouse SGLI coverage by completing SGLV 8286A.
- I am free to name anyone I want as my beneficiary. I certify that I understand if I 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 if I am married, my spouse may be notified that he/she (or my child) is not my designated beneficiary.
- I certify that the information provided on this form is true and correct to the best of my knowledge and belief. Any deception or knowingly false statement either by inference or omission may result in cancellation of the insurance or in the refusal to pay a claim.

Service Member Signature

Social Security Number

Date (MM, DD, YYYY)

Address

Submit this form to your Unit Personnel Clerk.

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	

Information for the Service Member

About your SGLI Coverage

Servicemembers' Group Life Insurance (SGLI) is granted under title 38, United States Code, and is subject to the provisions of that title and its amendments, and title 38 Code of Federal Regulations.

The following charts provide information you should review before naming a beneficiary or selecting a payment option.

Naming Beneficiaries who will receive the insurance

If you...	Then...
are married and decline coverage upon entry into service	your spouse will be notified that you declined coverage.
are married and designate any person other than your spouse or child for any amount of insurance	your spouse will be notified in writing that he/she or your child is not the named beneficiary, unless: – your spouse has been previously notified, OR – your spouse is not designated as beneficiary for any amount of insurance prior to the new election.
are married and your spouse is designated as beneficiary and you decline coverage or elect less than maximum coverage, and that election reduces your coverage from the automatic maximum or from a previously elected amount of coverage	your spouse will be notified in writing of your election to decline or reduce coverage.
have any life event such as marriage, divorce, or children after completing this form	you should complete a new beneficiary form. Beneficiaries are not automatically changed by life events.
name more than one beneficiary	the sum of the shares must equal 100% or the full dollar amount of your insurance.
want to name more than four primary or secondary beneficiaries	you must complete the SGLI Supplemental Beneficiary Form, SGLV 8286S.
name minors as beneficiaries	<ul style="list-style-type: none"> ■ SGLI will pay the insurance benefit to the court-appointed guardian of the children's estate if the beneficiary is a minor at time of claim. ■ you can establish a trust for the benefit of the children and name the trust as beneficiary. A trust names a trustee of your choice to be legally responsible for administering the insurance proceeds for the children. ■ naming a trust as a beneficiary on this form does NOT create a trust.
name more than one primary beneficiary and one or more of them predeceases you	SGLI will pay the shares equally among the remaining primary beneficiaries.
want to name a Trust as a beneficiary	you must create a trust. Please consult with a military attorney, professional financial planner, or estate planner to help you create Trust documents. (Please note: Trust documents are not needed until a claim is submitted.)
have no surviving primary beneficiaries	SGLI will divide the insurance benefit among the secondary beneficiaries.
do not name a beneficiary or there are no surviving primary or secondary beneficiaries OR indicate that payment should be made by law	<p>SGLI will pay the insurance benefit in the following order:</p> <ol style="list-style-type: none"> 1. Widow or widower 2. Children in equal shares (the share of any deceased child will be distributed equally among the descendants of that child) 3. Parent(s) in equal shares or all to surviving parent 4. A duly appointed executor or administrator of your estate 5. Other next of kin

Payment Options

If you want the beneficiary to...	Then...
receive the insurance proceeds in one lump sum	<p>write the phrase "lump sum" under Payment Options. If you elect a lump sum payment, your 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).</p> <p>* 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.</p>
receive the insurance proceeds in 36 equal monthly payments	<ul style="list-style-type: none"> ■ write "36" under the Payment Option. ■ your beneficiary cannot change this payment option.
have a choice	write the phrase "lump sum" under Payment Option or leave blank.

Instructions for Personnel Clerk and the Service Member

1. A representative of the Uniformed Services must complete the "For Branch of Service Official Use Only" section to indicate receipt of the form from the member after reviewing the following table:

If the service member...	The Personnel Clerk should inform the service member...	Then the Personnel Clerk should...
has just entered the service	he or she is automatically insured for \$400,000 SGLI, unless the service member declines or reduces coverage.	have the service member designate beneficiaries by completing SGLV 8286.
is increasing or restoring SGLI	he or she must complete Section 4, <i>About Your Health</i> .	<ul style="list-style-type: none"> ■ approve form if the responses to questions 4a through 4g are "No" and forward the form to payroll to change SGLI premium deductions. ■ send form to OSGLI if any answer to questions 4a through 4g are "Yes." Only inform payroll when approved by OSGLI.
Reduces, declines, or cancels SGLI	<ul style="list-style-type: none"> ■ an application with health questions is required to increase, elect, or restore coverage at a later date. ■ of the following: <ul style="list-style-type: none"> – the purpose and role of life insurance in financial planning. – the difference between term life insurance and whole life insurance. – the availability of commercial life insurance. – the relationship between SGLI and VGLI. – declining or canceling SGLI will also cancel Family SGLI— both spouse and dependent child coverage— and Traumatic Injury Protection (TSGLI). 	<ul style="list-style-type: none"> ■ forward the form to payroll to change SGLI premium deductions. ■ if canceling SGLI, have the service member complete SGLV 8286A to end payment of Family SGLI premiums. No form is required to end TSGLI premium deductions. ■ if the member is married and reduces, declines, or cancels SGLI, inform the member that his her spouse may be notified in writing of the member's election based on Title 38, USC 1967 (f).
is married or gets married after completing this form (and is not married to another member of the uniformed services)	<ul style="list-style-type: none"> ■ spouse SGLI automatically covers spouse. ■ he or she must register their spouse in DEERS for payroll to deduct premiums. ■ If the member wants to decline coverage or take a lesser amount of spouse coverage, the member must complete SGLV 8286A. 	if applicable, forward the form to payroll to begin premium deductions for the spouse coverage.
gets married to another member of the uniformed services on or after January 2, 2013	spouse SGLI coverage is not automatic and the member may apply for spouse SGLI coverage by completing SGLV 8286A.	if member wants spouse SGLI coverage, provide the member with SGLV 8286A, Spouse Coverage Election and Certificate, and follow the instructions therein.
has questions about this form	the advice of a military attorney is available at no expense.	direct them to the appropriate resource.
wants to designate more beneficiaries than the form allows	he or she must complete the Supplemental SGLI Beneficiary Form SGLV 8286S.	attach the Supplemental Beneficiary Form to the 8286.
designates any person other than his/her spouse or child for any amount of insurance	<ul style="list-style-type: none"> ■ while the member is free to designate anyone he or she chooses as beneficiary, the member must certify that he or she is designating someone other than a spouse or child and the person named will receive the benefit. ■ if the member is married, the member's spouse will be notified in writing that he/she or the member's child is not the named beneficiary, unless: <ul style="list-style-type: none"> – the spouse has been previously notified, OR – the spouse is not designated as beneficiary for any amount of insurance prior to the new election. 	<p>have the member sign SGLV 8286 to certify that he/she understands that:</p> <ul style="list-style-type: none"> ■ he/she is free to name anyone as beneficiary. ■ if he/she designated someone other than his/her spouse or child as beneficiary, the person the member has named is the person he/she intends to receive the insurance proceeds. ■ if married, the spouse will be notified that he/she (or any child) is not the designated beneficiary.

2. After the form is completed, Personnel Clerk should:

- File a copy in the member's official personnel file
- Provide a copy to the service member
- Provide a copy of the form to the payroll office for the member's unit
- Submit the form to OSGLI ONLY if the member is increasing or restoring SGLI coverage and answered "Yes" to one or more of the health questions

OSGLI
PO Box 41618
Philadelphia, PA 19176-9913

QUALIFICATION TO POSSESS FIREARMS OR AMMUNITION

PRIVACY ACT STATEMENT

AUTHORITY: 18 U.S.C. 922(g)(9); E.O. 9397.

PRINCIPAL PURPOSE(S): To obtain information to determine if you have been convicted of a crime of domestic violence which would disqualify you from shipping, transporting, possessing or receiving either Government-issued or private firearms or ammunition and to determine if reassignment, reclassification, detail or other administrative action is warranted. Your Social Security Number is solicited solely for purposes of verifying your identity.

ROUTINE USE(S): To the Department of Justice so that such information can be included in the National Instant Criminal Background Check System which may be used by firearm licensees (importers, manufacturers or dealers) to determine whether individuals are qualified to receive or possess firearms and ammunition.

DISCLOSURE: Mandatory for all personnel who are required to certify. Failure to provide the information may result in (1) (military only) the imposition of criminal or administrative penalties for failing to obey a lawful order, and (2) (civilian only) the imposition of administrative penalties, to include removal from Federal service. However, neither your answers nor information or evidence gained by reason of your answers can be used against you in any criminal prosecution for a violation of Title 18, United States Code, Section 922(g)(9), including (military only) prosecutions under the Uniform Code of Military Justice, based on a violation of Section 922(g)(9), for conduct which occurred prior to the completion of this form. The answers you furnish and any information resulting therefrom, however, may be used against you in a criminal or administrative proceedings if you knowingly and willfully provide false statements or information.

SECTION I - INSTRUCTIONS

An amendment to the Gun Control Act of 1968 (18 U.S.C. 922) makes it a felony for anyone who has been convicted of a misdemeanor crime of domestic violence to ship, transport, possess, or receive firearms or ammunition. It is also a felony for any person to sell or otherwise dispose of a firearm to any person so convicted.

The Department of Defense has, by policy, expanded the prohibitions contained in Title 18 Section 922(g)(9) to those military or civilian personnel who have felony convictions for crimes of domestic violence. Convictions of crimes of domestic violence do not include summary court-martial convictions, the imposition of nonjudicial punishment (Article 15, UCMJ), or deferred prosecutions (or similar alternative dispositions) in civilian courts. Furthermore, a person shall not be considered as having committed a "crime of domestic violence" for purposes of the firearms restriction of the Gun Control Act unless all of the following elements are present:

- (1) the person was convicted of a crime;
- (2) the offense has as its factual basis the use or attempted use of physical force, or threatened use of a deadly weapon;
- (3) the convicted offender was at the time of the offense:
 - (a) a current or former spouse, parent or guardian of the victim,
 - (b) a person with whom the victim shared a child in common,

- (c) a person who was cohabiting with or has cohabited with the victim as a spouse, parent, or guardian, or
- (d) a person who was similarly situated to a spouse, parent, or guardian of the victim;
- (4) the convicted offender was represented by counsel, or knowingly and intelligently waived the right to counsel;
- (5) if entitled to have the case tried by jury, the case was actually tried by jury or the person knowingly and intelligently waived the right to have the case tried by jury;
- (6) the conviction has not been expunged or set aside, or the convicted offender has not been pardoned for the offense or had civil rights restored, unless the pardon, expungement, or restoration of civil rights provides that the person may not ship, transport, possess or receive firearms.

If you have ever received a domestic violence conviction: (1) you may not possess any firearm or ammunition; and (2) you must return any Government-issued firearm or ammunition to your commander or immediate supervisor; and (3) you must take steps to relinquish possession of any privately owned firearms or ammunition. Furthermore, any previously issued authorization to possess a firearm or ammunition is revoked.

If you have any questions, or you are uncertain if you have such a conviction, you may wish to contact a legal assistance attorney, if eligible, or a private attorney, at your own expense.

SECTION II - QUALIFICATION INQUIRY *(Complete and return to your commander or immediate supervisor within 10 days of receipt)*

1. HAVE YOU EVER BEEN CONVICTED OF A CRIME OF DOMESTIC VIOLENCE AS DESCRIBED ABOVE: *(Initial and date)*

YES	NO	I DON'T KNOW <i>(Provide explanation on reverse)</i>
-----	----	--

2. IF YOU ANSWERED "YES" TO THE FIRST QUESTION, PROVIDE THE FOLLOWING INFORMATION WITH RESPECT TO THE CONVICTION:

a. COURT/JURISDICTION	b. DOCKET/CASE NUMBER
c. STATUTE/CHARGE	d. DATE SENTENCED <i>(YYYYMMDD)</i>

3. CERTIFICATION. I hereby certify that, to the best of my information and belief, all of the information provided by me is true, correct, complete, and made in good faith. I understand that false or fraudulent information provided herein may be grounds for criminal and/or administrative proceedings, to include (if civilian) adverse action, up to and including removal, and (if military) disciplinary action under the Uniform Code of Military Justice. I further understand that I have a continuing obligation to inform my Commander or Supervisor should I be convicted of a crime of domestic violence in the future.

a. NAME <i>(Last, First, Middle Initial)</i>	b. RANK/GRADE	c. SOCIAL SECURITY NUMBER
d. ORGANIZATION	d. SIGNATURE	e. DATE SIGNED <i>(YYYYMMDD)</i>