

Sample

[Must be prepared on your school's official letterhead-then delete this line]

**TRAINEE QUALIFICATIONS AND CREDENTIALS VERIFICATION LETTER
(TQCVL)**

**FOR ASSOCIATED HEALTH TRAINEES IN PROGRAMS SPONSORED BY
AN AFFILIATED PROGRAM OR INSTITUTION (US Citizens only)**

[Insert your School's Name HERE]

(NOTE: This sample letter is to be completed by the non-VA Program Director at the affiliated sponsoring institution and sent to the VA Facility Director through the VA Designated Educational Officer. This letter will be used to certify the qualifications and credentials of the trainees enrolled in the respective affiliated training program).

Department, Program, or Sponsoring Entity
Address
City, State, Zip Code

The specific school/university

Director, Durham VA Medical Center (00)
Durham VA Medical Center (DVAMC)
508 Fulton Street
Durham, North Carolina 27705

Thru: Durham VAMC, ACOS-E (14A)

Dear Ms. Seekins:

1. I certify that the information has been verified for the trainees on the enclosed list who are scheduled to receive clinical training at a Department of Veterans Affairs (VA) facility. *NOTE: All trainees listed on the TQCVL must have had all primary source verifications completed. Use a separate TQCVL for any trainee with a deficiency or discrepancy with the issues stated explicitly and an explanation provided.*

2. In addition, I certify that the trainees in the attached list:

- a. Are enrolled in the designated training program and have met criteria for the specified level of training;
- b. Have satisfactory health to perform the duties of the clinical training program;
- c. Have had tuberculosis screening as required by the Center for Disease Control (CDC) or VA standards. *NOTE: In cases in which the trainee has not had required tuberculosis screening, the VA facility will refuse the trainee appointment until the required health screenings/vaccinations have been performed. The tuberculosis screening may be done by the VA facility for training programs sponsored by VA.*
- d. Have had hepatitis B vaccination or have signed declination waivers; *NOTE: In cases in which the trainee has not had a hepatitis B vaccination, the VA facility will refuse the trainee appointment until the required health screenings/vaccinations have been performed or a declination waiver has been signed. The hepatitis B vaccination may be done by the VA facility for training programs sponsored by VA.*
- e. Have had primary source verification of educational credentials as required by the admission criteria of the training program;

f. Have had primary source verification of current and past license(s), registration(s) including DEA registration, or certification(s) through the state licensing board(s) and/or national and state certification bodies as required by the training program;

g. Have provided letters of reference as required by the training program;

h. Have/have not (circle) been screened against the National Practitioner Data Bank (NPDB) as appropriate for licensed trainees;

i. Have/have not (circle) been screened against the Health and Human Services' List of Excluded Individuals and Entities (LEIE) for all trainees.

3. I will notify the VA Designated Educational Officer as soon as possible but no later than 72 hours of changes in the academic status of individual trainees, adverse actions that affect the trainee appointment, or changes in health status that pose a risk to the safety of trainees, other employees, or patients.

4. I certify that all documents pertaining to the listed trainees are maintained on file and available to VA officials for review.

Name and Title of Sponsoring Entity

(Date)

Program Director or Designated Institutional Official (DIO)

NAVJEET SIDHU-MALIK, MD

(Date)

Durham VAMC Designated Education Officer (DEO)

Associate Chief Of Staff for Education

DEANNE M. SEEKINS, MBA, VHA-CM

Durham VA Medical Center Director

Accept/Do Not Accept _____

Comments: _____

Date _____

Attachment: List of Residents/Trainees [Department or Program]



Department of Veterans Affairs

APPLICATION FOR HEALTH PROFESSIONS TRAINEES

SEE LAST PAGE FOR PAPERWORK REDUCTION ACT, PRIVACY ACT AND INFORMATION ABOUT DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER

INSTRUCTIONS: Please submit this application furnishing all information in sufficient detail to enable the Department of Veterans Affairs (VA) to determine your eligibility for appointment. Type or print in ink. If additional space is needed, please attach a separate sheet and refer to items being answered by number. Applications for clinical training programs may require additional information. All information required by the training program to which you are applying, as well as information requested on all application forms, must be included.

VA must protect the safety of our patients. Therefore, at some point in the appointment process, you will be asked questions about your physical and mental health. This includes questions as to whether you have received tuberculin testing, hepatitis B vaccinations or any other vaccinations.

1A. NAME (Last, First, Middle) <i>Nurse, Ima G.</i>		1B. OTHER NAMES USED <i>n/a</i>	
2. PRESENT ADDRESS (Include ZIP Code) <i>123 Student Lane Chapel Hill, NC 27514</i>		3A - PRIMARY PHONE (Include area code) <i>919-333-3333</i>	
		3B - ALTERNATE PHONE (Include area code) <i>919-444-4444</i>	
4. SOCIAL SECURITY NUMBER <i>123-45-6789</i>	5A. PRIMARY EMAIL ADDRESS <i>nursci@email.unc</i>	5B. ALTERNATE EMAIL ADDRESS	6. DATE OF BIRTH (mm/dd/yyyy)
7A. VA TRAINING FACILITY (City, State) <i>Durham, N.C.</i>		7B. VA TRAINING START DATE (mm/yyyy) <input type="checkbox"/> UNKNOWN <i>01/2016</i>	7C. VA TRAINING END DATE (mm/yyyy) <input type="checkbox"/> UNKNOWN <i>08/2017</i>

II - U.S. MILITARY DUTY STATUS

8A. ARE YOU NOW IN U.S. MILITARY? <input type="checkbox"/> YES (If YES, complete 8c) <input checked="" type="checkbox"/> NO	8B. ARE YOU IN THE RESERVES OR NATIONAL GUARD? <input type="checkbox"/> YES (If YES, complete 8c) <input type="checkbox"/> NO	8C. BRANCH OF SERVICE
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III - CITIZENSHIP

9A. CITIZENSHIP <input checked="" type="checkbox"/> U.S. CITIZEN BY BIRTH <input type="checkbox"/> NATURALIZED U.S. CITIZEN <input type="checkbox"/> NOT A U.S. CITIZEN (Complete item 9B)	9B. COUNTRY OF CITIZENSHIP
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NOTE: Complete items 10A, 10B, 10C, or 10D ONLY if you are NOT a U.S. citizen.

10A. IMMIGRANT		10B. EXCHANGE VISITOR		10C. OTHER NON-IMMIGRANT		10D. FORM DS2019
"A" NUMBER	VISA TYPE	VISA NUMBER	VISA TYPE	VISA NUMBER	DO YOU HAVE A VALID DS2019? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DATE	ISSUE DATE	EXPIRATION DATE	ISSUE DATE	EXPIRATION DATE	DATE OF LAST VALIDATION (MM/DD/YYYY)	

IV- THIS SECTION TO BE COMPLETED BY DESIGNATED EDUCATION OFFICER (DEO) OR DESIGNEE

11A. The trainee has met all of the criteria of the Trainee Qualifications & Credentials Verification Letter (TQCVL).	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
11B. Incomplete items on the TQCVL have been addressed and resolved.	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
11C. Special attention has been given to the following items from the application forms.		
11D. Comments:		
11E. This applicant has been approved for appointment.	<input type="checkbox"/> YES <input type="checkbox"/> NO	
11F. Comments:		
12A. SIGNATURE OF FACILITY DESIGNATED EDUCATION OFFICER OR DESIGNEE	12B. TITLE	12C. DATE

LAST NAME, FIRST NAME, MIDDLE NAME Nurse, Ima G		SOCIAL SECURITY NUMBER 123-45-6789			
V- LICENSE, CERTIFICATION, OR REGISTRATION IN CURRENT CLINICAL PROFESSION					
13A. LIST ALL LICENSES, CERTIFICATIONS, AND REGISTRATIONS, INCLUDING THE DRUG ENFORCEMENT AGENCY (DEA), THAT YOU HAVE NOW OR HAVE HAD AS A HEALTH PROFESSIONAL, I.E. MEDICAL, NURSING, PHARMACY, ETC.	13B. STATE ISSUING LICENSE	13C. LICENSE, CERTIFICATION OR REGISTRATION NUMBER	13D. EXPIRATION DATE (MM/DD/YYYY)		
Nursing Assistant	NC	Certificate, Nursing Assistant	10/30/2017		
VI- LICENSE, CERTIFICATION, OR REGISTRATION IN OTHER/PREVIOUS CLINICAL PROFESSION(S)					
14A. LIST ALL LICENSES, CERTIFICATIONS, AND REGISTRATIONS, INCLUDING DEA, THAT YOU HAVE EVER HAD AS A HEALTH PROFESSIONAL, I.E. MEDICAL, NURSING, PHARMACY, ETC.	14B. STATE ISSUING LICENSE	14C. LICENSE, CERTIFICATION OR REGISTRATION NUMBER	14D. EXPIRATION DATE (MM/DD/YYYY)		
n/a					
15. ENTER YOUR NATIONAL PROVIDER IDENTIFIER (NPI)					
The following two questions apply to both your current health profession and any prior health profession.					
16. DO YOU HAVE PENDING, OR HAVE YOU EVER HAD ANY LICENSE, CERTIFICATION, OR REGISTRATION TO PRACTICE (INCLUDING DEA CERTIFICATE) REVOKED, SUSPENDED, DENIED, RESTRICTED, OR PLACED ON A PROBATIONARY STATUS, OR HAVE YOU EVER VOLUNTARILY RELINQUISHED A LICENSE, CERTIFICATION, OR REGISTRATION IN LIEU OF FORMAL ACTION?					
			<input type="checkbox"/> YES - EXPLAIN IN PART XI <input checked="" type="checkbox"/> NO		
17. DO YOU HAVE PENDING, OR HAVE YOU EVER HAD CLINICAL PRIVILEGES AT ANY HEALTH CARE INSTITUTION OR AGENCY REVOKED, SUSPENDED, DENIED, RESTRICTED, LIMITED, OR PLACED ON A PROBATIONARY STATUS, OR HAVE YOU EVER VOLUNTARILY RELINQUISHED CLINICAL PRIVILEGES IN LIEU OF FORMAL ACTION?					
			<input type="checkbox"/> YES - EXPLAIN IN PART XI <input checked="" type="checkbox"/> NO		
VII - EDUCATION AND TRAINING AFTER HIGH SCHOOL THROUGH GRADUATE / PROFESSIONAL SCHOOL (Continue in Part XI if necessary)					
18A. NAME OF SCHOOL	18B. ADDRESS (City, State, and Zip Code)	18C. START DATE (MM/YY)	18D. (EXPECTED) COMPLETION DATE (MM/YY)	18E. DIPLOMA, DEGREE, OR CERTIFICATE AWARDED OR IN PROGRESS	18F. MAJOR FIELD OF STUDY
Durham Technical Community College, Durham, NC		01/2014	02/2016		Nursing
VIII - GRADUATES OF AN INTERNATIONAL MEDICAL SCHOOL					
19A. ARE YOU A GRADUATE OF AN INTERNATIONAL MEDICAL SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO		19B. EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG) CERTIFICATE NUMBER		19C. ECFMG CERTIFICATE DATE	
IX- INTERNSHIP, RESIDENCY AND FELLOWSHIP TRAINING					
20A. NAME OF HOSPITAL OR INSTITUTION	20B. ADDRESS (City, State and ZIP Code)	20C. SPECIALTY	20D. START DATE (MM/YY)	20E. (EXPECTED) COMPLETION DATE (MM/YY)	20F. NUMBER OF MONTHS COMPLETED
n/a					

LAST NAME, FIRST NAME, MIDDLE NAME

Nurse, Irma G

SOCIAL SECURITY NUMBER

123-45-6789

AUTHORIZATION FOR RELEASE OF INFORMATION

In order for the Department of Veterans Affairs (VA) to assess and verify my educational background, professional qualifications and suitability for employment, I:

- Authorize VA to make inquiries about me to current and previous employers, educational institutions, state licensing boards, professional liability insurance carriers, other professional organizations or persons, agencies, organizations, or institutions listed by me as references, and to any other sources which VA may deem appropriate or be referred by those contacted;
- Authorize release of such information and copies of related records and documents to VA officials;
- Release from liability all those who provide information to VA in good faith and without malice in response to such inquiries;
- Authorize VA to disclose to such persons, employers, institutions, boards, or agencies identifying and other information about me to enable VA to make such inquiries; and
- Authorize VA to share any information about me with the affiliated institution or training program official.

SIGNATURE OF APPLICANT

Irma G Nurse

DATE

9/30/2015

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE

Public reporting burden for this collection of information is estimated to average 30 minutes, including the time for reviewing instructions, searching existing data sources, gathering data, completing, and reviewing the information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to VA Clearance Officer (005R1B), 810 Vermont Avenue NW, Washington, DC 20420. Do not send applications to this address.

AUTHORITY: The information requested on this form and Authorization for Release of Information is solicited under Title 38, United States Code, Chapters 73 and 74.

PURPOSES AND USES: The information requested on the application is collected to determine your qualifications and suitability for appointment to a VA clinical training program. If you are appointed by VA, the information will be used to make pay and benefit determinations and in personnel administration processes carried out in accordance with established regulations and systems of records.

ROUTINE USES: Information on the form may be released without your prior consent outside the VA to another federal, state or local agency. It may be used to check the National Practitioner Health Integrity and Protection Data Bank (HIPDB) or the List of Excluded Individuals and Entities (LEIE) maintained by Health and Human Services (HHS), Office of Inspector General (OIG), or to verify information with state licensing boards and other professional organizations or agencies to assist VA in determining your suitability for a clinical training appointment. This information may also be used periodically to verify, evaluate, and update your clinical privileges, credentials, and licensure status, to report apparent violations of law, to provide statistical data, or to provide information to a Congressional office in response to an inquiry made at your request. Such information may be released without your prior consent to federal agencies, state licensing boards, or similar boards or entities, in connection with the VA's reporting of information concerning your separation or resignation as a professional staff member under circumstances which raise serious concerns about your professional competence. Information concerning payments related to malpractice claims and adverse actions which affect clinical privileges also may be released to state licensing boards and the National Practitioner Data Bank. Information will be stored in a confidential and secure VA database for purposes of processing your application and may be verified through a computer matching program. Information from this form may also be used to survey you regarding employment opportunities in VA and to solicit you perceptions about your clinical training experiences at VA and non-VA facilities.

EFFECTS OF NON-DISCLOSURE: See statement below concerning disclosure of your social security number. Completion of this form is mandatory for consideration of your application for a clinical training position in VA; failure to provide this information may make impossible the proper application of Civil Service rules and regulations and VA personnel policies and may prevent you from obtaining employment, employee benefits, or other entitlements.

INFORMATION REGARDING DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER UNDER PUBLIC LAW 93-579 SECTION 7(b)

Disclosure of your Social Security Number (SSN) is mandatory to obtain the employment and benefits that you are seeking. Solicitation of the SSN is authorized under provisions of Executive Order 9397 dated November 22, 1943. The SSN is used as an identifier throughout your Federal career. It will be used primarily to identify your records. The SSN also will be used by Federal agencies in connection with lawful requests for information about you from former employers, educational institutions, and financial or other organizations. The information gathered through the use of the number will be used only as necessary in personnel administration processes carried out in accordance with established regulations and published notices of systems of records, 'Applicants for Employment' under Title 38, U.S.C.-VA (02VA135), in the 2003 Compilation of Privacy Act Issuances. The SSN will also be used for the selection of persons to be included in statistical studies of personnel management matters. The use of the SSN is necessary because of the large number of Federal employees and applicants with identical names and birth dates whose identities can only be distinguished by the SSN.



DEPARTMENT OF VETERANS AFFAIRS
 Medical Center
 508 Fulton Street
 Durham, NC 27705,

Month dd, yyyy 9/30/2015
 (Name)
 (Home Address) Ima G. Nurse
 (Home Address) 123 Student Lane
Chapel Hill, NC 27514

In Reply Refer To: 558/yy
 SSN: 12345-6789
 DOB: 05-16-06
 U.S. Citizen: Yes or No

make this date the graduation date

Dear MS. NURSE:

Welcome to the Veterans Affairs Medical Center. You will be assigned to our facility as a UNC-CH Nurse Affiliate from 01/2016 through 08/2017 under authority of 38 U.S.C., 7405(a)(1). During your period of affiliation with our facility, you are authorized to perform services as directed by Nursing Education G. Waddell-Schultz, MSN (Chief of Supervisor) (Name of Service)

In accepting this assignment you will receive no monetary compensation and you will not be entitled to those benefits normally given to regularly paid employees of the Department of Veterans Health Administration, such as leave, retirement, etc. You will, however, be eligible to receive benefits indicated below. Cash cannot be paid in lieu of any of these benefits.

Quarters Subsistence Uniforms Laundering Uniforms

Upon satisfactory completion of the Associate Health Care Training Program, and within 1 year after graduation, you are eligible for a noncompetitive career-conditional (or, if appropriate, career) appointment to a VA position in the health care discipline for which trained. Completion of these requirements does not, however, guarantee appointment.

If you agree to these conditions, please sign the statement below and return the letter in the enclosed postage-free envelope. This agreement may be terminated at any time by either party by written notice of such intent.

Please indicate your veteran status by circling the appropriate number below.

Sincerely yours,

JERRY FREEMAN
 Chief, Human Resources Management Service

*(Non-citizens Only)

DeAnne M. Seekins, MBA
 Director, DVAMC

Enclosure

I agree to serve in the above capacity under the conditions indicated
 Signature Dona S. Nurse Date 9/30/2015

- Veterans Status
 1-Vietnam Veteran
 2- Other Veteran
 3-Non-Veteran

* For this purpose, a Vietnam Veteran is one with Service between August 15, 1964 and May 7, 1975

FINGERPRINT RECORD PREP SHEET

WOC'S, INTERNS, RESIDENTS, VOLUNTEERS, CONTRACTORS, TERM EMPLOYEES	START DATE	END DATE
	01/2016	08/2017
	SON-1078	SOI-VA68

PLEASE PRINT CLEARLY

COMPLETE FORM ENTIRELY

NAME (LAST, FIRST, MIDDLE-IN THIS ORDER)	Nurse, Ima G	
ALIAS (LAST, FIRST, MIDDLE-IN THIS ORDER)	n/a	
GENDER	Female	
RACE	White	
EYE COLOR	Brown	
HAIR COLOR	Brown	
HEIGHT	FEET: 5	INCHES: 10
WEIGHT (LBS)	190	
DATE OF BIRTH	YEAR: 2006 MONTH: 5 DAY: 16	
PLACE OF BIRTH	COUNTRY: USA CITY: Chapel Hill STATE: NC	
COUNTRY OF CITIZENSHIP	USA	
FULL SOCIAL SECURITY NUMBER	123-45-6789	
DVAMC ASSIGNED SERVICE DEPARTMENT	1/2016	
OCCUPATION TITLE/ RESPONSIBLE POC	Nursing Student	L. Daniel, PSA, Nursing
HOME ADDRESS (NO P.O.BOX)	STREET 123 Student Lane	
	CITY Chapel Hill STATE NC ZIP 27514	
WOC, AFFILIATES, VOLUNTEERS, CONTRACTOR, INTERNS, RESIDENTS - TELEPHONE NUMBER	(919) 333-3333 or pickup VA ext.	
AFFILIATION DESCRIPTION/SERVICE	WOC	Nursing
APPLICANT'S EMAIL ADDRESS	nurse.i@email.unc	

To be completed by Human Resources Representative:

DATE FINGERPRINTED: _____ Employee Renewal
 New badge Lost badge Not Working

PRINTED BY: _____ Affiliate Courtesy Contractor Pre-Employment

VISN 6 Request and Authorization for Computer Access

Action: New User Re-activation Modification Service Transfer Transfer from another VA

Report Date: 01/2016

Termination Date: 08/2017

(Required for Contractors and Residents/Students)

REQUEST ACCESS TO:	APPOINTMENT STATUS:	TYPE OF ACCESS NEEDED:
<input type="checkbox"/> Asheville <input type="checkbox"/> Hampton <input type="checkbox"/> Beckley <input type="checkbox"/> Richmond <input checked="" type="checkbox"/> Durham <input type="checkbox"/> Salem <input type="checkbox"/> Fayetteville <input type="checkbox"/> Salisbury	<input type="checkbox"/> Full-Time <input checked="" type="checkbox"/> WOC <input type="checkbox"/> Part-Time <input checked="" type="checkbox"/> Student <input type="checkbox"/> Contractor <input type="checkbox"/> [] <input type="checkbox"/> Resident	<input type="checkbox"/> Network <input type="checkbox"/> VPN from other VISN, include username below. (Not for Durham) <input type="checkbox"/> Vista <input checked="" type="checkbox"/> Outlook/Email <input checked="" type="checkbox"/> CPRS

User Information

Last Name: Nurse First Name: Ima Middle Name: G
Social Security #: 123-45-6789 DOB: 05-16-08 Female Male

Service: Nursing Education Section: [] Title: [] Mail Code: []
Office Phone: [] Pager: [] NPI #: []

Requested Menus and Security Keys

VistA Primary Menu: []
VistA Secondary Menu(s): []
Security Keys: []
Mail Groups: []
Justification for Access/
Extended Termination Date: []

Certifications

VA Privacy and Information Security Awareness and Rules of Behavior Training - Certificate Attached
 Privacy and HIPAA Training - Certificate Attached
 Mandatory Training for Trainees - Certificate Attached (Trainees Only)
 VA National Rules of Behavior Hard Copy - Attached (New Employees attending NEO only)
 Contractor National Rules of Behavior from VA Handbook 6500.6 (Contractors Only)

Concurrences

Concurrence: I certify that the above employee is required to have this access to perform the duties assigned.

Authorizing Official: Print Name	Authorizing Official - Digital Signature	Phone #:
[]	[]	[]
Information Security Officer - Name	Information Security Officer - Signature	Phone #:
[]	[]	[]

Host and Remote ISO's signature is required on all inter-facility requests

Remote Information Security Officer - Name	Remote Information Security Officer - Signature	Phone #:
[]	[]	[]
		Date:
		[]

HSPD-12 Communication

Department of Veterans Affairs

Date: June 22, 2015

From: HSPD-12 Program Management Office

To: PIV Community

Subj: New Identity Source Document Guidelines

All,

Effective immediately, the requirements for identity source documents have changed based on new guidance in FIPS 201-2. Going forward, please refer to [FIPS 201-2](#) (pages 9-10) for the complete list of acceptable identity proofing documents; the Lists of Acceptable Documents table on the I-9 form should no longer be used as a reference for acceptable forms of ID for the issuance of a PIV credential.

Two identity source documents from the matrix on the following page are required. **Both documents CANNOT be expired or cancelled.** One ID must be from the Primary Identity Source Document column. The second ID can be from either the Primary Identity Source Document column (left) or the Secondary Identity Source Document column (right). Applicants can provide two documents from the Primary Identity Source Documents but cannot provide two documents from the Secondary Identity Source Documents. If the second ID is also from the Primary Identity Source Documents, it cannot be of the same type as the one already provided.

Primary Identity Source Document	Secondary Identity Source Document
<ul style="list-style-type: none"> • A U.S. Passport or U.S. Passport Card • A Permanent Resident Card or Alien Registration Receipt Card (Form I-551) • A foreign passport • An Employment Authorization Document that contains a photograph (Form I-766) • A Driver's license or an ID card issued by a State or possession of the United States provided it contains a photograph • A U.S. Military card • A U.S. Military dependent's ID card • A PIV Card 	<ul style="list-style-type: none"> • A U.S. Social Security Card issued by the Social Security Administration • An original or certified copy of a birth certificate issued by a state, county, municipality authority, or outlying possession of the U.S. bearing an official seal • An ID card issued by a federal, state, or local government agency or entity, provided it contains a photograph • A voter's registration card • A U.S. Coast Guard Merchant Mariner Card • A Certificate of U.S. Citizenship (Form N-560 or N-561) • A Certificate of Naturalization (Form N-550 or N-570) • A U.S. Citizen ID Card (Form I-197) • An Identification Card for Use of Resident Citizen in the United States (Form I – 179) • A Certification of Birth Abroad or Certification of Report of Birth issued by the Department of State (Form FS-545 or Form DS-1350) • A Temporary Resident Card (Form I-688) • An Employment Authorization Card (Form I-688A) • A Reentry Permit (Form I-327) • A Refugee Travel Document (Form I-571) • An Employment Authorization Document issued by Department of Homeland Security (DHS) • An Employment Authorization Document issued by DHS with photograph (Form I-688B) • A driver's license issued by a Canadian government entity • A Native American Tribal document

For example, an applicant can provide a U.S. Passport (left column) and a U.S. Social Security Card (right column) **OR** a U.S. Passport (left column) and a U.S. Military card (left column). However, they cannot provide a U.S. Social Security card (right column) and a voter's registration card (right column).

If you have any questions related to this communication, please submit inquiries to the Program Management Office at vacohtpd12pmo@va.gov.

Thank you,

HSPD-12 PMO Communications Team

*Student Identification Card
is not accepted.*