



**DEPARTMENT OF THE AIR FORCE  
AIR UNIVERSITY (AETC)**

# AFROTC

## Detachment 010

### University of Alabama

### Application Packet



(Last Updated July 2019-TSgt Wilson)

**PRIVACY ACT OF 1974 APPLIES**

## Attachment 2

## SCHOLARSHIP PROGRAM STATEMENT OF UNDERSTANDING

**Figure A2.1. Scholarship Program Statement of Understanding.**

**FOUR-YEAR SCHOLARSHIP SELECTEES (4YR HSSP).** I understand I must be enrolled as a full-time student each term and be enrolled and participating in AFROTC courses and Leadership Laboratory each term. I understand that I must pass the PFA prior to 31 December of my freshman year or my scholarship will be suspended. If I fail to pass the PFA during the subsequent term, I understand that my scholarship will be terminated. I understand I must achieve a Cumulative Grade Point Average (CGPA) of 2.5 or higher while I am contracted. If I do not, my scholarship eligibility may be impacted, suspended, or terminated. If I am disenrolled from AFROTC as an AS100 cadet, I will not be subject to recoupment of scholarship funding or call to active duty. I have been counseled by an AFROTC representative on the scholarship activation and retention standards prescribed in AFROTC instructions and I understand the activation and retention standards. Even if I achieve GPA standards but my Det/CC does not feel my performance warrants scholarship retention, I understand my scholarship can be suspended or terminated immediately. In such case, I may, at the discretion of my Det/CC, continue in AFROTC on a non-scholarship basis.

**THREE-YEAR SELECTEES (3YR HSSP).** I understand that I must be enrolled as a full-time student through the entire freshman year at the school where I will activate my scholarship and that I must be enrolled in and attending AFROTC classes and Leadership Laboratory each term. I understand that I must have a Term Grade Point Average (TGPA) of 2.5 during the spring term of my freshman year and have a CGPA of 2.5 or higher by the end of my freshman year to activate my scholarship in the fall of my sophomore year. I understand that once the scholarship is activated, I must be enrolled as a full-time student each term and be enrolled and participating in AFROTC courses and Leadership Laboratory each term. I also understand that I must achieve a TGPA of 2.5 or higher during all terms while I am contracted. I have been counseled by an AFROTC representative on the scholarship activation and fitness and retention standards prescribed in AFROTC instructions. I understand the activation and retention standards and that I must pass the PFA NLT the fall term of my AS200 year to keep my scholarship but I must have a passing PFA before my scholarship can be activated. If I fail to meet any of these standards, my scholarship offer will be withdrawn. In such case, even if I achieve these standards and my Det/CC does not feel my performance warrants scholarship retention, I understand my scholarship offer can be withdrawn immediately.

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 Cadet Signature / Date

(Only for Applicants under Minimum Enlistment Age)

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 Parent/Guardian Signature / Date

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 Printed Name Witness / Date

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 Witness Signature



**DEPARTMENT OF THE AIR FORCE  
AIR UNIVERSITY (AETC)**

**DATE** \_\_\_\_\_

MEMORANDUM FOR CADET (**Last Name, First Name**) \_\_\_\_\_

FROM: Air Force Reserve Officer Training Corps (AFROTC) Detachment (Det) 010

SUBJECT: Request and Consent for Release of Mail Access Authorization

1. The Detachment Commander (CC) and the Detachment staff will need to open official US Air Force (USAF) correspondence delivered to the detachment addressed to cadets. Access to these documents is for the verification and accuracy of the contents ONLY. Specific documents we open are: assignment orders for cadets entering active duty, cadet travel summaries, and cadet Leave and Earnings Statements (LES). We must verify these documents when received to ensure accuracy and to immediately correct or report any discrepancies to higher headquarters. In accordance with the Privacy Act, we must have your permission to access this mail.

2. Therefore, request you sign your payroll signature below to consent to our access. Giving consent is strictly voluntary. However, if you do not give your consent, delays may be encountered in processing these vital items. Only OFFICIAL USAF correspondence specifically approved by the detachment commander will be opened. Please sign below if you agree to authorize cadre members to open OFFICIAL USAF mail addressed to you.

//SIGNED//  
AFROTC Det 010

1<sup>st</sup> Ind, Student/Cadet/Applicant

**DATE:** \_\_\_\_\_

MEMORANDUM FOR AFROTC Det 010

I have read and understand your request for official copies of my school records. I hereby voluntarily consent to the release of such official records as you may require in your above-stated request and have signed the attached authorization for appropriate school officials to release to Det 010 personnel or to the appropriate DOD agency any and all official records, files, and data for their use as requested above.

\_\_\_\_\_  
(Student's Signature)

\_\_\_\_\_  
(Parent's Signature if student is under age 19)

\_\_\_\_\_  
Printed Name of Witness, Det 010 Staff or  
Notary

\_\_\_\_\_  
Signature of Witness, Det 010 Staff or Notary

**PRIVACY ACT OF 1974 APPLIES**



**DEPARTMENT OF THE AIR FORCE  
AIR UNIVERSITY (AETC)**

Date: \_\_\_\_\_

MEMORANDUM FOR \_\_\_\_\_ (Insert attending College/University)

FROM: CADET (Last Name, First Name) \_\_\_\_\_

SUBJECT: 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 (Det) 010 to conduct official AFROTC business. I therefore authorize appropriate school officials to release to Det 010 personnel or to the appropriate DOD agency any and all official records, files, and data for their use in official AFROTC business.

\_\_\_\_\_  
(Student's Signature)

\_\_\_\_\_  
(Parent's Signature, if student is under age 19)

\_\_\_\_\_  
Printed Name of Witness, Det 010 Staff or  
Notary

\_\_\_\_\_  
Signature of Witness, Det 010 Staff or Notary



**DEPARTMENT OF THE AIR FORCE  
AIR UNIVERSITY (AETC)**

**DATE** \_\_\_\_\_

MEMORANDUM FOR CADET (**Last Name, First Name**) \_\_\_\_\_

FROM: Air Force Reserve Officer Training Corps (AFROTC) Detachment (Det) 010

SUBJECT: Request and Consent for Release of Student Records to Det 010 Staff

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 AFROTC and Department of Defense (DOD) agencies, as may be required by these agencies.

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

//SIGNED//  
AFROTC Det 010

1<sup>st</sup> Ind, Student/Cadet/Applicant

**DATE:** \_\_\_\_\_

MEMORANDUM FOR AFROTC Det 010

I have read and understand your request for official copies of my school records. I hereby voluntarily consent to the release of such official records as you may require in your above-stated request and have signed the attached authorization for appropriate school officials to release to Det 010 personnel or to the appropriate DOD agency any and all official records, files, and data for their use as requested above.

\_\_\_\_\_  
(Student's Signature)

\_\_\_\_\_  
(Parent's Signature if student is under age 19)

\_\_\_\_\_  
Printed Name of Witness, Det 010 Staff or  
Notary

\_\_\_\_\_  
Signature of Witness, Det 010 Staff or Notary

Attachment:  
Consent for Release of Student Records

**PRIVACY ACT OF 1974 APPLIES**



# 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 may 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 diethylamide (LSD), phencyclidine (PCP), tetrahydrocannabinol (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 tetrahydrocannabinol (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 whatever 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**



<b>WITNESS</b>		
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
<div style="background-color: yellow; padding: 2px; margin-bottom: 5px;"><b>REMARKS</b></div> <p>1.) What Specific drug or combination of drugs (to include hemp derivatives did you consume? How many times did you consume each drug(s)? (Input N/a if you have NEVER experimented with, used or possessed marijuana, or any illegal drug or narcotic.)</p> <p>2.) Dates and Circumstances surrounding each occurrence. Input N/a if you have NEVER experimented with, used or possessed marijuana, or any illegal drug or narcotic.</p> <p>3.) Method of how it was used (orally, injected, skin-popping, sniffing etc.) Input N/a if you have NEVER experimented with, used or possessed marijuana, or any illegal drug or narcotic.</p> <p>4.) What residual effect did each drug(s) have on you? Specifically what effects were produced by the drug (none, relaxation, irritability, time or visual perception disturbance or distortion, panic, sleepiness, flashbacks, restless, loss of consciousness, increased insight, ect): Input N/a if you have NEVER experimented with, used or possessed marijuana, or any illegal drug or narcotic.</p> <p>5.) What are your current feelings towards each drug(s) and will you use them again? Also, Indicate any other information that would be helpful in evaluation of waiver. Input N/a if you have NEVER experimented with, used or possessed marijuana, or any illegal drugs.</p>		
<b>SECTION IV. RECERTIFICATION AT TIME OF ENLISTMENT, COMMISSIONING, OR APPOINTMENT</b>		<b>INITIALS</b>
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
<b>WITNESS</b>		
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



## DEPARTMENT OF THE AIR FORCE AIR UNIVERSITY (AETC)

### DRUG DEMAND REDUCTION PROGRAM MOU

#### 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 ROTC 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.

\_\_\_\_\_  
Student/Cadet Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Parent's Signature, if student is under age 19)

\_\_\_\_\_  
Student/Cadet Signature Printed Name

\_\_\_\_\_  
Printed Name of Witness, Det 010 Staff (or Notary)

\_\_\_\_\_  
Signature of Witness, Det 010 Staff (or Notary)



## RECORD OF EMERGENCY DATA

### PRIVACY ACT STATEMENT

**AUTHORITY:** 5 USC 552, 10 USC 655, 1475 to 1480 and 2771, 38 USC 1970, 44 USC 3101, and EO 9397 (SSN).

**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, missing 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. The purpose of soliciting the SSN is to provide positive identification. All items may not be applicable.

**ROUTINE USES:** None.

**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. **SSN**

3a. **SERVICE/CIVILIAN CATEGORY**

☐ ARMY ☐ NAVY ☐ MARINE CORPS ☒ AIR FORCE ☐ DoD ☒ CIVILIAN ☐ CONTRACTOR

b. **REPORTING UNIT CODE/DUTY STATION**

AFROTC DET010

4a. **SPOUSE NAME** (If applicable) (Last, First, Middle Initial)

b. **ADDRESS** (Include ZIP Code) **AND TELEPHONE NUMBER**

☐ SINGLE ☐ DIVORCED ☐ WIDOWED

5. **CHILDREN**

a. **NAME** (Last, First, Middle Initial)

b. **RELATIONSHIP**

c. **DATE OF BIRTH**  
(YYYYMMDD)

d. **ADDRESS** (Include ZIP Code) **AND TELEPHONE NUMBER**

6a. **FATHER NAME** (Last, First, Middle Initial)

b. **ADDRESS** (Include ZIP Code) **AND TELEPHONE NUMBER**

7a. **MOTHER NAME** (Last, First, Middle Initial)

b. **ADDRESS** (Include ZIP Code) **AND TELEPHONE NUMBER**

8a. **DO NOT NOTIFY DUE TO ILL HEALTH**

N/A

b. **NOTIFY INSTEAD**

N/A

9a. **DESIGNATED PERSON(S)** (Military only)

N/A

b. **ADDRESS** (Include ZIP Code) **AND TELEPHONE NUMBER**

N/A

10. **CONTRACTING AGENCY AND TELEPHONE NUMBER** (Contractors only)

N/A

# SECTION 2 - BENEFITS RELATED INFORMATION

<b>11a. BENEFICIARY(IES) FOR DEATH GRATUITY</b> <i>(Military only)</i>	<b>b. RELATIONSHIP</b>	<b>c. ADDRESS</b> <i>(Include ZIP Code)</i> <b>AND TELEPHONE NUMBER</b>	<b>d. PERCENTAGE</b>
<b>12a. BENEFICIARY(IES) FOR UNPAID PAY/ALLOWANCES</b> <i>(Military only)</i> <b>NAME AND RELATIONSHIP</b>		<b>b. ADDRESS</b> <i>(Include ZIP Code)</i> <b>AND TELEPHONE NUMBER</b>	<b>c. PERCENTAGE</b>
<b>13a. PERSON AUTHORIZED TO DIRECT DISPOSITION (PADD)</b> <i>(Military only)</i> <b>NAME AND RELATIONSHIP</b>		<b>b. ADDRESS</b> <i>(Include ZIP Code)</i> <b>AND TELEPHONE NUMBER</b>	
<b>14. CONTINUATION/REMARKS</b>			
<b>15. SIGNATURE OF SERVICE MEMBER/CIVILIAN</b> <i>(Include rank, rate, or grade if applicable)</i>	<b>16. SIGNATURE OF WITNESS</b> <i>(Include rank, rate, or grade as appropriate)</i>  DETACHMENT 010 STAFF MEMBER		<b>17. DATE SIGNED</b> <i>(YYYYMMDD)</i>

## INSTRUCTIONS FOR PREPARING DD FORM 93

(See appropriate Service Directives for supplemental instructions for completion of this form at other than MEPS)

All entries explained below are for electronic or typewriter completion, except those specifically noted. If a computer or typewriter is not available, print in black or blue-black ink insuring a legible image on all copies. Include "Jr.," "Sr.," "III" or similar designation for each name, if applicable. When an address is entered, include the appropriate ZIP Code. If the member cannot provide a current address, indicate "unknown" in the appropriate item. Addresses shown as P.O. Box Numbers or RFD numbers should indicate in Item 14, "Continuations/Remarks", a street address or general guidance to reach the place of residence. In addition, the notation "See Item 14" should be included in the item pertaining to the particular next of kin or when the space for a particular item is insufficient. If the address for the person in the item has been shown in a preceding item, it is unnecessary to repeat the address; however, the name must be entered. Those items that are considered not applicable to civilians will be left blank.

ITEM 1. Enter full last name, first name, and middle initial.

ITEM 2. Enter social security number (SSN).

ITEM 3a. Service. **Military:** Mark X in appropriate block. **Civilian:** Mark two blocks as appropriate. Examples: an Army civilian would mark Army and either Civilian or Contractor; a DoD civilian, without affiliation to one of the Military Services, would mark DoD and then either Civilian or Contractor as appropriate.

ITEM 3b. Reporting Unit Code/Duty Station. See Service Directives.

ITEM 4a. Spouse Name. Enter last name (if different from Item 1), first name and middle initial on the line provided. If single, divorced, or widowed, mark appropriate block.

ITEM 4b. Address and Telephone Number. Enter the "actual" address and telephone number, not the mailing address. Include civilian title or military rank and service if applicable. If one of the blocks in 4a is marked, leave blank.

ITEM 5a-d. Children. Enter last name (only if different from Item 1) first name and middle initial, relationship, and date of birth of all children. If none, so state. Include illegitimate children if acknowledged by member or paternity/maternity has been judicially decreed. Relationship examples: son, daughter, stepson or daughter, adopted son or daughter or ward. Date of birth example: 19950704. For children not living with the member's current spouse, include address and name and relationship of person with whom residing in item 5d.

ITEM 6a. Father Name. Last name, first name and middle initial.

ITEM 6b. Address and Telephone Number of Father. If unknown or deceased, so state. Include civilian title or military rank and service if applicable. If other than natural father is listed, indicate relationship.

ITEM 7a. Mother Name. Last name, first name and middle initial.

ITEM 7b. Address and Telephone Number of Mother. If unknown or deceased, so state. Include civilian title or military rank and service if applicable. If other than natural mother is listed, indicate relationship.

ITEM 8. Persons Not to be Notified Due to Ill Health.

a. List relationship, e.g., "Mother," of person(s) listed in Items 4, 5, 6, or 7 who are not to be notified of a casualty due to ill health. If more than one child, specify, e.g., "daughter Susan." Otherwise, enter "None".

b. List relationship, e.g., "Father" or name and address of person(s) to be notified in lieu of person(s) listed in item 8a. If "None" is entered in Item 8a, leave blank.

ITEM 9a. This item will be used to record the name of the person or persons, if any, other than the member's primary next of kin or immediate family, to whom information on the whereabouts and status of the member shall be provided if the member is placed in a missing status. Reference 10 USC, Section 655. **NOT APPLICABLE to civilians.**

ITEM 9b. Address and telephone number of Designated Person(s). **NOT APPLICABLE to civilians.**

ITEM 10. Contracting Agency and Telephone Number (**Contractors only**). **NOT APPLICABLE to military personnel.** Civilian contractors will provide the name of their contracting agency and its telephone number. Example: XYZ Electric, (703) 555-5689. The telephone number should be to the company or corporation's personnel or human resources office.

ITEM 11a. Beneficiary(ies) for Death Gratuity (**Military only**). Enter first name(s), middle initial, and last name(s) of the person(s) to receive death gratuity pay. A member may designate one or more persons to receive all or a portion of the death gratuity pay. The designation of a person to receive a portion of the amount shall indicate the percentage of the amount, to be specified only in 10 percent increments, that the person may receive. If the member does not wish to designate a beneficiary for the payment of death gratuity, enter "None," or if the full amount is not designated, the payment or balance will be paid as follows:

- (1) To the surviving spouse of the person, if any;
- (2) To any surviving children of the person and the descendants of any deceased children by representation;
- (3) To the surviving parents or the survivor of them;
- (4) To the duly appointed executor or administrator of the estate of the person;
- (5) If there are none of the above, to other next of kin of the person entitled under the laws of domicile of the person at the time of the person's death.

The member should make specific designations, as it expedites payment.



## INSTRUCTIONS FOR PREPARING DD FORM 93

(Continued)

ITEM 11a. (Continued) Seek legal advice if naming a minor child as a beneficiary. If a member has a spouse but designates a person other than the spouse to receive all or a portion of the death gratuity pay, the Service concerned is required to provide notice of the designation to the spouse. **NOT APPLICABLE to civilians.**

Item 11b. Relationship. **NOT APPLICABLE to civilians.**

ITEM 11c. Enter beneficiary(ies) full mailing address and telephone number to include the ZIP Code. **NOT APPLICABLE to civilians.**

ITEM 11d. Show the percentage to be paid to each person. Enter 10%, 20%, 30%, up to 100% as appropriate. The sum shares must equal 100 percent. If no percent is indicated and more than one person is named, the money is paid in equal shares to the persons named. **NOT APPLICABLE to civilians.**

ITEM 12a. Beneficiary(ies) for Unpaid Pay/Allowance (**Military only**). Enter first name(s), middle initial, last name(s) and relationship of person to receive unpaid pay and allowances at the time of death. The member may indicate anyone to receive this payment. If the member designated two or more beneficiaries, state the percentage to be paid each in item 10c. If the member does not wish to designate a beneficiary, enter "By Law." The member is urged to designate a beneficiary for unpaid pay and allowances as payment will be made to the person in order of precedence by law (10 USC 2271) in the absence of a designation. Seek legal advice if naming a minor child as beneficiary. **NOT APPLICABLE to civilians.**

ITEM 12b. Enter beneficiary(ies) full mailing address and telephone number to include the ZIP Code. **NOT APPLICABLE to civilians.**

ITEM 12c. If the member designated two or more beneficiaries, state the percentage to be paid each in this section. The sum shares must equal 100 percent. **NOT APPLICABLE to civilians.**

ITEM 13a. Enter the name and relationship of the Person Authorized to Direct Disposition (PADD) of your remains should you become a casualty. Only the following persons may be named as a PADD: surviving spouse, blood relative of legal age, or adoptive relatives of the decedent. If neither of these three can be found, a person standing in loco parentis may be named. **NOT APPLICABLE to civilians.**

ITEM 13b. Address and telephone number of PADD. **NOT APPLICABLE to civilians.**

ITEM 14. Continuations/Remarks. Use this item for remarks or continuation of other items, if necessary. Prefix entry with the number of the item being continued; for example, 5/John J./son/ 19851220/321 Pecan Drive, Schertz TX 78151. Also use this item to list name, address, and relationship of other persons the member desires to be notified. Other dependents may also be listed. This block offers the greatest amount of flexibility for the member to record other important information not otherwise requested but considered extremely useful in the casualty notification and assistance process. Besides continuing information from other blocks on this form, the member may desire to include additional information such as: NOK language barriers, location or existence of a Will, additional private insurance information, other family member contact numbers, etc. If additional space is required, attach a supplemental sheet of standard bond paper with the information.

ITEM 15. Signature of Service Member/Civilian. Check and verify all entries and sign all copies in ink as follows: First name, middle initial, last name. Include rank, rate, or grade if applicable. May be electronically signed (see DoD Instruction 1300.18 for guidelines).

ITEM 16. Signature of Witness. Have a witness (disinterested person) sign all copies in ink as follows: First name, middle initial, last name. Include rank, rate, or grade as appropriate. A witness signature is not required for electronic versions of the DD Form 93 (see DoD Instruction 1300.18).

ITEM 17. Date the member or civilian signs the form. This item is an ink entry and must be completed on all copies.

## RESTRICTIONS ON PERSONAL CONDUCT IN THE ARMED FORCES

1. Military life is fundamentally different from civilian life. The military has its own laws, rules, customs, and traditions, including numerous restrictions on personal behavior, that would not be acceptable in civilian society. These are necessary because military units and personnel must maintain the high standards of morale, good order, discipline, and unit cohesion that are essential for combat effectiveness.
2. The Armed Forces must be ready at all times for worldwide deployment. Military law and regulations, including the Uniform Code of Military Justice, apply to service members at all times, both on base and off base, from the time the member enters the service until the member is discharged or otherwise separated from the Armed Forces.
3. Members of the Armed Forces may be involuntarily separated before their term of service ends for various reasons established by law and military regulations, such as:
  - a. A member may be separated for a pattern of disciplinary infractions, a pattern of misconduct, commission of a serious offense, or civilian conviction.
  - b. A member who has been referred to a rehabilitation program for personal drug and alcohol abuse may be separated for failure through inability or refusal to participate in, cooperate in, or successfully complete such a program.
  - c. A member may be discharged by reason of parenthood, if it is determined the member, because of parental responsibilities, is unable to perform his or her duties satisfactorily or is unavailable for worldwide assignment or deployment.
  - d. A member may be separated for failure to meet service weight control standards or physical fitness standards.
  - e. A member may be separated for harassment of or violence against any service member.

DATE OF APPLICATION	NAME (Last, First, MI)	SIGNATURE
DATE OF ENLISTMENT	NAME (Last, First, MI)	SIGNATURE
DATE OF COMMISSION	NAME (Last, First, MI)	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. <b>RECRUIT/TRAINEE NAME</b> ( <i>Last, First, Middle</i> )	2. <b>PAY GRADE</b> CADET	3. <b>RECRUITING OFFICE/TRAINING COMMAND</b> AFROTC DETACHMENT 010
4. <b>RECRUITING OFFICE/TRAINING COMMAND ADDRESS</b> ( <i>City, State, ZIP Code</i> ) TUSCALOOSA, AL, 35487	5. <b>DATE SIGNED</b> ( <i>YYYYMMDD</i> )	6. <b>SIGNATURE</b>

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

(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. <b>VIOLATIONS.</b> Violations of any part of paragraph 7.a. through 7.h., not granted an exception in paragraph 8, may result in disciplinary action.
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## 10. APPROVED BY

a. NAME ( <i>Last, First, Middle Initial</i> )	b. TITLE	c. DATE SIGNED ( <i>YYYYMMDD</i> )	d. SIGNATURE/RANK
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# AU MAC STUDENT STANDARDS OF CONDUCT TRAINING AGREEMENT

## SECTION I. STUDENT/CADET/OFFICER TRAINEE INFORMATION

NAME: (Last, First, MI)		RANK: CADET
ORGANIZATION: AFOTC DET 010	CLASS/FLIGHT: AS _____	PHONE: _____

## SECTION II. OBLIGATIONS

### READ ALL STATEMENTS CAREFULLY

**NOTE: Initial only after careful review. Failure to comply could result in disciplinary action.**

		INITIALS
1.	I have read and understand AFI 36-2909, <i>Professional and Unprofessional Relationships</i> , AETCI 36-2909, <i>Recruiting, Education, and Training Standards of Conduct</i> , and AU Mission Area Commander Guidance.	
2.	I understand that AFI 36-2909, AETCI 36-2909 and AU MAC Guidance applies to all individuals assigned or attached to, or operating in an AU unit as an instructor, recruiter, cadre member, faculty or staff member, as well as to students, cadets, trainees, DoD civilians, international military or civilian personnel, and contractor personnel. I understand that the AETCI 36-2909 applies from initial contact with an applicant and continues to apply throughout all entry level and initial skills training, including breaks in between. It also applies when an individual returns to AU as a student for continuing professional education or training courses.	
3.	I understand military members who violate AFI 36-2909, AETCI 36-2909, or the AU MAC Guidance are subject to prosecution or disciplinary actions under Article 92 of the Uniform Code of Military Justice (UCMJ), as well as any other applicable article of the UCMJ. Civilian personnel who violate AFI 36-2909, AETCI 36-2909, or AU MAC Guidance are subject to disciplinary action under AFI 36-704, <i>Discipline and Adverse Actions</i> .	
4.	I understand a "student", "cadet", and "officer or enlisted trainee" includes military and civilian personnel who are assigned or on temporary duty to other AETC bases, wings, detachments, or schools to attend training or courses of instruction for officer training and accessions, entry level training, initial skills training, technical training, reporting to their permanent duty stations, professional continuing education, or other training and developmental courses.	
5.	I understand these rules apply to personnel who are awaiting or have completed training or instruction, as well as those who have been eliminated or disenrolled from training or instruction and are awaiting reassignment or discharge. I understand my special responsibilities apply to ALL AETC students, cadets, trainees, or other entry level or initial skills students, in every AETC course of instruction, under every circumstance, until six months after they complete initial skills training, and are no longer a student, cadet, or trainee but are signed in as a permanent party of their duty location.	
6.	I understand that instructors, recruiters, faculty and staff must also follow these rules and must dedicate themselves to conduct that is professional and in line with Air Force standards of conduct.	
7.	In accordance with the above regulations, I <b>WILL NOT</b> do the following with <b>ANY</b> instructor, recruiter, cadre member, faculty or staff:	
	a. Engage in any social contact of a personal nature while in a training environment.	
	b. Establish or attempt to establish personal, social contact or develop a relationship of a personal, intimate or sexual nature. This includes but is not limited to: kissing, hand holding, embracing, caressing and engaging in sexual activities. <b>Personal social contact or personal relationships are prohibited whether conducted face-to-face or via cards, letters, emails, telephone calls, instant messages, video, photograph or by any other means.</b>	
	c. Make, seek or accept sexual advances or favors	
	d. Gamble	
	e. Lend or borrow money, hire for services (babysitting, moving, etc.) or establish a business together	
	f. Establish a common household (share the same living area) unless required by military operations	
	g. Attend social gatherings, other than approved official functions, or frequent clubs, bars or theaters together unless it is an outside the classroom event approved by my commander	
	h. Accept or consume alcohol unless it is at an event approved by my commander	
8.	I <b>WILL NOT</b> allow even the appearance of an unprofessional relationship exist between myself and an instructor, recruiter, cadre member, faculty or staff member.	
9.	I <b>WILL NOT</b> engage in, nor tolerate in others, maltreatment, maltraining, or hazing under any circumstances.	
10.	I <b>WILL</b> dedicate myself to conduct that is professional and beyond reproach.	
11.	I understand I should report any allegations of a violation of AETCI 36-2909.	
12.	I <b>WILL REPORT</b> any and all incidents of maltreatment, maltraining, hazing, unprofessional relationship, or inappropriate social conduct about which I learn, whether through personal observation, end of course surveys, critiques (anonymous or otherwise), or oral accounts from any party (students, cadets, officer or enlisted trainees, instructors, recruiters, cadre members, faculty or staff).	

*I WILL BE ALERT TO ANY VIOLATION, OR PERCEIVED VIOLATION, OF THE GUIDELINES ABOVE. I WILL ALWAYS REMAIN AN EXAMPLE OF PROFESSIONALISM AND HONOR.*

DATE _____	SIGNATURE _____
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## 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 (OEI); 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://dpcl.d.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)

**USAF STATEMENT OF UNDERSTANDING FOR DEPENDENT CARE RESPONSIBILITY***(This form is subject to the Privacy Act of 1974. Use Blanket PAS - AF Form 883)***I. MARITAL STATUS**☐ SINGLE ☐ MARRIED (Civilian) ☐ MARRIED (Military) ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED**II. STATEMENT OF UNDERSTANDING**

I understand:

My eligibility is based on my marital and dependency status and failure to claim all my dependents may result in my involuntary separation from the Air Force. I have read and understand the following definitions the Air Force considers a dependent for accession purposes. 1. A spouse. 2. Any person under the age of 18 for whom the applicant or spouse has legal or physical custody, control, care, maintenance, or support. Includes children from a previous marriage, a relative by blood or marriage and stepchildren or adopted children of the applicant or spouse. 3. Any unmarried natural children of the applicant or spouse regardless of current residence. For male applicants, the term natural child includes those born out of wedlock. 4. Any person who is dependent upon the applicant or spouse for their care, maintenance, or support regardless of age. (5) FOR MALE APPLICANTS ONLY. An unborn child of the spouse or one claimed by or a court order determines is his. ( ☐ )

It is my responsibility to provide legal documents (marriage certificate, birth certificate, etc.) to substantiate my dependent(s) and it is my responsibility to support myself and my dependent(s) on the pay and allowances I receive. I also understand arrangements for care of my dependent(s) is my personal responsibility and will not interfere with my assigned Air Force duties, including shift work, weekend duty, temporary duty away from my assigned duty station and short notice deployments and evacuations. I further understand my dependent(s) will not prevent me from being available for worldwide assignment and failure to perform my military dependent(s) may result in disciplinary action, to include involuntary discharge. ( ☐ )

If applying for an enlisted program, my dependent(s) are not permitted to accompany me during basic training, and it is recommended they not accompany me during any technical training. If applying for an officer program, it is strongly recommended my dependent(s) not accompany me while attending training. I also understand government family quarters are assigned based on application date, grade, date of grade, number of dependents, and availability. ( ☐ )

Military couples with dependent(s) are required to make dependent care arrangements that allow both members to meet all military obligations and duties. I also understand each member is considered to be serving in his or her own right and must be available for worldwide assignment regardless of marital or dependent status. Additionally, I understand married Air Force couples may apply for a joint spouse assignment but there is no guarantee they will be assigned together. ( ☐ )

**III. REMARKS**

NONE

CADET Initial ABOVE

**IV. APPLICANT CERTIFICATION**

I have read the information on this form and understand how it applies to me and my dependent(s). I also understand the needs of the Air Force come first and I may be involuntarily discharged should I violate any of these provisions. I certify the information on this form is of my personal knowledge and is true and correct and my recruiter did not advise me to conceal any dependency information.

DATE	NAME (Last, First, Middle Initial)	SSN	SIGNATURE

**V. RECRUITER CERTIFICATION**

I certify the information on this form was explained to the applicant and I verified the applicant's dependent(s) and marital status from appropriate source documents.

DATE	RECRUITER'S NAME/GRADE	SIGNATURE
	CADRE, DETACHMENT 010	

**VI. APPLICANT FINAL CERTIFICATION**

On the date of enlistment or commissioning or appointment and prior to signing the oath, I reviewed the information on this form and hereby reaffirm complete knowledge and understanding of the statements contained herein. I further certify all changes to my marital or dependent status since initiation of this form are explained in Section III.

DATE	SIGNATURE

**VII. AIR FORCE REPRESENTATIVE FINAL CERTIFICATION**

I have verified all known changes to the applicant's marital or dependent status since initiation of this form and certify they are explained in Section III.

DATE	NAME/GRADE OF AIR FORCE REPRESENTATIVE	SIGNATURE
	CADRE, DETACHMENT 010	



## Air Force Physical Fitness Screening Questionnaire (FSQ)

### Privacy Statement

**AUTHORITY:** Title 10 United States Code 9013, Secretary of the Air Force; AFI 36-2905, *Physical Fitness Program*.

**PRIMARY PURPOSE:** You are being asked these questions for your safety and health. The Fitness Assessment is a maximum effort test. Airmen who have not been exercising regularly and/or have underlying medical risk factors (as screened below) are at increased risk of injury or death during a fitness assessment. *Answering these questions honestly is in your best interest.*

**ROUTINE USES:** Disclosures are permitted under Title 5 United States Code 552a(b), Privacy Act of 1974, as amended.

**DISCLOSURE:** Mandatory use by Regular Air Force, Reserve and Guard members.

### PART I. MEMBER COMPLETES

NAME:

RANK:

CADET

OFFICE SYMBOL:

AFROTC DET 010

DUTY PHONE:

205-348-5900

**1. Have you experienced any of the symptoms/problems listed below and not been medically evaluated and cleared for unrestricted participation in a physical training program?**

- a. Unexplained chest discomfort with or without exertion
- b. Unusual or unexplained shortness of breath
- c. Dizziness, fainting, or blackouts associated with exertion
- d. Unpleasant feelings of rapid, irregular, or forceful heartbeats
- e. Unusual leg pain, cramping, or weakness during exercise
- f. Family history of sudden death before age of 40 in a first degree relative (e.g., biological mother, father, sibling, or child)
- g. Other medical conditions (e.g., diabetes, kidney disease, heart disease, a history of rhabdomyolysis, heat stroke, new medications, etc.) or surgical considerations that may prevent you from safely participating in a fitness assessment and have not been addressed with adequate restrictions on an AF Form 469, *Duty Limiting Condition Report*

**Have you answered "Yes" to ANY of the above conditions?**

- ☐ **Yes: Stop.** Notify your unit fitness program manager (UFPD) (to address rescheduling, etc.) and contact your primary care provider (PCP) for evaluation/recommendations (for Air Reserve Component, contact the medical liaison officer (MLO) for duty limiting conditions documentation and referral to PCP). Hand carry this form to your PCP or MLO.
- ☐ **No:** Proceed to next question.

**2. Do you know your sickle cell trait (SCT) screening test status? If unknown, you may access <https://imr.afms.mil/imr/myIMR.aspx>. (Note: this system is not your official medical record, but it contains readiness data.)**

- ☐ **Yes:** Proceed to question 3. If your SCT screening was negative, answer "Yes" to question 3.
- ☐ **No: Stop.** Notify your UFPD that you are not cleared for a fitness assessment. Complete the remainder of your questionnaire and hand carry this form to your medical provider for evaluation.

**3. If you have SCT, you are directed to complete two (2) counseling sessions regarding SCT with a health care provider at some time in your career AND watch the educational video about SCT once a year (<https://www.hprc-online.org/articles/sickle-cell-trait-awareness> OR <https://www.youtube.com/watch?v=8s9nKcFd-Fk>). Based on your SCT screening test result, have you completed the necessary counseling and education?**

- ☐ **Yes:** I completed training OR my SCT screening test was negative. Proceed to question 4.
- ☐ **No: Stop.** Notify your UFPD that you are not cleared for a fitness assessment. Complete the remainder of your questionnaire and hand carry this form to your medical provider for evaluation.

**4. Have you engaged in vigorous physical activity (i.e., activity causing sweating and moderate to severe increase in breathing and heart rate) averaging at least 30 minutes per session, 3 days per week, over the last 3 months?**

- ☐ **Yes: Stop.** Sign form and return to your UFPD. Airman may take the fitness assessment.
- ☐ **No:** Proceed to the next question.

(OVER)

**Air Force Physical Fitness Screening Questionnaire (FSQ) Continued**

**5. Do one (1) or more of the following risk factors apply to you? Note: this question only applies if you answered "No" to question 4.**

- a. Smoked tobacco products in the last 30 days
- b. Diabetes
- c. High blood pressure **OR** high cholesterol that is not controlled
- d. Family history of heart disease (developed in father/brother before age 55 or mother/sister before age 65)
- e. Age > 45 years for males; > 55 years for females

**Have you answered "Yes" to ANY of the above conditions in block 5?**

- ☐ **Yes: Stop.** Notify your UFPD that you are not cleared for a fitness assessment. Complete the remainder of your questionnaire and hand carry this form to your medical provider for evaluation.
- ☐ **No: Stop.** Sign form and return to your UFPD. Airman may take the fitness assessment if they were not disqualified by questions 1 through 4.

By signing below, I affirm that this questionnaire was filled out truthfully. Further, I acknowledge that if I recognize any of the following warning signs I should stop my fitness assessment immediately and seek medical attention:

- a. Unexplained chest pain
- b. Shortness of breath
- c. Dizziness
- e. Blurry vision
- f. Unusual leg pain, cramping, and or weakness

DATE:

SIGNATURE:

**PART II. MEDICAL PROVIDER COMPLETES**

If medical evaluation is required in accordance with this FSQ, the provider will complete the following.

\*\*\*\*\*

I medically evaluated \_\_\_\_\_ on \_\_\_\_\_.  
(RANK, NAME) (DATE)

Medical recommendations are:

- Member (is / is not) medically cleared for best effort on the maximal effort 1.5-mile run.
- Member (is / is not) medically cleared for best effort on the sub-maximal effort 2.0-km walk.
- Member (is / is not) medically cleared for push-ups.
- Member (is / is not) medically cleared for sit-ups.

**NOTE:** An AF Form 469 has been initiated if appropriate. Airmen with fitness limitations greater than 30 days should be given an exercise prescription in accordance with AFI 36-2905.

\_\_\_\_\_  
(SIGNATURE/STAMP OF PROVIDER)

**AIR FORCE ROTC PRE-PARTICIPATORY SPORTS PHYSICAL**

<b>1. CADET/APPLICANT NAME</b>		<b>2. AFROTC DETACHMENT</b> DET010	
<p><b>MEDICAL AUTHORITY:</b> Measure height and weight of cadet/applicant. Compare results to AF standards listed on reverse, check block 7 and certify as requested below.</p> <p><b>AFROTC CADRE:</b> If cadet/applicant exceeds AF weight standards, conduct a Body Fat Measurement IAW DoDI 1308.3.</p>			
<b>3. CADET/APPLICANT MEASUREMENTS</b>	<b>HEIGHT</b>	<b>WEIGHT</b>	
<b>4. AIR FORCE WEIGHT STANDARDS</b> (found on reverse)	<b>MINIMUM</b>	<b>MAXIMUM</b>	
<b>5. BODY FAT MEASUREMENT</b>		<b>6. BODY FAT STANDARDS:</b> FEMALE - 28% MALE - 20%	
<b>7. CHECK APPLICABLE BOX</b>	<input type="checkbox"/> IS WITHIN AIR FORCE WEIGHT STANDARDS <input type="checkbox"/> EXCEEDS AIR FORCE WEIGHT STANDARDS <input type="checkbox"/> IS BELOW AIR FORCE WEIGHT STANDARDS		
<b>8. MEDICAL AUTHORITY: PLEASE REVIEW THE ABOVE INFORMATION. CONDUCT COUNSELING BELOW IN APPLICABLE AREAS, AND SIGN</b>			
I, (print name) _____, HAVE EXAMINED THIS CADET/APPLICANT AND REVIEWED HIS/HER MEDICAL HISTORY. THE FOLLOWING ARE THE RESULTS:			
<b>9. (IF CADET/APPLICANT IS BELOW AIR FORCE WEIGHT STANDARDS)</b> I CERTIFY THIS CADET/APPLICANT'S LEAN BODY MASS POSES NO HEALTH RISK; NO SIGNS OF EATING DISORDERS EXIST. I HAVE DISCUSSED THE IMPORTANCE OF NUTRITION AND WEIGHT MANAGEMENT. _____ (Medical Authority Initials)			
<b>10. (IF CADET/APPLICANT EXCEEDS AIR FORCE WEIGHT STANDARDS)</b> I HAVE DISCUSSED APPROPRIATE AND SAFE WEIGHT LOSS WITH THE CADET/APPLICANT. _____ (Medical Authority Initials)			
<b>11. (FOR ALL CADETS/APPLICANTS)</b> I DID / DID NOT (please circle) FIND MEDICAL CONDITION(S) OR PHYSICAL IMPAIRMENT(S) THAT WOULD PRECLUDE THIS CADET/APPLICANT FROM PARTICIPATING IN A RIGOROUS PHYSICAL TRAINING PROGRAM. IF A MEDICAL CONDITION/PHYSICAL IMPAIRMENT EXISTS THAT MAY PRECLUDE THE INDIVIDUAL FROM PARTICIPATING, PLEASE EXPLAIN:			
<b>EXAMINATION DATE</b>		<b>PHYSICIAN OR MEDICAL AUTHORITY SIGNATURE</b>	
<b>AFROTC CADRE: A DISQUALIFIED DODMERB OR MEPS PHYSICAL SUPERSEDES THIS FORM. A CADET MAY NOT PARTICIPATE IN THE AFROTC PHYSICAL TRAINING PROGRAM IF THEY HAVE A DISQUALIFIED DODMERB OR MEPS PHYSICAL.</b>			
<b>DATE</b>	<b>AFROTC CADRE SIGNATURE</b>		



**ACCESSION HEIGHT AND WEIGHT STANDARDS & BODY FAT MEASUREMENT (BFM) STANDARDS**  
 (Per AFRSI 36-2001, *Recruiting Procedures for the Air Force*)

HEIGHT (INCHES)	POUNDS	
	MINIMUM (BMI = 19 kg/m)	MAXIMUM (BMI = 27.5 kg/m)
58	91	131
59	94	135
60	97	141
61	100	145
62	104	150
63	107	155
64	110	160
65	114	165
66	117	170
67	121	175
68	125	180
69	128	186
70	132	191
71	136	197
72	140	202
73	144	208
74	148	214
75	152	220
76	156	225
77	160	231
78	164	237
79	168	244
80	173	250

## DODMERB APPLICANT INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ MI: \_\_\_\_\_

SSN: \_\_\_\_\_

Birth Date (MM/DD/YYYY): \_\_\_\_\_

Gender: \_\_\_\_\_

Applicant Email: \_\_\_\_\_

Local Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

### Applicant Address

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

FOR CADRE USE ONLY

☐ Submitted into DODMETS: DATE: \_\_\_\_\_

☐ Email sent to Cadet with instructions: DATE: \_\_\_\_\_

☐ Cadet Appt. Dates: \_\_\_\_\_

☐ Waiver ☐ IS or ☐ IS NOT required.

☐ If waiver required, has necessary documents been obtained and sent to DODMERB. DATE: \_\_\_\_\_

☐ Qualified

☐ Disqualified ☐ Waiver Granted ☐ Waiver Denied

## STATE OF LEGAL RESIDENCE CERTIFICATE

### DATA REQUIRED BY THE PRIVACY ACT OF 1974

**AUTHORITY:** Tax Reform Act of 1976, Public Law 94-455.

**PURPOSE:** Information is required for determining the correct State of legal residence for purposes of withholding State income taxes from military pay.

**ROUTINE USES:** Information herein will be furnished State authorities and to Members of Congress.

**MANDATORY OR VOLUNTARY DISCLOSURE:** Disclosure is voluntary. If not provided, State income taxes will be withheld based on the tax laws of the State previously certified as your legal residence, or in the absence of a prior certification, the tax laws of the applicable State based on your home of record.

**NAME** (Last, first, middle initial)

**SOCIAL SECURITY NUMBER (SSN)**

**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.

**SIGNATURE**

**CURRENT MAILING ADDRESS** (Include ZIP Code)

**DATE**



**DEPARTMENT OF THE AIR FORCE  
AIR UNIVERSITY (AETC)**

That concludes the  
Detachment 010, University of Alabama  
Application Packet unless you have been  
identified as a recipient in one of the  
following programs:

- High School Scholarship Program (HSSP)
- In-College Scholarship Program (ICSP)
- The Enlisted Commissioning Program (ECP)



(Last Updated July 2019-TSgt Wilson)

# FAST START

## 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.

<b>1. EMPLOYEE INFORMATION</b> (SSN) EMPLOYEE PAYROLL IDENTIFICATION NUMBER <span style="border: 1px solid black; display: inline-block; width: 150px; height: 1.2em; vertical-align: middle;"></span>  <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;">                     EMPLOYEE NAME (as on payroll records) <span style="border: 1px solid black; display: inline-block; width: 350px; height: 1.2em; vertical-align: middle;"></span>                      (Last, First, Initials)                 </div> <div style="width: 35%;"></div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 45%;">                     TELEPHONE NUMBER (WORK) <span style="border: 1px solid black; display: inline-block; width: 100px; height: 1.2em; vertical-align: middle;"></span> </div> <div style="width: 45%;">                     (HOME) <span style="border: 1px solid black; display: inline-block; width: 100px; height: 1.2em; vertical-align: middle;"></span> </div> </div>			
<b>2. TYPE OF ACCOUNT</b> <input type="checkbox"/> Checking <input type="checkbox"/> Savings  <b>TYPE OF PAYMENT</b> <input checked="" type="checkbox"/> Net Pay <input type="checkbox"/> Travel <input type="checkbox"/> Other Federal employment related payments	<b>3. DIRECT DEPOSIT ACCOUNT INFORMATION - NET PAY/TRAVEL/OTHER (Use Sec. 4 for allotments)</b> A voided personal check/sharedraft may be attached in lieu of completing this section. See instructions on back of this form.  <div style="display: flex; justify-content: space-between;"> <div style="width: 55%;">                     ROUTING TRANSIT NUMBER <span style="border: 1px solid black; display: inline-block; width: 100px; height: 1.2em; vertical-align: middle;"></span> </div> <div style="width: 40%;"> <input type="checkbox"/> Check Digit                 </div> </div> <div style="margin-top: 5px;">                     ACCOUNT NUMBER <span style="border: 1px solid black; display: inline-block; width: 250px; height: 1.2em; vertical-align: middle;"></span> </div> <div style="margin-top: 5px;">                     ACCOUNT TITLE <span style="border: 1px solid black; display: inline-block; width: 450px; height: 1.2em; vertical-align: middle;"></span>                      (Account Holder's Name)                 </div> <div style="margin-top: 5px;">                     FINANCIAL INSTITUTION NAME <span style="border: 1px solid black; display: inline-block; width: 450px; height: 1.2em; vertical-align: middle;"></span> </div>		
<b>4. ALLOTMENT INFORMATION</b> 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.			
<div style="border: 1px solid black; padding: 2px;"> <b>TYPE OF ALLOTMENT</b> (Check One)                     </div> <input type="checkbox"/> Savings (whole dollar amounts only) <input type="checkbox"/> Discretionary or Third Party	<div style="border: 1px solid black; padding: 2px;"> <b>TYPE OF ACCOUNT</b> (Check One)                     </div> <input type="checkbox"/> SAVINGS <input type="checkbox"/> CHECKING	<div style="border: 1px solid black; padding: 2px;"> <b>ACTION</b> (Check One)                     </div> <input type="checkbox"/> START <input type="checkbox"/> CANCEL <input type="checkbox"/> CHANGE	<div style="border: 1px solid black; padding: 2px;"> <b>AMOUNT</b> (Check One)                     </div> <input type="checkbox"/> INCREASE TO: <input type="checkbox"/> DECREASE TO: New Total \$ <span style="border: 1px solid black; display: inline-block; width: 100px; height: 1.2em; vertical-align: middle;"></span>
<div style="display: flex;"> <div style="width: 25%;">                         ALLOTTEE NAME (person/company who will receive allotment)                     </div> <div style="width: 75%;"> <span style="border: 1px solid black; display: inline-block; width: 350px; height: 1.2em; vertical-align: middle; text-align: center;">N/A</span> </div> </div> <div style="display: flex; margin-top: 10px;"> <div style="width: 35%;">                         ALLOTTEE'S ROUTING NUMBER                     </div> <div style="width: 65%;"> <span style="border: 1px solid black; display: inline-block; width: 100px; height: 1.2em; vertical-align: middle; text-align: center;">N/A</span> <div style="margin-left: 10px;"> <input type="checkbox"/> Check Digit                         </div> </div> </div> <div style="display: flex; margin-top: 10px;"> <div style="width: 35%;">                         ALLOTTEE'S ACCOUNT NUMBER                     </div> <div style="width: 65%;"> <span style="border: 1px solid black; display: inline-block; width: 250px; height: 1.2em; vertical-align: middle; text-align: center;">N/A</span> </div> </div> <div style="display: flex; margin-top: 10px;"> <div style="width: 35%;">                         ALLOTTEE'S ACCOUNT TITLE (Account Holder's Name)                     </div> <div style="width: 65%;"> <span style="border: 1px solid black; display: inline-block; width: 350px; height: 1.2em; vertical-align: middle; text-align: center;">N/A</span> </div> </div> <div style="display: flex; margin-top: 10px;"> <div style="width: 35%;">                         FINANCIAL INSTITUTION NAME                     </div> <div style="width: 65%;"> <span style="border: 1px solid black; display: inline-block; width: 350px; height: 1.2em; vertical-align: middle; text-align: center;">N/A</span> </div> </div>			
<b>5. AUTHORIZATION</b>  <div style="display: flex; justify-content: space-between; align-items: flex-end;"> <div style="width: 60%;">                         * <span style="border: 1px solid black; display: inline-block; width: 250px; height: 1.2em; vertical-align: middle;"></span>                          EMPLOYEE'S SIGNATURE                     </div> <div style="width: 35%;"> <span style="border: 1px solid black; display: inline-block; width: 150px; height: 1.2em; vertical-align: middle;"></span>                          DATE                     </div> </div>			
<b>6. AGENCY USE:</b>			



## **Service-members Group Life Insurance Premium Rate Reduction (SGLI) Brief**

SGLI is a program that provides low-cost term life insurance coverage to eligible Airmen. If eligible, you are automatically issued the maximum SGLI coverage. If you qualify for SGLI, you are automatically enrolled and do not need to apply for coverage. SGLI is available in \$50,000 increments, up to a maximum of \$400,000. Part-time coverage is also provided to Reserve members who do not qualify for full-time coverage.

Airmen can make changes to their SGLI coverage. For EXAMPLE, Airmen can decline SGLI coverage, select a lesser amount than maximum coverage, designate beneficiaries, and/or make other changes. The SGLI premium rate is decreasing on 1 July 2019. You can get the same great coverage for an even lower price. Premiums are dropping \$4 per month for those with maximum coverage. Learn how to get SGLI after previously declining at [Department of Veteran Affairs Life Insurance](#). The reduction is automatic and will reflect in your LES accordingly.

### **SGLI New Monthly Premium Rates Vs. Old Monthly Premium Rates (as of 1 July 2019)**

Coverage Amount	New Monthly Premium Rate	TSGLI Premium	Total Monthly Premium Deduction	Old Monthly Premium Rate	Old TSGLI Premium	Old Total Monthly Premium Deduction
400,000	\$24.00	\$1.00	\$25.00	\$28.00	\$1.00	\$29.00
350,000	\$21.00	\$1.00	\$22.00	\$24.50	\$1.00	\$25.50
300,000	\$18.00	\$1.00	\$19.00	\$21.00	\$1.00	\$22.00
250,000	\$15.00	\$1.00	\$16.00	\$17.50	\$1.00	\$18.50
200,000	\$12.00	\$1.00	\$13.00	\$14.00	\$1.00	\$15.00
150,000	\$9.00	\$1.00	\$10.00	\$10.50	\$1.00	\$11.50
100,000	\$6.00	\$1.00	\$7.00	\$7.00	\$1.00	\$8.00
50,000	\$3.00	\$1.00	\$4.00	\$3.50	\$1.00	\$4.50

### **SGLI Traumatic Injury Protection Program (TSGLI) Brief**

Service-members Group Life Insurance Traumatic Injury Protection (TSGLI) provides automatic traumatic injury coverage to all service members covered under SGLI program. It provides short-term financial assistance to severely injured Service members and veterans to assist them in their recovery from traumatic injuries. TSGLI is not only for combat injuries, but provides insurance coverage for injuries on or off duty.

#### **Related Resources**

- [PSDM 17-38, Service members' Group Life Insurance Online Enrollment System](#)
  - [Service members' Group Life Insurance Online Enrollment System PSD Guide](#)
- [Service members' Group Life Insurance Online Enrollment System FSS Briefing Slides](#)



# Prudential

Office of Servicemembers'  
Group Life Insurance

## Servicemembers' Group Life Insurance Election and Certificate

### 1. About You

<input type="text"/>	CADET	<input type="text"/>
Print Name (First, Middle, Last)	Rank, title or grade	Social Security Number
AFROTC-DETACHMENT 010 - THE UNIVERSITY OF ALABAMA	USAF - (AFROTC)	<input type="text"/>
Duty Location	Branch of Service	Current Amount of SGLI

### 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.*
- " \_\_\_\_\_ "

**SGLI coverage is available in increments of \$50,000 up to a maximum of \$400,000. Traumatic Injury Protection (TSGI) 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.	<input type="text"/>			
2.	<input type="text"/>			
3.	<input type="text"/>			
4.	<input type="text"/>			
<b>Secondary</b>				
1.	<input type="text"/>			
2.	<input type="text"/>			
3.	<input type="text"/>			
4.	<input type="text"/>			

- ☐ **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:**

- 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?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<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. 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 \$400,000. VGLI is lifetime 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 uniform 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.

<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------

Service Member Signature

Social Security Number

Date (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 <input type="checkbox"/>
Contact telephone/email	Disapprove <input type="checkbox"/>
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 shall be notified in writing, by the Branch of Service, of this election.
are married and designate any person other than your spouse or child for any amount of insurance	your spouse shall be notified in writing, by the Branch of Service, 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 shall 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 or attach additional documentation to complete your beneficiary designation.
name minors as beneficiaries	<ul style="list-style-type: none"> <li>■ OSGLI will pay the insurance benefit to the court-appointed guardian of the minor's estate if the beneficiary is a minor at time of claim; or</li> <li>■ you can establish a trust for the benefit of the minor and name the trustee of the trust as beneficiary.</li> <li>■ naming a trust as a beneficiary on this form does NOT create a trust.</li> </ul>
name more than one primary beneficiary and one or more of them predeceases you	OSGLI 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: Do not send Trust documents to OSGLI until the time of claim.)
have no surviving primary beneficiaries	OSGLI will pay the insurance benefit to the secondary beneficiaries, if any.
do not name a beneficiary or there are no surviving primary or secondary beneficiaries OR indicate that payment should be made by law	OSGLI will pay the insurance benefit in the following order: 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	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).  *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.
receive the insurance proceeds in 36 equal monthly payments	<ul style="list-style-type: none"> <li>■ write "36" under the Payment Option.</li> <li>■ your beneficiary cannot change this payment option.</li> </ul>
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 shall advise 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"> <li>■ approve form if the responses to questions 4a through 4g are "No" and forward the form to payroll to change SGLI premium deductions.</li> <li>■ send form to OSGI if any answer to questions 4a through 4g are "Yes." Only inform payroll when approved by OSGI.</li> </ul>
Reduces, declines, or cancels SGLI	<ul style="list-style-type: none"> <li>■ of the following, and furnish the member general information concerning                             <ul style="list-style-type: none"> <li>– the purpose and role of life insurance in financial planning.</li> <li>– the difference between term life insurance and whole life insurance.</li> <li>– the availability of commercial life insurance.</li> <li>– the relationship between SGLI and VGLI.</li> </ul> </li> <li>■ declining or canceling SGLI will also cancel Family SGLI—both spouse and dependent child coverage and Traumatic Injury Protection (TSGLI). The member will be ineligible to apply for VGLI.</li> <li>■ reducing SGLI may also impact FSGLI spouse coverage and will reduce the amount of VGLI available at separation.</li> </ul>	<ul style="list-style-type: none"> <li>■ forward the form to payroll to change SGLI premium deductions.</li> <li>■ 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.</li> <li>■ if the member is married and reduces, declines, or cancels SGLI, inform the member that his/her spouse shall be notified in writing, by the Branch of Service, of the member's election based on Title 38, USC 1967 (f).</li> </ul>
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 the member wants spouse SGLI coverage, provide the member with SGLV 8286A, Spouse Coverage Election and Certificate, and follow the instructions therein.
is married or gets married after completing this form and is <b>not</b> married to another member of the uniformed services	<ul style="list-style-type: none"> <li>■ spouse SGLI automatically covers spouse.</li> <li>■ he or she must register their spouse in DEERS for payroll to deduct premiums.</li> <li>■ If the member wants to decline coverage or take a lesser amount of spouse coverage, the member must complete SGLV 8286A.</li> </ul>	if applicable, forward the form to payroll to begin premium deductions for the spouse coverage.
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 or attach additional documentation to complete your beneficiary designation.	attach the Supplemental Beneficiary Form to the SGLV 8286 or attach additional documentation to complete your beneficiary designation.
designates any person other than his/her spouse or child for any amount of insurance	<ul style="list-style-type: none"> <li>■ 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.</li> <li>■ if the member is married, the member's spouse will be notified in writing, by the Branch of Service, that he/she or the member's child is not the named beneficiary, unless:                             <ul style="list-style-type: none"> <li>– the spouse has been previously notified, OR</li> <li>– the spouse is not designated as beneficiary for any amount of insurance prior to the new election.</li> </ul> </li> </ul>	<p>have the member sign SGLV 8286 to certify that he/she understands that:</p> <ul style="list-style-type: none"> <li>■ he/she is free to name anyone as beneficiary.</li> <li>■ 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.</li> <li>■ if married, the spouse will be notified that he/she (or any child) is not the designated beneficiary.</li> </ul>

### 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 OSGI ONLY if the member is increasing or restoring SGLI coverage and answered "Yes" to one or more of the health questions

OSGI

PO Box 41618

Philadelphia, PA 19176-9913

If a member is making a Beneficiary change only, the form DOES NOT have to be forwarded to OSGI.



**Employee's Withholding Certificate****2022**

- ▶ **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.**

**Step 1:  
Enter  
Personal  
Information**

(a) First name and middle initial	Last name	(b) Social security number
Address		▶ <b>Does your name match the name on your social security card?</b> If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to <a href="http://www.ssa.gov">www.ssa.gov</a> .
City or town, state, and ZIP code		
(c) <input type="checkbox"/> <b>Single</b> or <b>Married filing separately</b> <input type="checkbox"/> <b>Married filing jointly</b> or <b>Qualifying widow(er)</b> <input type="checkbox"/> <b>Head of household</b> (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, when to use the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App), and privacy.

**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](http://www.irs.gov/W4App) for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **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 accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . ▶ ☐

**TIP:** To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

**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  
Dependents**

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 and 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)
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Exception to SF 1012 approved by GSA/IRMS 12-91.  
Adobe Professional 8.0

## PRIVACY ACT STATEMENT

**AUTHORITY:** 5 U.S.C. Section 301; Departmental Regulations; 37 U.S.C. Section 404, Travel and Transportation Allowances, General; DoD Directive 5154.29, DoD Pay and Allowance Policy and Procedures; Department of Defense Financial Management Regulation (DoDFMR) 7000.14.R., Volume 9; and E.O. 9397 (SSN), as amended.

**PRINCIPAL PURPOSE(S):** To provide an automated means for computing reimbursements for individuals for expenses incurred incident to travel for official Government business purposes and to account for such payments.

Applicable SORN: T7333 (<http://privacy.defense.gov/notices/dfas/T7333.shtml>).

**ROUTINE USE(S):** Certain "Blanket Routine Uses" for all DoD maintained systems of records have been established that are applicable to every record system maintained within the Department of Defense, unless specifically stated otherwise within the particular record system notice. These additional routine uses of the records are published only once in each DoD Component's Preamble in the interest of simplicity, economy, and to avoid redundancy. Applicable SORN: <http://dpco.defense.gov/privacy/SORNS/component/dfas/preamble.html>.

**DISCLOSURE:** Voluntary; however, failure to furnish the requested information may result in total or partial denial of the amount claimed. The Social Security Number is requested to facilitate the possible collection of indebtedness or credit to the DoD traveler's pay account for any residual or shortage.

## PENALTY STATEMENT

There are severe criminal and civil penalties for knowingly submitting a false, fictitious, or fraudulent claim (U.S. Code, Title 18, Sections 287 and 1001 and Title 31, Section 3729).

## INSTRUCTIONS

### ITEM 1 - PAYMENT

Member must be on electronic funds (EFT) to participate in split disbursement. Split disbursement is a payment method by which you may elect to pay your official travel card bill and forward the remaining settlement dollars to your predesignated account. For example, \$250.00 in the "Amount to Government Travel Charge Card" block means that \$250.00 of your travel settlement will be electronically sent to the charge card company. Any dollars remaining on this settlement will automatically be sent to your predesignated account. Should you elect to send more dollars than you are entitled, "all" of the settlement will be forwarded to the charge card company. Notification: you will receive your regular monthly billing statement from the Government Travel Charge Card contractor; it will state: paid by Government, \$250.00, 0 due. If you forwarded less dollars than you owe, the statement will read as: paid by Government, \$250.00, \$15.00 now due. Payment by check is made to travelers only when EFT payment is not directed.

### REQUIRED ATTACHMENTS

1. Original and/or copies of all travel orders/authorizations and amendments, as applicable.
2. Two copies of dependent travel authorization if issued.
3. Copies of secretarial approval of travel if claim concerns parents who either did not reside in your household before their travel and/or will not reside in your household after travel.
4. Copy of GTR, MTA or ticket used.
5. Hotel/motel receipts and any item of expense claimed in an amount of \$75.00 or more.
6. Other attachments will be as directed.

### ITEM 15 - ITINERARY - SYMBOLS

#### 15c. MEANS/MODE OF TRAVEL (Use two letters)

GTR/TKT or CBA (See Note)	- T	Automobile	- A
Government Transportation	- G	Motorcycle	- M
Commercial Transportation		Bus	- B
(Own expense)	- C	Plane	- P
Privately Owned		Rail	- R
Conveyance (POC)	- P	Vessel	- V

Note: Transportation tickets purchased with a CBA must not be claimed in Item 18 as a reimbursable expense.

#### 15d. REASON FOR STOP

Authorized Delay	- AD	Leave En Route	- LV
Authorized Return	- AR	Mission Complete	- MC
Awaiting Transportation	- AT	Temporary Duty	- TD
Hospital Admittance	- HA	Voluntary Return	- VR
Hospital Discharge	- HD		

### ITEM 15e. LODGING COST

Enter the total cost for lodging.

### ITEM 19 - DEDUCTIBLE MEALS

Meals consumed by a member/employee when furnished with or without charge incident to an official assignment by sources other than a government mess (see JFTR, par. U4125-A3g and JTR, par. C4554-B for definition of deductible meals). Meals furnished on commercial aircraft or by private individuals are not considered deductible meals.

### 29. REMARKS

- a. INDICATE DATES ON WHICH LEAVE WAS TAKEN:
- b. ALL UNUSED TICKETS (including identification of unused "e-tickets") MUST BE TURNED IN TO THE T/O OR CTO.



# AFROTC, DETACHMENT 010

## CADET TUITION STATEMENT OF UNDERSTANDING

(REF: AFROTCI 36-2011)

DATE: JULY 12, 2019

You are to read this document and fill out the needed information. Please ensure you initial, sign, date all highlighted areas.

**SCHOLARSHIP CADET NAME:** \_\_\_\_\_

**Current School Term:** Fall 2019 (Example: Fall 2017)

**1. Scholarship Program:** I understand that the AFROTC scholarship program consists of three main parts: the High School Scholarship Program (HSSP), the In-College Scholarship Program (ICSP), and the Enlisted Commissioning Program (ECP). **I was awarded/accepted into the:** **(Select what applies)** HSSP ICSP ASCP program. (\_\_\_\_\_) **Cadet Initials**

**2. Scholarship Types:** (\_\_\_\_\_) **Cadet Initials**

I understand that AFROTC/RR has established the following types of scholarships to be used only at AFROTC-affiliated schools:

- **Type 1** scholarship: Provides full tuition and fees (with no cap on tuition and authorized fees) and \$600 per year for textbooks. Type 1U scholarship is an upgrade from a high school Type 2 offer in a critical technical major.

- **Type 2** scholarship: Provides up to \$18,000 per year (up to \$9,000 per semester or up to \$6,000 per quarter) towards tuition and fees and \$600 per year for textbooks. At schools where tuition and authorized fees are over the scholarship cap, students are liable for the difference even if the tuition is below the cap when the student starts at the school, but then increases above the cap during the student's academic program.

- **Type 3** scholarship (ICSP only): Provides up to \$9,000 per year (up to \$4,500 per semester or up to \$3,000 per quarter) towards tuition and fees and \$600 per year for textbooks. At schools where tuition and authorized fees are over the scholarship cap, students are liable for the difference even if the tuition is below the cap when the student starts at the school, but then increases above the cap during the student's academic program.

- **Type 6** scholarship (ICSP only): Provides up to \$3,000 per year (up to \$1,500 per semester or up to \$1,000 per quarter) towards tuition and fees and \$600 per year for textbooks. At schools where tuition and authorized fees are over the scholarship cap, students are liable for the difference even if the tuition is below the cap when the student starts at the school, but then increases above the cap during the student's academic program.

- **Type 7** scholarship (HSSP only): Provides full tuition and fees at the in-state rate and \$600 per year for textbooks. The Type 7 selectee must attend a school where he/she qualifies for the in-state tuition rate. If the annual tuition and fees increase after the scholarship has been awarded due to inflation adjustments, AFROTC will continue to pay the full in-state amount. **I was awarded/accepted Type:** \_\_\_\_\_ **Scholarship and I should receive** \_\_\_\_\_ **in-state/** \_\_\_\_\_ **out-of-state tuition rate.**

**3. Scholarship Grade Point Average (GPA) Requirements.** I understand that Cadets must have a TGPA and CGPA of 2.5 or higher to be nominated for and to activate a scholarship (Exception: 4-year HSSP cadets activating scholarship the freshman year without a college GPA yet). After

scholarship activation, cadets must maintain a 2.5 TGPA to remain in good academic standing. If TGPA falls below 2.5, award a conditional event (CE) (reference Table 4.2 of this instruction). **My GPA is currently:** \_\_\_\_\_. (\_\_\_\_\_) **Cadet Initials**

**4. Textbook Reimbursement Entitlement for Scholarship Program.** I understand that Cadets on scholarship will receive an annual flat rate for textbooks (that rate was outlines in the scholarship types portion above). NOTE: The annual flat rate amount for textbooks will be paid each term. Textbook payments are not authorized when the scholarship is not active (e.g., suspended or completed). (\_\_\_\_\_) **Cadet Initials**

**5. 45-Day Rule.** I understand that the 45-day requirement applies only to the fall term. All scholarship tuition, fees, and textbooks must be billed against the next fiscal year as of the 45th calendar day of institutional classes. Scholarship cadets must be enrolled in AFROTC and in an active status at close of business on the 45th day of classes (at each school) or after but not later than the last day of the term at the institution of attendance in order for AFROTC to pay tuition and fees. The 45-day rule applies to each institution a cadet attends if the institution charges for the course or courses. Scholarships that have not been activated by the last day of the term will be withdrawn, unless a prior waiver is obtained from HQ AFROTC/RRFA. I acknowledge and understand the PT safety briefing given to me. I understand the importance of staying hydrated especially since I will be involved in a rigorous PT program. I understand the importance of keeping my body healthy. I will to the best of my ability try to eat a healthy diet and get enough rest whenever possible. (\_\_\_\_\_) **Cadet Initials**

**6. Documents to turn into the Detachment NCO.** (\_\_\_\_\_) **Cadet Initials**

I understand that once my university bills my account for tuition I have until the 7<sup>th</sup> day of each school semester term to provide the detachment NCO the following:

- *AFROTC Form 48 (With All Previous Completed Semesters Signed by Cadet)*
- *An official Invoice from the university outlining tuition fees*
- *Direct Deposit form (Only if information has changed)*

**7. Standards.** I understand that as a scholarship recipient, I am required to take and pass a minimum of **12 semester/18 quarter hours of the same foreign language or 24 semester/36 quarter hours of Math/Physics/Chemistry. I understand that I must maintain at least a “C-” or the institutional equivalent in each course.** I also understand that failure to accomplish this requirement prior to commissioning could result in loss of my scholarship and/or disenrollment from the AFROTC program. If dis-enrolled, I may have to repay my scholarship or be called to serve on active duty in my enlisted grade for a period of two years. If there are any changes in my academics, to include changing an academic major, I will coordinate those changes with Detachment cadre. (Cadre must pre-approve major changes for cadets) I am completely aware of the retention and scholarship standards, scholarship entitlements (if applicable), and the consequences should these standards not be met. Failure to do so may result in diminished opportunities for an EA or scholarships, scholarship termination, withdrawal of the scholarship offer, or disenrollment from AFROTC. This documentation will be associated with any counseling trail should adverse actions such as dismissal (Det drop), scholarship suspension, termination, or



disenrollment from AFROTC become necessary. NOTE: Nursing students are exempt from this requirement because their major corresponds directly to a needed AFSC. (\_\_\_\_\_) **Cadet Initials**

## 8. TUITION PAYMENT & ADDITIONAL FUNDS STATEMENT & ACKNOWLEDGEMENT

- a) I acknowledge that any costs NOT associated tuition, including parking fees, travel, room, board or any other costs that I incurred which are over and above those I would normally incur for tuition are my personal responsibility. (\_\_\_\_\_) **Cadet Initials**
- b) I have ensured that the charges on this terms invoice do not include **unauthorized expenses**; e.g., repeat courses, flight operations, personal equipment or services. (\_\_\_\_\_) **Cadet Initials**
- c) I have ensured that in-state or out-of-state tuition rate is accurate and out-of-state tuition rates are not paid for any student entitled to in-state tuition rates. (\_\_\_\_\_) **Cadet Initials**

## 9. Additional Scholarship/Grants or Funding

Below is an outline of additional scholarship/grants or funding that I receive.

Scholarship/Grant/Additional Funding Title	Amount	Start date of funding	How much is applied to your tuition?

**10. What will AFROTC pay?** This is to certify that out of the amount/Fees outlined on my invoice, I would like for the Air force to pay \_\_\_\_\_ (**<-Insert tuition Price**) outlined on my Invoice as allocated funds accredited to my AFROTC Scholarship entitlements for this term. **By signing below, I am stating that I have accurately provided the information on this document to the best of my knowledge and if anything changes, I will contact the AFROTC/DET 010 Scholarship staff ASAP!**

\_\_\_\_\_  
**Typed/Printed Cadet Name**

\_\_\_\_\_  
**Cadet Signature Date**

### THE BELOW SPACE IS FOR CADRE USE ONLY

Notes/Comments:

Reviewed by:

\_\_\_\_\_  
(Print Cadre Name Above)

\_\_\_\_\_  
Cadre signature

### Attachment 3

#### ACADEMIC PLAN FOR FOREIGN LANGUAGE OR TECHNICAL REQUIREMENT FOR NON-TECHNICAL SCHOLARSHIP CADETS

##### Figure A3.1. Academic Plan.

I understand that as a scholarship recipient I am required to take and pass a minimum of 4 semesters /6 quarters of the same foreign language or 24 semester/36 quarter hours of Math/Physics/Chemistry/Engineering. I understand that I must maintain at least a “C-” or the institutional equivalent in each course. I also understand that failure to accomplish this requirement prior to commissioning could result in loss of my scholarship and/or disenrollment from the AFROTC program. If disenrolled, I may have to repay my scholarship or be called to serve on active duty in my enlisted grade for a period of two years. In order to fulfill this requirement, I plan to take the following courses:

Course #	Course Title	Hours	Term Schedule	Term Complete	Cadet Initial	Cadre Initial
<b>Total:</b>						

\_\_\_\_\_  
Cadet Signature      Date

\_\_\_\_\_  
Cadre Signature      Date

\_\_\_\_\_  
Typed/Printed Cadet Name

\_\_\_\_\_  
Typed/Printed Cadre Name

I reviewed the completed course work for Cadet \_\_\_\_\_ and verify that he/she has completed a minimum of 4 semesters /6 quarters of the same foreign language or 24 semester/36 quarter hours of Math/Physics/Chemistry/Engineering, or will complete this requirement prior to commissioning (Except Nurses and 1-2-year scholarship winners).

\_\_\_\_\_  
AS Instructor

\_\_\_\_\_  
Date