

# SAC - Special Agreement Check

## Finger Prints and PIV I.D. Badge

Name: \_\_\_\_\_  
*(Last Name) (First Name) (Middle Name) (Suffix, Jr.)*

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Alias (Maiden): \_\_\_\_\_ Race: \_\_\_\_\_ Sex: \_\_\_\_\_

Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Place of Birth: \_\_\_\_\_  
*(City/State/Country)*

Home Address: \_\_\_\_\_  
*(Street address, city, state and zip code)*

Personal or School Email: \_\_\_\_\_

Country of Citizenship: \_\_\_\_\_

Position or Job Title: \_\_\_\_\_

Scars, Marks, Tattoos(s): \_\_\_\_\_

### Check all that apply

Have you ever been fingerprinted by this, or any other, VA Hospital? \_\_\_\_\_  
*(City/State)*

Do you currently hold ANY medical professional license? \_\_\_\_\_  
*(License Type)*

Will you be working at a VA Hospital other than in Milwaukee? \_\_\_\_\_

### TYPE OF APPOINTMENT (check one)

Paid Employment (paid by this VA Medical Center)       Volunteer       Fee Basis/Contract VA Employee

WOC (Without Compensation - not being paid by this VA Medical Center. Residents, Students, Research, Interns, etc.)

### COMPLETE THE FOLLOWING ONLY IF YOU ARE A WOC NEW TO THE ZABLOCKI VA MEDICAL CENTER

Appointment/Rotation Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Department or Service you will work in: \_\_\_\_\_

Zablocki VA Department/Service Contact: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date