Form Approved Through 02/28/2023
OMB No. 0925-0002

Department of Health and Human Services
Public Health Services

Statement of Appointment

(Please Type)

Follow attached instructions carefully. Submit this form to the PHS awarding component at the time the individual is appointed, is reappointed, or the reported appointment is amended. For a new postdoctoral trainee under a Kirschstein-NRSA award, a signed and dated payback agreement **must** accompany this form.

1. PHS GRANT NUMBER

Type	Activity	ID Serial No.

2. APPOINTEE'S NAME *(Last, first, initial)*

3. SEX
☐ M ☐ F
☐ Do Not Wish to Provide

4. TYPE OF ACTION *(Check only one type)*
☐ NEW appointment (NOT previously supported by this grant)
☐ REAPPOINTMENT (Previously supported by this grant)
☐ AMENDMENT of items checked: ☐ 15 ☐ 20

5. PRIOR NRSA SUPPORT *(Individual or institutional)*
☐ NO ☐ YES (If "Yes," see instructions)

6. SOCIAL SECURITY NO.
XXX-XX-

7. BIRTHDATE *(Month, day, year)*

8. CITIZENSHIP *(See instructions)*
☐ U.S. Citizen or Noncitizen National

Non-U.S. Citizen
☐ With a Permanent U.S. Resident Visa ("Green Card")
☐ With a Temporary
☐ Not Residing in the U.S.
If not a U.S. citizen, of which country are you a citizen?

10. PERMANENT MAILING ADDRESS

E-mail

9. ORCID ID

11. Are you Hispanic (or Latino)? ☐ YES ☐ NO ☐ Do Not Wish to Provide

12. What is your racial background? *Check one or more*
☐ American Indian or Alaska Native
☐ Native Hawaiian or other Pacific Islander
☐ Asian
☐ Black or African American
☐ White
☐ Do Not Wish to Provide

13. Do you have a disability?
☐ YES ☐ NO ☐ Do Not Wish to Provide

If yes, which of the following categories describe your disability(ies):
☐ Hearing ☐ Mobility/Orthopedic Impairment
☐ Visual ☐ Other

14. Are you from a disadvantaged background? *(Applies to high school and undergraduate appointees only)*
☐ Not Applicable ☐ YES ☐ NO ☐ Do Not Wish to Provide

15. FIELD OF RESEARCH TRAINING OR CAREER DEVELOPMENT *(for this appointment)*
Enter a 3 digit code from instructions: ☐ ☐ ☐ ☐

16. PERIOD OF APPOINTMENT *(Month, day, year)*
From: To:

17. Education/Career Level: ☐ High School Student ☐ Undergraduate Student ☐ Postbaccalaureate ☐ Post-master's ☐ Graduate Student ☐ Postdoctorate ☐ Faculty or Other Professional

18. EDUCATION – AFTER HIGH SCHOOL *(Indicate all academic and professional education. For foreign degrees, give U.S. equivalent.)*

(a) Name of Institution and Location (List most recent first)	(b) Degree(s) Received		(c) Major Field	(d) Minor Field
	Degree	Mo./Yr.		

19. DEGREE(S) SOUGHT ☐ YES ☐ NO	If yes, indicate type of degree(s)

Are you in a dual degree program (e.g., M.D./Ph.D.)? ☐ YES ☐ NO

20. EXPECTED COMPLETION DATE FOR DEGREE(S) *(mm/yyyy, if applicable)*

21. NAME OF SPECIALTY BOARDS *(if applicable)*

22. SUPPORT FOR PERIOD OF APPOINTMENT

TYPE	Total for this Grant *(Omit cents)*
Stipend / Salary / Other Compensation	$
TOTAL	$

23. STATEMENT OF NONDELINQUENCY ON U.S. FEDERAL DEBT. Is the appointee delinquent on the repayment of any U.S. Federal debt(s)?

☐ NO ☐ YES *(If "Yes," please explain below.)*

24. CERTIFICATION AND ACCEPTANCE: I certify that the statements herein are true and complete to the best of my knowledge and that I will comply with all applicable Public Health Service terms and conditions governing my appointment. I am aware that any false, fictitious or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties.	(a) SIGNATURE OF APPOINTEE	(b) DATE
25. This individual is qualified for this program and is eligible to receive financial support for the period specified above. A copy of this appointment form will be given to the individual.	(a) SIGNATURE OF PROGRAM DIRECTOR	(b) DATE

(c) NAME OF PROGRAM DIRECTOR

(d) INSTITUTION'S NAME, ADDRESS, AND PHONE NO.
(Street, city, state, zip code)