



DEPARTMENT OF VETERANS AFFAIRS

Robert J. Dole
VA Medical Center
5500 E. Kellogg
Wichita, KS 67218

In Reply Refer To: 589A7/EDU

Robert J. Dole Medical Center
5500 E. Kellogg
Wichita, KS 67218

Dear _____:
(Student Name)

Welcome to the Department of Veterans Affairs, Robert J. Dole Medical Center, Wichita, KS. You will be assigned to our facility as a Student from _____ through _____, under authority of 38 U.S.C. 7405(a) (1) (D). During your period of affiliation with our facility, you are authorized to perform services as directed by the Service Director(s), Associate Director of Patient Care.

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

Quarters Subsistence Uniforms Launder of uniforms None

If you agree to these conditions, please fill in the information requested on the reverse side of this document and sign the statement. This agreement may be terminated at any time by either party by written notice of such intent.

Sincerely,

NANCY J. GERSTNER
Human Resources Director

Social Security No:

Date of Birth:

VHA Contact Phone Ext: 57905 VHA Supv/Mentor: Travis Nickelson, RN, BSN

I agree to serve in the above capacity under the conditions indicated. If you agree, sign below.

Signature: _____

Date:

Veteran Status (Please circle one)

1 - Vietnam Veteran*

2 - Other Veteran

3 - Non-Veteran

* For this purpose, a Vietnam Veteran is one with service between August 5, 1964 and May 7, 1975.

Please indicate your veteran status in box at left.



Pursuant to the Privacy Act of 1974, the information about your veteran status is requested under Title 38 United States Code and will be used to help identify veterans status of all VA trainees for statistical and program planning purposes. It will not be used for any other purpose. Disclosure of the information sought is voluntary. Failure to furnish this information will have no adverse effect on any benefits to which you may be entitled.

RCS 10-0161 Report

School Affiliation:

Type of Program (Place X in box): Doctoral Masters BA/BS Associate

Certificate Diploma Other (Specify) _____

Program Title:

WOC Position Title:

Approximate total hours scheduled to be at VAMC: