

DIRECTIONS FOR COMPLETING ANNUAL VERIFICATION PACKAGE (AVP) ***PLEASE READ THIS DOCUMENT IN ITS ENTIRETY BEFORE COMPLETING**

1. Annual Health Screening Questionnaire. Please make sure all information is accurate to the best of your ability. When submitting your completed documents, include copies of all medical documentation for the medical conditions reported on the health screening, as well as your HIV testing results (as applicable). Scan and email the documents to OH@med.navy.mil. If you have questions or concerns, please contact OH@med.navy.mil.

2. Dependency Application/Record of Emergency Data. Also known as the "Page 2," this two-page document identifies and designates beneficiaries. It designates your Primary Next of Kin (PNOK), Secondary Next of Kin (SNOK) and Person Authorized Direct Disposition (PADD), the individual designated to make burial decisions on your behalf when you are deceased. Directions for completing this form are included after the "Page 2" located in this package.

Things to include:

- If married, include your spouse's maiden or name as applicable.
- If you are newly married or adding children, a copy of your marriage license and/or birth certificates.
- Current address of birth/adopted mother and father (no P.O. Boxes permitted). If either parent is deceased or the current address is unknown, please be sure to indicate that on the form. Do not include step-parents in this section.
- Under the REMARKS section, please be sure to designate the individual as PNOK, SNOK and PADD. For each of these individuals, include the full address, telephone number and relationship to you.
- Please write in your religious preference.

3. Academic Year Statement (AYS). This form must be completed in its entirety. It requires your signature at the bottom. Information about your school and course of study must be filled in by your school's Registrar. Your AYS should be returned with your completed package

4. Personal Information Data (PG 7). This form allows us to verify your current address, email address, and phone number maintained on file in the Accessions Department student information system.

***Failure to complete these documents and submit to the Medical Records Department in a timely manner could result in loss of stipend. If you are unable to complete these forms, please notify the medical records staff immediately at OH@med.navy.mil. ALL students must complete the Annual Verification documents, even if on LWOP.**

RECORD OF EMERGENCY DATA

Use this as a guide to fill in the blocks on the Record of Emergency Data

Blocks 12, 17, 22, 27, 32, 35, and 38 - These boxes ask if the person listed on the same line is considered a dependent.

Blocks 5-12 - Fill out if married. If not, write "N/A." You will need to send a copy of your marriage certificate. If you are married, also indicate "YES" in block 12 (DEP); if spouse is affiliated with any branch of the armed forces indicate **NO** and be sure to put his or her full SSN, branch, rank/rate, and affiliation (i.e. active, reserves, etc).

Blocks 13-32 - Fill out for children Information. If you have no children, write "N/A." You will need to send a copy of your child's birth certificate. Indicate "YES" in blocks 17, 22, etc. if you are claiming your children as dependents. Indicate "NO" if you have a military spouse who is claiming the child as a dependent. Only one spouse can claim "YES," the other must claim "NO." If you claim a child who does not reside with you, include the name of the custodian in Block 16.

Block 33-35 - Fill out for your father's information. If father is deceased, please fill out father's name and write "deceased" in the address block. If the address is unknown, write "unknown." Indicate "NO" in block 35, *unless* you provide over 50% of his support and wish to claim him as a dependent.

Block 36-38 - Fill out for your mother's information. If your mother is deceased, please fill out your mother's name and write "deceased" in the address block. If her address is unknown, write "unknown." Indicate "NO" in block 38, unless you provide over 50% of her support and wish to claim her as a dependent.

Blocks 39-42 - If you were previously married, fill in all blocks. If not, place a check mark in block 39 under "no," and continue to block 43. You will need to send a copy of your divorce decree.

Blocks 43-46 - If your spouse was previously married, fill in all blocks. If not, place a check mark in block 43 under "no," and continue to block 47. You will need to send a copy of your spouse's divorce decree.

Blocks 47-49 - If you would like someone other than your mother, father or spouse to be notified in case of an emergency, please place their information in the blocks.

Blocks 50-52 - Fill out your **SPOUSE's** next of kin. Please insure all blocks are filled out.

Blocks 53 - "Beneficiary(s) for Unpaid Pay and Allowances": In the event of your death, the person you designate will receive your unpaid pay and allowances.

Block 54-55 - Fill out the address and relationship of who you selected as the beneficiary for your "Unpaid Pay and Allowances" as noted in Block 53 above.

Block 56 - Select the percentage of your unpaid pay and allowances you want to go to that person. If you have only one person designated, write 100%. If you have more than 1 person, ensure that the total percentage adds up to 100%.

Block 57 - "Person to Receive Allotment if in a Missing Status": In the event that you are Missing in Action (MIA), this person will receive up to 80% of your pay and allowances. This can be your spouse, parents, etc.

Block 58 - Fill out the address and relationship of who you selected as the person to receive the Allotment if in a Missing Status.

Block 59 - Select the percentage you want for that person. If you have only one person designated, write 80%. If you have more than 1 person, ensure that the total percentage adds up to 80%.

Block 60 - "Beneficiary(s) for Gratuity Pay": In the event of your death while on active duty (i.e. during an HPSP annual training period), this person will receive a check for Gratuity Pay in the amount of \$100,000.

ATTENTION: Public Law 110-181 requires we notify the spouse whenever a service member does not designate or designates all or part of the Death Gratuity to anyone other than his or her current lawful spouse. We are not authorized to disclose the name of any other beneficiary; we are only required to notify the spouse of your decision. This would only be paid if the death occurred while on Annual Training.

Block 61-62 - Fill out the address and relationship of the person selected to receive Gratuity Pay.

Block 63 - Select the percentage of Gratuity Pay you want that person to receive. If you have only one person designated, write 100%. If you have listed more than 1 person, ensure that the total percentage adds up to 100%.

Blocks 64-66 - If you have life insurance other than SGLI, place that information in the appropriate blocks.

Block 67 - If you practice a religion, indicate the name of that religion in the block. If you do not practice a religion, write "none" or "no preference."

Block 70 - Fill in your rank.

Block 73 - Write your name; Last, First, Middle.

Block 74 - Fill in your full social security number.

Block 77 - If you have a will or other valuable papers, please document their location or custodian in this block.

Block 78 - Enter your next of kin and secondary next of kin information. If you pay or receive child support, place that information here.

Block 79 - Fill in your signature.

Block 80 - Leave this blank.

You are the "Designator." Your name is entered in the blocks labeled "Designator." Once complete, send the form along with any supporting documents (i.e. birth certificate, marriage, divorce decree, etc.) to the Accessions Department Personnel Section by scanning and emailing. The personnel clerk will type and submit the official form.



Annual Health Screening Form for HPSP, NCP, FAP and NADDS Participants

Medical Questionnaire: **Submit appropriate documentation for all "YES" answers.**

1. Personal Information

Name:	Rank:	Phone:
E-Mail:	Last four SSN:	Grad Year:
Program: HPSP: 1975 (Medical Corps)	1985 (Dental Corps)	1995 (Medical Service Corps)
NCP	FAP	NADDS

2. Have you had any injury, illness or disease within the past 12 months which required hospitalization or caused you to be absent from school or training? YES NO

If yes, explain:

3. Are you now, or have you been in the care of a Health Professional during the past 12 months? YES NO

If yes, explain

4. Have you been prescribed or taken any prescription medications in the past 12 months? YES NO

If yes, please list PRESCRIBED medications and reasons for their use:

5. Do you have any physical or psychological concerns which might restrict your performance on active duty or prevent you from coming on active duty? YES NO

If yes, explain:

6. Date of your last HIV test:

HIV testing is required every two years. Please submit proof of testing and results if a new test was required.

7. Current Height in Inches: Current Weight in Pounds: Age: Sex:

I certify that the information contained in this form is true and complete to the best of my knowledge. I understand that I may be asked to provide additional documentation for any "YES" answer(s).

Member's Signature:

Date:

PRIVACY ACT STATEMENT: Authority 44 USC 3101 and EQ 9397. Principal Purpose: College information. The SSN is used to positively identify student. Routine Use: Information used to manage HPSP/FAP/NCP/NADDS program students. Disclosure: Voluntary, however, failure to supply this information could result in suspension/termination of benefits (LWOP or separation).

Please return to the Medical Readiness and Records Department.

Email: OH@med.navy.mil Attn: Medical Records

DEPENDENCY APPLICATION/RECORD OF EMERGENCY DATA

1. UNIT I.D. 8806N		2. SHIP OR STATION		3.		4.		
5. NAME OF SPOUSE				6. DATE OF BIRTH OF SPOUSE		7. RELATIONSHIP		
8. PLACE OF MARRIAGE (CITY & STATE IF COUNTRY)				9 DATE MARRIED		10. CITIZENSHIP OF SPOUSE		
11. ADDRESS OF SPOUSE						12. DEP		
13. NAME OF CHILD OR DEPENDENT				14. DATE OF BIRTH		15. RELATIONSHIP		
16. ADDRESS (INCLUDE NAME OF CUSTODIAN IF OTHER THAN CLAIMANT)						17. DEP		
18. NAME OF CHILD OR DEPENDENT				19. DATE OF BIRTH		20. RELATIONSHIP		
21. ADDRESS (INCLUDE NAME OF CUSTODIAN IF OTHER THAN CLAIMANT)						22. DEP		
23. NAME OF CHILD OR DEPENDENT				24. DATE OF BIRTH		25. RELATIONSHIP		
26. ADDRESS (INCLUDE NAME OF CUSTODIAN IF OTHER THAN CLAIMANT)						27. DEP		
28. NAME OF CHILD OR DEPENDENT				29. DATE OF BIRTH		30. RELATIONSHIP		
31. ADDRESS (INCLUDE NAME OF CUSTODIAN IF OTHER THAN CLAIMANT)						32. DEP		
33. NAME OF FATHER								
34. ADDRESS OF FATHER (SEE SPECIAL INSTRUCTIONS BEFORE COMPLETING BOX 35)						35. DEP		
36. NAME OF MOTHER								
37. ADDRESS OF MOTHER (SEE SPECIAL INSTRUCTIONS BEFORE COMPLETING BOX 38)						38. DEP		
39. WERE YOU PREVIOUSLY MARRIED?		40. PRIOR MARRIAGE DISSOLVED BY			41. DATE	42. PLACE (CITY & STATE OR COUNTY)		
YES NO		DEATH	ANNULMENT	DIVORCE				
43. WAS SPOUSE PREVIOUSLY MARRIED?		44. PRIOR MARRIAGE DISSOLVED BY			45. DATE	46. PLACE (CITY & STATE OR COUNTY)		
YES NO		DEATH	ANNULMENT	DIVORCE				
47. OTHER POINT OF CONTACT FOR NOTIFICATION			48. ADDRESS			49. RELATIONSHIP		
50. NEXT OF KIN OF SPOUSE (NOT HUSBAND, WIFE OR MINOR CHILD)			51. ADDRESS			52. RELATIONSHIP		
53. BENEFICIARY(S) FOR UNPAID PAY AND ALLOWANCES			54. ADDRESS			55. RELATIONSHIP	56. %	
57. PERSON TO RECEIVE ALLOTMENT IF IN A MISSING STATUS. (SUBJECT TO SECNAV DETERMINATION)			58. ADDRESS				59. %	
60. BENEFICIARY(S) FOR GRATUITY PAY			61. ADDRESS			62. RELATIONSHIP	63. %	
64. LIFE INSURANCE DATA (NAME OF CO)(DO NOT INCLUDE SGLI)			65. ADDRESS			66. POLICY NUMBER		
67. RELIGION			68.	69.	70. RANK / RATE		71. PAGE	72. OF PAGES
					ENS/O1		1	2
73. NAME OF DESIGNATOR (LAST, FIRST, MIDDLE)					74. SSN		75. USN	USNR
								X

77. LOCATION OF WILL OR OTHER VALUABLE PAPERS

78. REMARKS

Name, address and phone of:
 Primary Next of Kin (PNOK):

Secondary Next of Kin (SNOK):

Person Authorized Direct Disposition (PADD):

Other Remarks:

Is beneficiary designation of S.G.L.I on file?

DATE ON FILE (IF YES)

NOTE: THIS FORM DOES NOT DESIGNATE OR CHANGE BENEFICIARIES OF GOV'T LIFE INSURANCE.

79. SIGNATURE OF DESIGNATOR

80. SIGNATURE OF APPROVING OFFICER, TITLE, AND DATE

CERTIFICATION OF DESIGNATOR

I have reviewed the data entered on this form and certify that it is correct.
 Execute a new NAVPERS 1070/602 if data is not correct.

DATE	SIGNATURE OF DESIGNATOR	DATE	SIGNATURE OF DESIGNATOR

Please provide the following information below:

Full Name: _____

Last 4 SSN: _____

Email address: _____

Current Mailing address: (Where you receive your personal mail)

Line 1 _____

Line 2 _____

City _____ State _____

Zip _____

Primary Phone #: _____ Cell (); Home (); Work ()

Secondary Phone #: _____ Cell (); Home (); Work ()

ATTENTION: FAILURE TO PROVIDE CURRENT AND ACCURATE CONTACT INFORMATION CAN LEAD TO LEAVE WITHOUT PAY (LWOP).

Member Signature: _____ Date: _____