

Department of Health and Human Services
Public Health Services
Statement of Appointment
(Please Type)

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

1. PHS GRANT NUMBER			2. APPOINTEE'S NAME (Last, first, initial)	3. SEX
Type	Activity	ID Serial No.		<input type="checkbox"/> M <input type="checkbox"/> F

4. TYPE OF ACTION (Check only one type)	5. PRIOR NRSA SUPPORT (Individual or institutional)
<input type="checkbox"/> NEW appointment (NOT previously supported by this grant) <input type="checkbox"/> REAPPOINTMENT (Previously supported by this grant) <input type="checkbox"/> AMENDMENT of items checked: <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 15 <input type="checkbox"/> 20	<input type="checkbox"/> NO <input type="checkbox"/> YES (If "Yes," see instructions)

6. SOCIAL SECURITY NO. XXX-XX-	7. BIRTHDATE (Month, day, year)
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8. CITIZENSHIP (See instructions)	9. PERMANENT MAILING ADDRESS
<input type="checkbox"/> U.S. Citizen or Noncitizen National Non-U.S. Citizen <input type="checkbox"/> With a Permanent U.S. Resident Visa ("Green Card") <input type="checkbox"/> With a Temporary U.S. Visa If not a U.S. citizen, of which country are you a citizen?	E-mail

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

11. What is your racial background? Check one or more	12. Do you have a disability?
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Do Not Wish to Provide	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Do Not Wish to Provide If yes, which of the following categories describe your disability(ies): <input type="checkbox"/> Hearing <input type="checkbox"/> Mobility/Orthopedic Impairment <input type="checkbox"/> Visual <input type="checkbox"/> Other
	13. Are you from a disadvantaged background?
	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Do Not Wish to Provide

14. FIELD OF RESEARCH TRAINING OR CAREER DEVELOPMENT (for this appointment)	15. PERIOD OF APPOINTMENT (Month, day, year)
Enter a 4 digit code from instructions: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	From: _____ To: _____

16. 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.		

17. NAME OF SPECIALTY BOARDS (if applicable)

18. DEGREE(S) SOUGHT YES NO If yes, indicate type of degree

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

19. EXPECTED COMPLETION DATE OF DEGREE REQUIREMENTS (if applicable)

20. SUPPORT FOR PERIOD OF APPOINTMENT

TYPE	Total for this Grant (Omit cents)
Stipend / Salary / Other Compensation	\$
Tuition/fees (estimated)	\$
Travel (estimated)	\$
TOTAL	\$

21. 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.)

22. 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
23. 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) TYPED NAME OF PROGRAM DIRECTOR Dr. David Kumrow, Traineeship Director

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

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