STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY ▪ GAVIN NEWSOM, GOVERNOR

Board of Vocational Nursing and Psychiatric Technicians
2535 Capitol Oaks Drive Suite 205, Sacramento, CA 95833-2945
Phone 916-263-7800 Fax 916-263-7855 www.bvnpt.ca.gov

RECORD OF MILITARY SERVICE

To Be Completed By Applicant Who May Qualify On The Basis Of U.S. Military Service

The PSYCHIATRIC TECHNICIANS LAW, SECTION 2575 states, in part, that "Persons applying for licensure under this section must meet one of the following: (b) Completion of an armed forces course involving neuropsychiatric nursing and an armed forces or civilian course from an accredited school in the care of the developmentally disabled client. …" This section refers to the ***United States Military*** only.

PRINT OR TYPE (DO NOT USE PENCIL)

1. NAME (LAST) (FIRST) (MIDDLE)

2. ADDRESS (STREET OR BOX NUMBER) (APT. NO)

3. CITY STATE ZIP

4. BIRTHDATE (Month/Day/Year)

5. SOCIAL SECURITY NUMBER / INDIVIDUAL TAXPAYER IDENTIFICATION NUMBER*

6. TELEPHONE NUMBER
Business _____
Home _____

7. SPECIFY THE BRANCH OF MILITARY YOU SERVED IN: ☐AIR FORCE ☐ARMY ☐COAST GUARD ☐MARINES ☐NAVY

8. DATE OF ENLISTMENT: _____ DATE OF DISCHARGE:_____ ARE YOU STILL ON ACTIVY DUTY? ☐YES ☐NO

9. ARMED FORCES COURSE INVOLVING NEUROPSYCHIATRIC NURSING RECEIVED AT THE FOLLOWING PLACE: _____

10. NAME OF COURSE :_____ DATE STARTED:_____ DATE COMPLETED:_____

11. YOU **MUST** ENCLOSE THE FOLLOWING DOCUMENTS WITH THIS FORM:

A. TRANSCRIPTS OR CERTIFICATE SHOWING COMPLETION OF AN ARMED FORCES COURSE INVOLVING NEUROPSYCHIATRIC NURSING AND AN ARMED FORCES OR CIVILIAN COURSE FROM AN ACCREDITED SCHOOL IN THE CARE OF THE DEVELOPMENTALLY DISABLED CLIENT.

B. PROOF OF COMPLETION OF AT LEAST ONE YEAR OF VERIFIED FULL TIME PAID WORK EXPERIENCE, INCLUDING:

1. MILITARY SERVICE EVALUATIONS VERIFYING AT LEAST SIX MONTHS IN A MILITARY CLINICAL FACILITY RENDERING BEDSIDE CARE TO CLIENTS WITH MENTAL DISORDERS SHOWING THE DATES OF SERVICE, WARDS ASSIGNED AN DUTIES PERFORMED FOR EACH ASSIGNMENT, AND

2. MILITARY OR CIVILIAN SERVICE EVALUATIONS VERIFYING AT LEAST SIX MONTHS IN A MILITARY OR CIVILIAN CLINICAL FACILITY RENDERING BEDSIDE CARE TO CLIENTS WITH DEVELOPMENTAL DISABLITIES SHOWING THE DATES OF SERVICE, WARDS ASSIGNED AND DUTIES PERFORMED AT EACH ASSIGNMENT.

12. **PLEASE READ CAREFULLY BEFORE SIGNING**. – *I hereby certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. False statements included in this application can result in licensure denial.*

SIGNATURE:_____ DATE:_____

***SOCIAL SECURITY NUMBER/INDIVIDUAL TAXPAYER IDENTIFICATION NUMBER DISCLOSURE STATEMENT –**
Disclosure of your Social Security Number/Individual Taxpayer Identification Number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 [(42 USCA (c) (2) (C))] authorizes collection of your Social Security Number/Individual Taxpayer Identification Number. Your Social Security Number/Individual Taxpayer Identification Number will be used exclusively for tax enforcement purposes and for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your Social Security Number/Individual Taxpayer Identification Number, your application for initial license will not be processed and you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.