

Massachusetts State Defense Force Application Instructions

Those persons interested in serving with the MSDF should first consult TAGMA Pam 10-6-1 (MSDF Personnel Management) in order to determine their eligibility for membership. Prospective applicants should review Paragraph 2-3 as well as the appropriate section for either officers (Paragraphs 3-1 and 3-2), warrant officers (Paragraph 4-1), or enlisted personnel (Paragraph 5-1).

All applicants will submit the following to the MSDF for processing (see Paragraph 6-1, TAGMA Pam 10-6-1):

1. MSDF Membership Application (be sure to initial each page)
2. DD Form 2807-1 (Report of Medical History)
3. Copy of birth certificate, documentation of lawful permanent residency, or evidence of citizenship
4. Verification of Social Security Number (copy of Social Security card will suffice for this requirement)
5. Copies of all DD Forms 214 and/or NGB Forms 22
6. Copies of any military awards not annotated on a DD Form 214 or NGB Form 22
7. MSDF CORI Form
8. Evidence of highest civilian schooling attained
9. Evidence of highest military schooling attained
10. Evidence of valid motor vehicle operator permit and certified driving record
11. (For professional appointments only) Proof of current, unrestricted licensure, registration, certification, or ecclesiastical endorsement

Be sure to maintain a photocopy of all information submitted for your own records.

All applications should be mailed to:

**Massachusetts State Defense Force
Joint Force Headquarters
2 Randolph Road
Hanscom AFB, MA 01731**

Massachusetts State Defense Force Membership Application

1. General Information		Answer each question in the space provided.			
Last Name		First Name		Middle Name	
Date of Birth		Place of Birth		SSN	
Home Address (Street)		City		State	
Mailing Address (if different)		City		State	
Home Telephone		Alternate (Cell) Telephone		E-Mail Address	
Marital Status		Next of Kin		Relationship	
Next of Kin Home Address		City		State	
				Zip	
2. Civilian Education		List all schools attended (attach additional sheet if necessary).			
High School		City		State	
				Year	
College		City		State	
				Year	
Graduate School		City		State	
				Year	
Chief Undergraduate Subject				Undergraduate Degree	
Chief Graduate Subject				Graduate Degree	
3. Work History		Cover the last 5 years (attach additional sheet if necessary).			
May inquiry be made of your present employer regarding your character, qualification, and record of employment? (A "No" answer will not affect your consideration for membership.)				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Name and Address of Employer			Dates Employed		
			From	To	
Title of Position		Supervisor Name and Telephone Number		Number of Employees Supervised	
Type of Business		Reason for Leaving (Leave Blank if Currently Employed)			
Description of Work					
Name and Address of Employer			Dates Employed		
			From	To	
Title of Position		Supervisor Name and Telephone Number		Number of Employees Supervised	
Type of Business		Reason for Leaving			
Description of Work					
4. Skills and Qualifications					
List any current professional licenses/certification (attach copies to this application)					
List any special skills/qualifications with software, emergency management, logistics, communications, public health, etc. (attach additional sheet if necessary).					

5. Military Experience	Attach additional sheet(s) if necessary.
-------------------------------	--

Military Service: Start with most recent service and show changes in grade and duty in reverse chronological order.

From	To	Component	Grade	Organization	Duty

Military Education: Enter information for all military courses successfully completed.

Resident Courses	Duration		Correspondence Courses	Hours
	Weeks	Days		

Military Qualifications: List any Military Occupational Specialty and Secondary Skill Identifier awarded on orders.

MOS/SSI	Date Awarded	How Qualification was Obtained (Service School, On the Job Training, Civilian Experience, etc.)

6. Personal Background Questionnaire

YES	NO	All applicants must complete; attach separate sheet(s) fully detailing any "YES" answers (except questions 9 and 10).
<input type="checkbox"/>	<input type="checkbox"/>	1. Have you ever been convicted of a felony by any civilian or military court?
<input type="checkbox"/>	<input type="checkbox"/>	2. Are you currently on parole or probation?
<input type="checkbox"/>	<input type="checkbox"/>	3. Have you ever been dropped from the rolls or released from any Uniformed Service of the United States under other than honorable conditions, for unsatisfactory service, by resignation in lieu of court martial, by elimination for any form of corrective or disciplinary action, for the good of the service, or for presenting a security risk?
<input type="checkbox"/>	<input type="checkbox"/>	4. Have you ever received a military discharge with a reenlistment code of either RE-4 or RE-3?
<input type="checkbox"/>	<input type="checkbox"/>	5. Are you presently serving in the Armed Forces of the United States or any reserve component thereof?
<input type="checkbox"/>	<input type="checkbox"/>	6. Are you presently serving in the State Defense Force of any other state or territory?
<input type="checkbox"/>	<input type="checkbox"/>	7. Have you ever been discharged for cause by the State Defense Force of this or any other state or territory, the Civil Air Patrol, the U.S. Coast Guard Auxiliary, or any similar organization?
<input type="checkbox"/>	<input type="checkbox"/>	8. Are you a member of any paramilitary training organization not authorized by Congress or the Massachusetts General Court?
<input type="checkbox"/>	<input type="checkbox"/>	9. Do you meet MSDF height/weight standards outlined in Appendix B of TAGMA Pam 10-6-1?
<input type="checkbox"/>	<input type="checkbox"/>	10. (Males born after December 31, 1959 only) Are you registered with the Selective Service System?

7. Information Use and Safeguarding

The primary use of information provided on this application is to determine your eligibility for membership in the Massachusetts State Defense Force. As such, this information may be disclosed to individuals and agencies as required to investigate your statements. Furnishing the information on this form, including your Social Security Number, is voluntary, but failure to do so may result in disapproval of this application. The safeguarding of information you provide is governed by the provisions of Massachusetts General Laws (MGL) Chapter 4, Section 7, Clauses 26 (a) - (s); MGL Chapter 66; and MGL Chapter 66a.

8. Statements of Understanding, Certification, and Authorization for Release of Information

I understand that members of the Massachusetts State Defense Force serve in a voluntary and generally uncompensated capacity and will only be paid in the event that they are called into active state military service. I further understand that members of the Massachusetts State Defense Force shall be required to attend reasonably scheduled drill periods (at least one per quarter) in order to satisfy performance standards.

My statements on this form, and on any attachments to it as well as all other forms required to complete the Massachusetts State Defense Force application process, are true, complete, and correct to the best of my knowledge and belief and are made in good faith. I have carefully read the foregoing instructions to complete this and all other applicable forms. I understand that a knowing and willful false statement on this and other required forms can be punished as allowed by law. I understand that intentionally withholding, misrepresenting, or falsifying information may have a negative effect on my ability to serve in the Massachusetts State Defense Force and/or may result in my removal and debarment from state military service.

I have completed this application and all related/required forms with the knowledge and understanding that any or all items contained herein may be subject to investigation as permitted by law. I consent to the release of information concerning my capacity and fitness by any employer (except my present employer if so indicated in Section 3 of this application form), educational institution, law enforcement agency, and/or other individuals and agencies to MSDF S1 personnel for the purposes of verifying my information and determining my suitability for membership in the Massachusetts State Defense Force. This authorization is valid for the entirety of my affiliation with the Massachusetts State Defense Force.

Print Full Name:

Signature:

Date:

REPORT OF MEDICAL HISTORY
 (This information is for official and medically confidential use only
 and will not be released to unauthorized persons.)

OMB No. 0704-0413
 OMB approval expires
 Mar 31, 2010

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services Directorate (0704-0413). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397 (SSAN).
PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.
ROUTINE USE(S): None.
DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a \$10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	2. SOCIAL SECURITY NUMBER	3. TODAY'S DATE (YYYYMMDD)
4.a. HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code)	5. EXAMINING LOCATION AND ADDRESS (Include ZIP Code)	
b. HOME TELEPHONE (Include Area Code)		

X ALL APPLICABLE BOXES:			7.a. POSITION (Title, Grade, Component)
6.a. SERVICE <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	6.b. COMPONENT <input type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	6.c. PURPOSE OF EXAMINATION <input type="checkbox"/> Enlistment <input type="checkbox"/> Medical Board <input checked="" type="checkbox"/> Other (Specify) <input type="checkbox"/> Commission <input type="checkbox"/> Retirement MSDF <input type="checkbox"/> Retention <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> Separation <input type="checkbox"/> ROTC Scholarship Program	b. USUAL OCCUPATION

8. CURRENT MEDICATIONS (Prescription and Over-the-counter)	9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance)
--	--

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO	12. (Continued)	YES	NO
10.a. Tuberculosis	<input type="radio"/>	<input type="radio"/>	f. Foot trouble (e.g., pain, corns, bunions, etc.)	<input type="radio"/>	<input type="radio"/>
b. Lived with someone who had tuberculosis	<input type="radio"/>	<input type="radio"/>	g. Impaired use of arms, legs, hands, or feet	<input type="radio"/>	<input type="radio"/>
c. Coughed up blood	<input type="radio"/>	<input type="radio"/>	h. Swollen or painful joint(s)	<input type="radio"/>	<input type="radio"/>
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	<input type="radio"/>	<input type="radio"/>	i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	<input type="radio"/>	<input type="radio"/>
e. Shortness of breath	<input type="radio"/>	<input type="radio"/>	j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	<input type="radio"/>	<input type="radio"/>
f. Bronchitis	<input type="radio"/>	<input type="radio"/>	k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	<input type="radio"/>	<input type="radio"/>
g. Wheezing or problems with wheezing	<input type="radio"/>	<input type="radio"/>	l. Bone, joint, or other deformity	<input type="radio"/>	<input type="radio"/>
h. Been prescribed or used an inhaler	<input type="radio"/>	<input type="radio"/>	m. Plate(s), screw(s), rod(s) or pin(s) in any bone	<input type="radio"/>	<input type="radio"/>
i. A chronic cough or cough at night	<input type="radio"/>	<input type="radio"/>	n. Broken bone(s) (cracked or fractured)	<input type="radio"/>	<input type="radio"/>
j. Sinusitis	<input type="radio"/>	<input type="radio"/>	13.a. Frequent indigestion or heartburn	<input type="radio"/>	<input type="radio"/>
k. Hay fever	<input type="radio"/>	<input type="radio"/>	b. Stomach, liver, intestinal trouble, or ulcer	<input type="radio"/>	<input type="radio"/>
l. Chronic or frequent colds	<input type="radio"/>	<input type="radio"/>	c. Gall bladder trouble or gallstones	<input type="radio"/>	<input type="radio"/>
11.a. Severe tooth or gum trouble	<input type="radio"/>	<input type="radio"/>	d. Jaundice or hepatitis (liver disease)	<input type="radio"/>	<input type="radio"/>
b. Thyroid trouble or goiter	<input type="radio"/>	<input type="radio"/>	e. Rupture/hernia	<input type="radio"/>	<input type="radio"/>
c. Eye disorder or trouble	<input type="radio"/>	<input type="radio"/>	f. Rectal disease, hemorrhoids or blood from the rectum	<input type="radio"/>	<input type="radio"/>
d. Ear, nose, or throat trouble	<input type="radio"/>	<input type="radio"/>	g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	<input type="radio"/>	<input type="radio"/>
e. Loss of vision in either eye	<input type="radio"/>	<input type="radio"/>	h. Frequent or painful urination	<input type="radio"/>	<input type="radio"/>
f. Worn contact lenses or glasses	<input type="radio"/>	<input type="radio"/>	i. High or low blood sugar	<input type="radio"/>	<input type="radio"/>
g. A hearing loss or wear a hearing aid	<input type="radio"/>	<input type="radio"/>	j. Kidney stone or blood in urine	<input type="radio"/>	<input type="radio"/>
h. Surgery to correct vision (RK, PRK, LASIK, etc.)	<input type="radio"/>	<input type="radio"/>	k. Sugar or protein in urine	<input type="radio"/>	<input type="radio"/>
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)	<input type="radio"/>	<input type="radio"/>	l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	<input type="radio"/>	<input type="radio"/>
b. Arthritis, rheumatism, or bursitis	<input type="radio"/>	<input type="radio"/>	14.a. Adverse reaction to serum, food, insect stings or medicine	<input type="radio"/>	<input type="radio"/>
c. Recurrent back pain or any back problem	<input type="radio"/>	<input type="radio"/>	b. Recent unexplained gain or loss of weight	<input type="radio"/>	<input type="radio"/>
d. Numbness or tingling	<input type="radio"/>	<input type="radio"/>	c. Currently in good health (If no, explain in Item 29 on Page 2.)	<input type="radio"/>	<input type="radio"/>
e. Loss of finger or toe	<input type="radio"/>	<input type="radio"/>	d. Tumor, growth, cyst, or cancer	<input type="radio"/>	<input type="radio"/>

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER
---	------------------------

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO		YES	NO
15.a. Dizziness or fainting spells	<input type="radio"/>	<input type="radio"/>	19. Have you been refused employment or been unable to hold a job or stay in school because of:		
b. Frequent or severe headache	<input type="radio"/>	<input type="radio"/>	a. Sensitivity to chemicals, dust, sunlight, etc.	<input type="radio"/>	<input type="radio"/>
c. A head injury, memory loss or amnesia	<input type="radio"/>	<input type="radio"/>	b. Inability to perform certain motions	<input type="radio"/>	<input type="radio"/>
d. Paralysis	<input type="radio"/>	<input type="radio"/>	c. Inability to stand, sit, kneel, lie down, etc.	<input type="radio"/>	<input type="radio"/>
e. Seizures, convulsions, epilepsy or fits	<input type="radio"/>	<input type="radio"/>	d. Other medical reasons (If yes, give reasons.)	<input type="radio"/>	<input type="radio"/>
f. Car, train, sea, or air sickness	<input type="radio"/>	<input type="radio"/>	20. Have you ever been treated in an Emergency Room? (If yes, for what?)	<input type="radio"/>	<input type="radio"/>
g. A period of unconsciousness or concussion	<input type="radio"/>	<input type="radio"/>	21. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)	<input type="radio"/>	<input type="radio"/>
h. Meningitis, encephalitis, or other neurological problems	<input type="radio"/>	<input type="radio"/>	22. Have you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give age at which occurred.)	<input type="radio"/>	<input type="radio"/>
16.a. Rheumatic fever	<input type="radio"/>	<input type="radio"/>	23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)	<input type="radio"/>	<input type="radio"/>
b. Prolonged bleeding (as after an injury or tooth extraction, etc.)	<input type="radio"/>	<input type="radio"/>	24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)	<input type="radio"/>	<input type="radio"/>
c. Pain or pressure in the chest	<input type="radio"/>	<input type="radio"/>	25. Have you ever been rejected for military service for any reason? (If yes, give date and reason for rejection.)	<input type="radio"/>	<input type="radio"/>
d. Palpitation, pounding heart or abnormal heartbeat	<input type="radio"/>	<input type="radio"/>	26. Have you ever been discharged from military service for any reason? (If yes, give date, reason, and type of discharge, whether honorable, other than honorable, for unfitness or unsuitability.)	<input type="radio"/>	<input type="radio"/>
e. Heart trouble or murmur	<input type="radio"/>	<input type="radio"/>	27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? (If yes, specify what kind, granted by whom, and what amount, when, why.)	<input type="radio"/>	<input type="radio"/>
f. High or low blood pressure	<input type="radio"/>	<input type="radio"/>	28. Have you ever been denied life insurance?	<input type="radio"/>	<input type="radio"/>
17.a. Nervous trouble of any sort (anxiety or panic attacks)	<input type="radio"/>	<input type="radio"/>	29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)		
b. Habitual stammering or stuttering	<input type="radio"/>	<input type="radio"/>			
c. Loss of memory or amnesia, or neurological symptoms	<input type="radio"/>	<input type="radio"/>			
d. Frequent trouble sleeping	<input type="radio"/>	<input type="radio"/>			
e. Received counseling of any type	<input type="radio"/>	<input type="radio"/>			
f. Depression or excessive worry	<input type="radio"/>	<input type="radio"/>			
g. Been evaluated or treated for a mental condition	<input type="radio"/>	<input type="radio"/>			
h. Attempted suicide	<input type="radio"/>	<input type="radio"/>			
i. Used illegal drugs or abused prescription drugs	<input type="radio"/>	<input type="radio"/>			
18. FEMALES ONLY. Have you ever had or do you now have:					
a. Treatment for a gynecological (female) disorder	<input type="radio"/>	<input type="radio"/>			
b. A change of menstrual pattern	<input type="radio"/>	<input type="radio"/>			
c. Any abnormal PAP smears	<input type="radio"/>	<input type="radio"/>			
d. First day of last menstrual period (YYYYMMDD)					
e. Date of last PAP smear (YYYYMMDD)					

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER
---	------------------------

30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)*

a. COMMENTS

Additional information required by the Massachusetts State Defense Force to be completed by the Provider:

1. Blood Pressure: _____ Heart Rate: _____ Height: _____ Weight: _____
2. Brief description on examination of the following (use additional space below if necessary):
 - 2a. Cardiovascular System: _____
 - 2b. Lungs: _____
 - 2c. Abdomen: _____
 - 2d. Extremities: _____
3. Listing of all medications: _____

4. Pertinent laboratory data (e.g. HgA1c): _____

b. TYPED OR PRINTED NAME OF EXAMINER <i>(Last, First, Middle Initial)</i>	c. SIGNATURE	d. DATE SIGNED <i>(YYYYMMDD)</i>
---	--------------	-------------------------------------



The Commonwealth of Massachusetts

Military Division

50 Maple Street
Milford, Massachusetts 01757
Tel: (508) 233-6552
www.mass.gov/guard

CORI REQUEST FORM

The Massachusetts National Guard is certified by the Criminal History Systems Board for access to the conviction and pending criminal case data in order to screen members and employees of the Commonwealth's Armed Forces and Military Division; I understand that a criminal record check will be conducted on me. The information below is correct to the best of my knowledge.

Participant/Volunteer Signature

Date

PARTICIPANT/VOLUNTEER INFORMATION (PLEASE PRINT)

Last Name

First Name

Middle Name

Date of Birth

Place of Birth

Mother's Maiden Name

Maiden Name or Alias
(If Applicable)

Social Security Number
(Optional – Not Required)

ID Theft Index PIN
(If Applicable)

Former Addresses: _____

Sex: _____ Height: _____ ft _____ in Weight: _____ Eye Color: _____

Driver License Number: _____ State of Issue: _____

MILITARY DIVISION USE ONLY

THE ABOVE INFORMATION WAS VERIFIED BY REVIEWING THE FOLLOWING FORM OF GOVERNMENT ISSUED PHOTOGRAPHIC IDENTIFICATION: _____

Requested by: _____
Signature of CORI Authorized Employee

CHSB USE ONLY

Record Attached: _____ No Record: _____