U.S. Department of Veterans Affairs

VA San Diego Healthcare System

Attachment A-1

Sponsoring/Responsible Institution:		**Date TQCVLSigned:**		**Consortium #:**	
Training Program:		**VHA Point of Contact:**	Suzanne Carranza	**VA Training Start Date (MM/DD/YY):**	
Program Director:		**Course Title:**	**Course #:**	**VA Training End Date (MM/DD/YY):**	
		Clinical Day(s):	**Clinical Time:**		
		Unit:	**Semester/Year:**		
Clinical Instructor:		**Clinical Instructor's Email:**	**Clinical Instructor's Phone:**	**Program End Date (MM/DD/YY):**	

Name below must **EXACTLY** match two (2) pieces of identification (http://www.va.gov/PIVPROJECT/ID%20Matrix%20(update).pdf.

Last Name	**First Name**	**Middle Name**	**SSN (numbers only)**	**DOB (MM/DD/YYYY)**	**Required to Register with SSS.gov (Y or N)**	**If required, has complied with SSS.gov law (Register or SIL)**	**Country of Citizenship if not USA**	**Active Duty (AD) or VA Employee (VA)**

***Note: Submit this form as an attachment to the Trainee Qualification and Credential Verification Letter (TQCVL). Preliminary copies of this form can be emailed to expedite processing of the trainees. List entire middle name or leave blank if no middle name. Full 9-digit social security number is required. Must have a response to Selective Service System (SSS) section for each trainee. Non-US citizens must provide copies of immigration documents. Use Password or Encryption when emailing this form.