OPERATION WARFIGHTER

Approval for Participation Instructions
Installation:_____

Part A – Wounded, Ill, and Injured Service Member Information

Last Name: **First Name:** **Rank:**

Unit: **Location *(if different from Installation)*:**

Service: **Component:** ☐ Active ☐ Guard ☐ Reserve

Telephone: **Email:** **DOD ID#**

Separation Date *(Estimated)*:

Clearance Status: ☐ Confidential ☐ Secret ☐ Top Secret ☐ Other

Does the Service member have transportation, or able to use public transportation, in the local area?

☐ Yes ☐ No Explain:

How long does the recovering Service member anticipate being able to intern in the local area?

months

Part B – Terms and Conditions

With my signature below I_____, hereby affirm and/or understand that:

- I have voluntarily chosen to participate in this program and I will not be paid for this internship.
- The primary purposes of this internship are work therapy and work hardening.
- A secondary purpose of this internship is exposure to civilian employment practices/opportunities in a federal agency.
- My OWF internship may be terminated for cause at any time.
- If this internship does not meet with my needs and/or my satisfaction, I must *first* discuss my concerns with my chain of command *and* the OWF Coordinator before my participation is terminated; I *may not* simply choose to terminate my internship without first discussing my concerns with my chain of command *and* the OWF Coordinator.
- My participation in an OWF internship does not guarantee permanent employment with any Organization.
- My personally identifiable information (PII) I have provided in my application and resume will be shared with Organizations and open OWF internship positions. My PII will be maintained and destroyed in accordance with the provisions of the Federal Records Act and the regulations and records schedules of the National Archives and Records Administration and in some cases may be covered by the Privacy Act and subject to the Freedom of Information Act.

Signature: _____ **Date:** _____

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Part C – Signatures

Primary Care Manager / Designated Medical Representative:

☐ Concur
☐ Non-Concur

Print Name	*Signature*	*Date*

Phone: _____ Email: _____

Command Decision (UCMJ Authority):

☐ Concur
☐ Non-Concur

Print Name	*Signature*	*Date*

Phone: _____ Email: _____

Please return completed document to your OWF Regional Coordinator for disposition.

This is a Department of Defense Operation Warfighter document. Previous contents may not be edited or changed in any way. Additional comments from Medical or Command may be inserted in the field below: