STATE OF CALIFORNIA – MILITARY DEPARTMENT

CALIFORNIA STATE MILITARY RESERVE

Headquarters, CA SMR
9800 Goethe Road
P.O.Box 269101
Sacramento, California 95826

REQUIRED APPLICATION DOCUMENTS

You are requested to submit the following documents with your application package. When submitting your package please submit all documentation and forms in one envelope. Note that your application package cannot be processed until ALL necessary forms and documentation are submitted. Please ensure all application forms are signed and dated with an original signature. Photocopies of your signature are not acceptable on the application.

[ ] Form-1, CSMR Application for Appointment or Enlistment.

[ ] Form SF-93, Report of Medical Status.

[ ] Form DD-214 or NGB-22.
(For prior military service applicants. Include one copy for EACH period of service).

[ ] Photocopy of California Driver's License.

[ ] Photocopy of Social Security Card. Other official verification is acceptable.

[ ] Photocopy of Birth Certificate.

[ ] Photocopy of Official documents verifying all military education completed.

[ ] Transcripts of Highest civilian education completed.

[ ] Current color photo, size 5"x7".
(Full length, class "B" uniform or civilian business attire without jacket).

[ ] Professional status documentation. Required for Medical, Chaplain and Legal Officer appointments.
Provide copies of all education, licensure and certifications as appropriate.

[ ] Exception to Policy Request (required for applicants who do not meet ALL established requirements).

[ ] Special instructions as noted:

If you have any questions regarding the application process or required documents,
you may send an Email to your selected unit Recruiting Contact, or call for assistance,
see: http://www.calguard.ca.gov/casmr/unitcontacts.htm

MILITARY DEPARTMENT - STATE OF CALIFORNIA

California State Military Reserve

APPLICATION FOR APPOINTMENT OR ENLISTMENT

Personal Qualification Statement

1. NAME (Last, First, Middle)	2. SOCIAL SECURITY NUMBER	3. DATE

4. HOME ADDRESS	5. BUSINESS ADDRESS
A. TELEPHONE ( )	A. TELEPHONE ( )

6. DATE OF BIRTH (mm/dd/yy)	7. PLACE OF BIRTH (City, County, State)	8. CA DRIVER'S LICENSE NO

9. ANSWER ITEMS "A" THROUGH "E" BY PLACING AN "X" IN THE PROPER COLUMN	Yes	No
A. Are you a citizen of the United States ? if "No", give the country of which you are a citizen:		
B. Are you now, or have you been, within the past ten years, a member of an organization that, to your present knowledge, seeks the overthrow of the constitutional form government of the United States by force or other unlawful means? If your answer is yes, please explain on a separate sheet of paper indicating the dates of your membership, and the purpose of the organization while you were a member.		
C. To insure that you are not placed in a position which might impair your health, or which might be a hazard to others, you are required to submit Standard Medical Form 93 with this application and provide the following information: Have you ever applied for compensation for any physical or mental disability? If yes, please explain on SF 93.		
D. Have you ever been convicted of an offense against the law or forfeited collateral, or are you now under charges for any offense against the law ? (You may omit minor traffic violations where the fine was under $50.00)		
E. While on military duty, were you ever convicted by a general court-martial? If the answer to "D" or "E" is yes, explain on a separate sheet of paper. Show for each offense, Date, Charge, Court, and action taken.		

Military Experience

10. Do you have prior military service? (Check all applicable boxes)	Yes	No	Active	Reserve
A. Circle Branch(es): Army, Navy, USAF, USMC, Coast Guard Provide DD Form 214 or other approved document to substantiate service.				

11. Have you ever been discharged from the armed services under other than honorable conditions? If yes provide details	Yes	No

12. List military schools attended and major courses taken. Use additional sheets if necessary. Provide copies of all diplomas and completion certificates.

CSMR Form 1 29 Feb 96 Replaces all previous editions

Professional Experience

13. Please list your present position and work background for the past 10 years. Also account for periods of unemployment.

May inquiry be made to your present employer regarding your character, qualifications. and record of employment? (A "No" answer will not affect consideration for appointment except for field grade positions)	Yes	No

A	Dates of Employment (Month, year)	Exact Title or Position	Grade if Federal or Military Service
	Name of Immediate Supervisor Telephone ( )	Name of Employer (Firm, organization, etc.) and Address	
B	Dates of Employment (Month, year)	Exact Title or Position	Grade if Federal or Military Service
	Name of Immediate Supervisor Telephone ( )	Name of Employer (Firm, organization, etc.) and Address	
C	Dates of Employment (Month, year)	Exact Title or Position	Grade if Federal or Military Service
	Name of Immediate Supervisor Telephone ( )	Name of Employer (Firm, organization, etc.) and Address	

14. Civilian Education

A. Did you graduate from High School?

Yes	Month/Year	No	Highest Grade Completed

B. Name and Location (City, State and Zip Code) of College or university.	Dates Attended		Major	Degree	Year
	From	To			

ATTENTION - THIS STATEMENT MUST BE SIGNED

A false answer to any question in this statement may be grounds for not appointing you, or for discharging you after your appointment, together with any additional sanctions allowed by the California Military and Veterans Code, All statements are subject to verification including a review of Department of Motor Vehicles records, police records (if warranted), and former employers.

CERTIFICATION	SIGNATURE (Sign in ink)	DATE SIGNED
I certify that all of the statements made in this Declaration are true, complete, and correct to the best of my knowledge and belief, and are made in good faith.		

FOR NATIONAL GUARD USE ONLY Unit of Assignment	TDA Para and Line #	State Order #	Date

STANDARD FORM 93
REV. OCTOBER 1974
GSA FPMR 101-11.8

APPROVED
OFFICE OF MANAGEMENT AND BUDGET No. 29-RO191

REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME-FIRST NAME-MIDDLE NAME		2. SOCIAL SECURITY OR IDENTIFICATION NO.
3. HOME ADDRESS (No. street or RFD, city or town, State, and ZIP CODE)		4. POSITION (title, grade, component)
5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION	7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS

8. STATEMENT OF EXAMINEES PRESENT HEALTH AND MEDICATIONS CURRENTLY USED

9. HAVE YOU EVER (Please cheek each item)			10. DO YOU (Please check each item)		
YES	NO	(Check each item)	YES	NO	(Check each item)
		Lived with anyone who had tuberculosis			Wear glasses or contact lenses
		Coughed up blood			Have vision in both eyes
		Bled excessively after injury or tooth extraction			Wear a hearing aid
		Attempted suicide			Stutter or stammer habitually
		Been a sleepwalker			Wear a brace or back support

11. HAVE YOU EVER HAD OR HAVE NOW (Please check at left of each item)

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
			Scarlet fever, erysipelas				Cramps in your legs				"Trick" or locked knee
			Rheumatic fever				Frequent indigestion				Foot trouble
			Swollen or painful joints				Stomach, liver, or intestinal trouble				Neuritis
			Frequent or sever headache				Gall bladder trouble or gallstones				Paralysis (Including Infantile
			Dizziness or fainting spells				Jaundice or hepatitis				Epilepsy or fits
			Eye trouble				Adverse reaction to serum, drug, or medication				Car, train, sea or air sickness
			Ear, nose or throat trouble				Broken bones				Frequent trouble sleeping
			Hearing loss				Tumor, growth, cyst, cancer				Depression or excessive worry
			Chronic or frequent colds				Rupture/hernia				Loss of memory or amnesia
			Severe tooth or gum trouble				Piles or rectal disease				Nervous trouble of any sort
			Sinusitis				Frequent or painful urination				Periods of unconsciousness
			Hay fever				Bed wetting since age 12				
			Head injury				Kidney stone or blood in urine				
			Skin diseases				Sugar or albumin in urine				
			Thyroid trouble				VD-Syphilis, gonorrhea, etc.				
			Tuberculosis				Recent gain or loss of weight				
			Asthma				Arthritis, Rheumatism or Bursitis				
			Shortness of breath				Bone, joint or other deformity				
			Pain or pressure in chest				Lameness				
			Chronic cough				Loss of finger or toe				
			Palpitation or pounding heart				Painful or "trick" shoulder or elbow	12. FEMALES ONLY: HAVE YOU EVER			
			Heart trouble				Recurrent back pain				Been treated for a female disorder
			High or low blood pressure								Has a change of menstrual pattern

13. WHAT IS YOUR USUAL OCCUPATION?	14. ARE YOU (Check one)	
	Right handed	Left handed

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT	
		15. Have you been refused employment or been unable to hold a job or stay in school because of:	
		A. Sensitivity to chemicals, dust, sun light, etc.	
		B. Inability to perform certain motions.	
		C. Inability to assume certain positions.	
		D. Other medical reasons (if yes, give reasons)	
		16. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details.)	
		17. Have you ever been denied life insurance? (If yes, state reason and give details.)	
		18. Have you had, or have you been advised to have any operations? (If yes, describe and give age at which occurred.)	
		19. 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.)	
		20. Have you ever had any illness or injury other than those already noted? (If yes, specifically when, where, and give details.)	
		21. 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.)	
		22. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give, date and reason for rejection.)	
		23. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.)	
		24. Have you ever received, is there pending or have you applied for pension or compensation for existing disability? (If yes, specify what kind granted by whom, and what amount, when, why.)	

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF APPLICANT	SIGNATURE

ADDITIONAL COMMENTS:

HEIGHT IN INCHES: _____ WEIGHT: _____

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS

REVERSE OF STANDARD FORM 93