



Part A - Recovering Service Member Information:

Last Name: _____ First Name: _____ Rank: _____

Installation: _____ Location (if different from Installation): _____

Telephone: _____ Email: _____

Separation Date (Estimate): _____ Clearance Status: Secret Top Secret TS/SCI

Does the RSM 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? _____

Part B – Terms and Conditions:

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

- While I am required by the Fleet Liaison to participate in a work program, I have voluntarily chosen the OWF Internship Program over other options such as on base work.
- I have voluntarily chosen to participate in this program and I will not be paid for this internship.
- The primary purpose of this internship is work therapy.
- A secondary purpose of this internship is exposure to civilian employment practices/opportunities in an Organization.
- 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 with 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:** _____



OFFICE OF
WARRIOR CARE POLICY



OPERATION WARFIGHTER
Approval for Participation—Navy
Installation: _____

Part C – Signatures :

Patient Administration/NSH:

<input type="checkbox"/> Concur	_____	_____	_____
	<i>Print Name</i>	<i>Signature</i>	<i>Date</i>
<input type="checkbox"/> Nonconcur	_____	_____	_____

Nurse Case Manager/Physician:

<input type="checkbox"/> Concur	_____	_____	_____
	<i>Print Name</i>	<i>Signature</i>	<i>Date</i>
<input type="checkbox"/> Nonconcur	_____	_____	_____

LPO/Division Chief:

<input type="checkbox"/> Approve	_____	_____	_____
	<i>Print Name</i>	<i>Signature</i>	<i>Date</i>
<input type="checkbox"/> Disapprove	_____	_____	_____

Please return to Transition Coordinator or Wounded Warrior Program POC upon completion.

This is a Department of Defense Operation Warfighter form. Please note that the above contents may not be edited or changed in any way. Military Installations or Wounded Warrior Units may include additional signatures and/or requirements in the section below: