New Hampshire Air National Guard
157th Air Refueling Wing Pilot Application

AUTHORITY: 10 USC 837; EO 9397

PRINCIPAL PURPOSE: Provides necessary information to determine if applicant meets qualifications established for appointment in the Air National Guard. Use of SSN is necessary to make positive identification of an applicant and records.

ROUTINE USES: To make selections and tender appointment in commissioned grades and to evaluate qualifications for assignment to crew member positions.

DISCLOSURE IS VOLUNTARY: If information is not provided, all further processing will be terminated.

Completion Instructions

To complete your application, please email the following items to the pilot hiring coordinators.
NOTE: if you have never served in the military, some items will not be applicable.

1. Completed Application
2. Current Resume
3. Cover Letter addressed to: Lt Col Brian Carloni, Commander, 157th Operations Group,
   New Hampshire Air National Guard
   302 Newmarket St., Bldg 264
   Pease ANGB, NH 03803-0157
4. Last three Officer Performance Reports, Enlisted Performance Reports or equivalent evaluation reports (N/A Civilian Applicants)
5. Data Verification Brief or equivalent summary of military experience (N/A Civilian Applicants)
6. Military/Civilian flight time summary
7. Military fitness report (N/A Civilian Applicants)
8. Copy of college transcripts
9. Copy of FAA certificates
10. AFOQT scores and TBAS scores
11. Report of Medical History, Standard Form 93, attached below. **NOTE: form does NOT need signature of Physician or Examiner.**
12. Letters of recommendation -- a minimum of one recommendation is required, but normally candidates submit three.
13. Any additional items that may improve your application.

Combine all items into one PDF and upload to MilRecruiter.com.
Email questions to 133arspilothiring@gmail.com

Section 1: Personal Information

Date of Application:_____

1.	Name (Last, First MI):				
2.	Address:				
3.	Home Phone:				
4.	Cell Phone:				
5.	Email Address:				
6.	SSN:				
7.	Are you a U.S. Citizen?				
8.	Date of Birth:				
9.	Place of Birth:				
10.	Are you currently employed with a US Government Agency?				Yes ☐ No ☐
11.	Have you ever been arrested, indicted, or convicted of any violation of civil or military law excluding minor traffic violations for which a fine or forfeiture of $25 or more was imposed? If yes, explain in remarks section.				Yes ☐ No ☐
12.	Have you applied or visited the unit before?				Yes ☐ No ☐
13.	Have you ever been charged, arrested, cited, or held by any law enforcer agency to include juvenile offenses regardless of their disposition? If yes, explain in remarks section.				Yes ☐ No ☐
14.	Have you ever received a less than honorable or dishonorable discharge from any branch of the military? If yes, explain in remarks section.				Yes ☐ No ☐
15.	Have you ever been considered for but not selected for promotion as an officer in the military? If yes, explain in remarks section.				Yes ☐ No ☐
16.	Do you presently have a military medical profile? If yes, explain in remarks section.				Yes ☐ No ☐
17.	Have you ever applied for and been denied a security clearance? If yes, explain in remarks section.				Yes ☐ No ☐

Section 2: Experience

Please list all your civilian education starting with high school				
Name of School & Location	Graduation Date		Degree	GPA
	Month	Year		

Employment	
Current Occupation:	
Supervisor's Name:	
Supervisor's Phone Number:	
Supervisor's Email Address:	

References. Please list three individuals who can attest to your work ethic and character.	
Name:	
Phone Number:	
Email Address:	
Name:	
Phone Number:	
Email Address:	
Name:	
Phone Number:	
Email Address:	

Military Service			
Do you have prior service in any branch of the military? If no, go to next section.			
What is your Date of Service (DOS)?			
Have you previously served as a commissioned officer? If no, skip to the next section.			
Date of Commission:			
Source of Commission:			
DoD security clearance type			
DoD security clearance issue date:			

Flight Experience	
Are you a rated Air Force Pilot?	
Are you a rated pilot in another branch of service?	
List any FAA Aeronautical Ratings:	
Total Flight Time:	
Aircraft Flown:	

AFOQT Scores (Rated applicants skip this section)	
Pilot:	
Navigator:	
Academic Aptitude:	
Verbal:	
Quantitative:	
PCSM:	

Section 3: Remarks

Remarks. Please further explain any yes or no answer by providing the question number followed by the explanation. Also, please provide any additional information

Certification Signature
I certify that the above answers are true and correct to the best of my knowledge and belief.
X

NO. OF ATTACHED SHEETS:

MEDICAL RECORD	REPORT OF MEDICAL HISTORY	DATE OF EXAM

NOTE: This information is for official and medically-confidential use only and will not be released to unauthorized persons

1. NAME OF PATIENT *(Last, first, middle)*			2. IDENTIFICATION NUMBER	3. GRADE
4a. HOME STREET ADDRESS *(Street or RFD; City or Town; State; and ZIP Code)*			5. EXAMINING FACILITY	
4b. CITY	4c. STATE	4d. ZIP CODE		
6. PURPOSE OF EXAMINATION				

7. STATEMENT OF PATIENT'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Use additional pages if necessary)*

a. PRESENT HEALTH	b. CURRENT MEDICATION	REGULAR OR INTERM.
c. ALLERGIES *(Include insect bites/stings and common foods)*		
	d. HEIGHT	e. WEIGHT
8. PATIENT'S OCCUPATION	9. ARE YOU *(Check one)* ☐ RIGHT HANDED ☐ LEFT HANDED	

10. PAST/CURRENT MEDICAL HISTORY

CHECK EACH ITEM	YES	NO	DON'T KNOW	CHECK EACH ITEM	YES	NO	DON'T KNOW	CHECK EACH ITEM	YES	NO	DON'T KNOW
Household contact with anyone with tuberculosis				Shortness of breath				Bone, joint or other deformity			
				Pain or pressure in chest				Loss of finger or toe			
Tuberculosis or positive TB test				Chronic cough				Painful or "trick" shoulder or elbow			
Blood in sputum or when coughing				Palpitation or pounding heart							
				Heart trouble				Recurrent back pain or any back injury			
Excessive bleeding after injury or dental work				High or low blood pressure							
				Cramps in your legs				"Trick" or locked knee			
Suicide attempt or plans				Frequent indigestion				Foot trouble			
Sleepwalking				Stomach, liver or intestinal trouble				Nerve Injury			
Wear corrective lenses				Gall bladder trouble or gallstones				Paralysis *(including infantile)*			
Eye surgery to correct vision								Epilepsy or seizure			
Lack vision in either eye				Jaundice or hepatitis				Car, train, sea or air sickness			
Wear a hearing aid				Broken bones				Frequent trouble sleeping			
Stutter or stammer				Adverse reaction to medication				Depression or excessive worry			
Wear a brace or back support				Skin diseases				Loss of memory or amnesia			
Scarlet fever				Tumor, growth, cyst, cancer				Nervous trouble of any sort			
Rheumatic fever				Hernia				Periods of unconsciousness			
Swollen or painful joints				Hemorrhoids or rectal disease				Parent/sibling with diabetes, cancer, stroke or heart disease			
Frequent or severe headaches				Frequent or painful urination							
Dizziness or fainting spells				Bed wetting since age 12				X-ray or other radiation therapy			
Eye trouble				Kidney stone or blood in urine				Chemotherapy			
Hearing loss				Sugar or albumin in urine				Asbestos or toxic chemical exposure			
Recurrent ear infections				Sexually transmitted diseases							
Chronic or frequent colds				Recent gain or loss of weight				Plate, pin or rod in any bone			
Severe tooth or gum trouble				Eating disorder (anorexia bulimia, etc.)				Easy fatigability			
Sinusitis								Been told to cut down or criticized for alcohol use			
Hay fever or allergic rhinitis				Arthritis, Rheumatism, or Bursitis							
Head injury								Used illegal substances			
Asthma				Thyroid trouble or goiter				Used tobacco			

11. FEMALES ONLY

CHECK EACH ITEM	YES	NO	DON'T KNOW	DATE OF LAST MENSTRUAL PERIOD	DATE OF LAST PAP SMEAR	DATE OF LAST MAMMO-GRAM
Treated for a female disorder						
Change in menstrual pattern						

CHECK EACH ITEM. IF "YES" EXPLAIN IN BLANK SPACE TO RIGHT. LIST EXPLANATION BY ITEM NUMBER.

ITEM	YES	NO
12. Have you been refused employment or been unable to hold a job or stay in school because of:		
a. Sensitivity to chemicals, dust, sunlight, etc.		
b. Inability to perform certain motions.		
c. Inability to assume certain positions.		
d. Other medical reasons *(If yes, give reasons.)*		
13. Have you ever been treated for a mental condition? *(If yes, specify when, where, and give details.)*		
14. Have you ever been denied life insurance? *(If yes, state reason and give details.)*		
15. Have you had, or have you been advised to have, any operation. *(If yes, describe and give age at which occurred.)*		
16. 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.)*		
17. 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.)*		
18. Have you ever been rejected for military service because of physical, mental, or other reasons? *(If yes, give date and reason for rejection.)*		
19. 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.)*		
20. Have you ever received, is there pending, or have you ever applied for pension or compensation for existing disability? *(If yes, specify what kind, granted by whom, and what amount, when, why.)*		
21. Have you ever been arrested or convicted of a crime, other than minor traffic violations. *(If yes, provide details.)*		
22. Have you ever been diagnosed with a learning disability? *(If yes, give type, where, and how diagnosed.)*		

23. LIST ALL IMMUNIZATIONS RECEIVED

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. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

24a. TYPED OR PRINTED NAME OF EXAMINEE	24b. SIGNATURE	24c. DATE

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

25. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (*Physician shall comment on all positive answers in Items 7 through 11. Physician may develop by interview any additional medical history deemed important, and record any significiant findings here.)*