



## *Orientation Administrative Forms - (AO Folder)*

### Visiting Fellows Forms:

- Local Contact Information Sheet
- ACH Vendor/Miscellaneous Payment Enrollment Form (SF3881)
- Training Acknowledgement
- Individual Agreement (If not already signed)
- FPS Activation Form
- FPS Health Insurance Forms
- Report of Medical History (SF93) (Required on case-by-case basis)

### Degree Submission:

- I HAVE provided a copy of my degree to my Administrative Officer.
- I HAVE NOT yet provided a copy of my degree to my Administrative Officer.

### Confirmation of Receipt:

I have received the NICHD Orientation Package and an Explanation of the included content.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## Local Contact Information Sheet

Date Reported: \_\_\_\_\_

Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Local Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_

Contact's Phone Number: \_\_\_\_\_

Position Title: \_\_\_\_\_

Supervisor: \_\_\_\_\_

Branch/Building/Room #: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_

Are you a U.S. Citizen or Permanent Resident? \_\_\_\_\_ Yes \_\_\_\_\_ No

If No – Visa Type: \_\_\_\_\_

Date of Visa expiration: \_\_\_\_\_



Complete Yellow  
Highlighted Boxes

### ACH VENDOR/MISCELLANEOUS PAYMENT ENROLLMENT FORM

OMB No. 1510-0056

This form is used for Automated Clearing House (ACH) payments with an addendum record that contains payment-related information processed through the Vendor Express Program. Recipients of these payments should bring this information to the attention of their financial institution when presenting this form for completion. See reverse for additional instructions.

#### PRIVACY ACT STATEMENT

The following information is provided to comply with the Privacy Act of 1974 (P.L. 93-579). All information collected on this form is required under the provisions of 31 U.S.C. 3322 and 31 CFR 210. This information will be used by the Treasury Department to transmit payment data, by electronic means to vendor's financial institution. Failure to provide the requested information may delay or prevent the receipt of payments through the Automated Clearing House Payment System.

#### AGENCY INFORMATION

FEDERAL PROGRAM AGENCY

National Institutes of Health, Office of Financial Management

AGENCY IDENTIFIER:

NIH Treasury 303

AGENCY LOCATION CODE (ALC):

75-08-0031

ACH FORMAT:

CCD+

CTX

ADDRESS:

2115 East Jefferson Street, MSC 8500, Suite 4B-432, Bethesda, MD 20892-8500

(For FedEx, UPS, and other courier services, use Rockville, MD 20852)

CONTACT PERSON NAME:

Fellowship Payment, Office of Financial Management

TELEPHONE NUMBER:

( 301 ) 496-5635

ADDITIONAL INFORMATION:

To be entered and attached in the NBS FPS

#### PAYEE/COMPANY INFORMATION

NAME:

SSN NO. OR TAXPAYER ID NO.:

ADDRESS:

CONTACT PERSON NAME:

TELEPHONE NUMBER:

#### FINANCIAL INSTITUTION INFORMATION

NAME:

ADDRESS:

ACH COORDINATOR NAME:

TELEPHONE NUMBER:

NINE-DIGIT ROUTING TRANSIT NUMBER:

DEPOSITOR ACCOUNT TITLE:

DEPOSITOR ACCOUNT NUMBER:

LOCKBOX NUMBER:

TYPE OF ACCOUNT:

CHECKING

SAVINGS

LOCKBOX

SIGNATURE AND TITLE OF AUTHORIZED OFFICIAL:

(Could be the same as ACH Coordinator)

TELEPHONE NUMBER:



# Training Acknowledgment Agreement

I understand that I received the training requirement information and am required to provide proof of completion of these requirements to my Administrative Officer within two weeks of my start date. Failure to do so may result in the loss of NIH privileges.

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Printed Name

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Signature

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Date

