

New York Naval Militia Enlistment Application

FOR FEDERALLY SEPARATED OR RETIRED ENLISTED APPLICANTS ONLY

In order to become a member of the New York Naval Militia, an applicant using this form must first be separated/prior-service or retired from either the United States Coast Guard, Marine Corps, or Navy.

1. This package of forms is designed to be completed by the applicant on a personal computer. All forms must be completed and submitted as part of the application package.

The forms include:

- NYNM FORM 100A/B APPLICATION FOR ENLISTMENT
- NYNM FORM 1070 CIVILIAN-MILITARY SKILLS QUESTIONNAIRE
- NYNM FORM 93 REPORT OF MEDICAL HISTORY
- NYNM FORM 88 REPORT OF MEDICAL EXAM, to be completed by a medical professional.

2. Additional required documents required along with the application package include:

- Copies of DD FORM 214 (all).
- Copy of CDC COVID-19 Vaccination Record Card, indicating fully vaccinated.
- NY Naval Militia Indoctrination Course completion certificate. Follow this link:
dmna.ny.gov/nynm/training/NYNM_INDOCTRINATION_Link_Information.pdf
- Copy of valid driver license, or government-issued identification card.

3. Options for package submission:

- a. Applications can be sent electronically via email to: NG.NY.NYARNG.MBX.NYNavalMilitia@army.Mil
- b. Via fax to (518)786-4427
- c. Via post to: New York Naval Militia Headquarters, 330 Old Niskayuna Rd Latham, NY 12110

PRIVACY ADVISORY STATEMENT

NEW YORK NAVAL MILITIA

Accession, Program and Separation Personal Information


AUTHORITY FOR COLLECTION OF PERSONAL INFORMATION: Personal Privacy Protection Law of New York State; Privacy Act of 1974, 5 U.S. Code, sections 552-522a.

WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION: The requested information is mandatory for New York Naval Militia (NYNM) members to insure that: (1) persons applying to join the New York Naval Militia and/or its specific programs meet all eligibility requirements; (2) required pay and tax information is available for purposes of any orders to state active duty; or (3) eligibility for separation from the New York Naval Militia, if applicable. If the requested information is not furnished, the NYNM member will not be considered for accession, or assignment for routine or emergency state active duty. If a NYNM member currently serving on routine or emergency state active duty declines to provide the requested information, the NYNM member's assignment to routine or emergency state active duty may be terminated.

ROUTINE USES: This all inclusive Privacy Act Statement will apply to all requests for personal information made by the New York Naval Militia. It will become part of your New York Naval Militia service record. The intended use is to maintain a rapid recall capability, and to facilitate and document your eligibility for various New York Naval Militia programs.

PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED: The primary use of this information is to identify NYNM members who are eligible to serve in the New York Naval Militia and its specific programs. This form provides you the advice required by the New York State Personal Privacy Act and the federal Privacy Act of 1974.

THIS FORM IS NOT A CONSENT FORM TO RELEASE PERSONAL INFORMATION PERTAINING TO YOU TO AGENCIES AND ENTITIES OUTSIDE OF THE NEW YORK STATE DIVISION OF MILITARY AND NAVAL AFFAIRS AND THE JOINT FORCES OF THE NEW YORK STATE ORGANIZED MILITIA.

New York Naval Militia (NYNM) 	Application for Enlistment	FOR OFFICIAL USE ONLY NYNM Form 100A			
NOTICE					
<u>Acknowledgement</u>					
1. Persons receiving an enlistment in the New York Naval Militia acknowledge the following: <ol style="list-style-type: none"> New York Naval Militia members are subject to recall to State Active Duty by the Governor of the State of New York. The New York Naval Militia is a state military agency under the Division of Military and Naval Affairs. It is not part of the United States Department of Defense or Department of Homeland Security. Persons 68 years of age and older are not eligible for membership in the New York Naval Militia. The applicant consents to a background check which may include investigation of my employment history, educational background, criminal history, military records, credit history and department of motor vehicle records. 					
I am prior-service or a drilling reservist from the following federal military component:					
Check One: U.S. Coast Guard U.S. Marine Corps U.S. Navy					
1. APPLICANT INFORMATION					
Complete SSN	Last Name	First Name	MI	Suffix	
Designator/MOS	Rank/Paygrade	Date of Rank	Federal Pay Entry Base Date	Gender M F X	Date of Birth
Home Address (mailing address)		City	County	State	Zip Code
Cell Phone		Home Phone		Work Phone	
Primary Email Address			Secondary Email Address		
Next of Kin (NOK) Name and Relationship				Next of Kin (NOK) Phone	
Marital Status: Single Married/Civil Union			Number of Dependent Exemptions Claimed:		
2. FEDERAL RESERVE PROGRAM (USNR, USMCR, USCGR) INFORMATION			Check if not applicable		
Reserve Center/USCG Command Name		Reserve Unit Name / UIC			
3. CRIMINAL HISTORY (including DUI, DWAI, BUI)					
Offense, Date, Location (List all criminal history or select N/A if none):					
4. PRIOR SERVICE INFORMATION (List all periods of prior/broken military service)					
Component	Date Start		Date End		
5. REFERRAL INFORMATION					
Recruited or Referred By (Last Name, First Name, Rank, Unit):					

NYNM Form 100A (Rev 08/22) Fax all documents to **(518) 786-4427**.

New York Naval Militia, 330 Old Niskayuna Road, Latham, New York 12110



Oath of Enlistment

I, _____
(First Name) (Middle Name) (Last Name)

A citizen of the United States, do hereby acknowledge to have voluntarily accepted an enlistment on this _____ day of _____, 20____, as a member of the New York Naval Militia under the conditions prescribed by law, unless sooner discharged by proper authority, and I do also agree to accept from the State of New York such benefits as are or may be established by law, and I do solemnly swear (or affirm) that I will bear true faith and allegiance to the United States of America and the State of New York; that I will serve them honestly and faithfully; and that I will obey the orders of the Governor of the State of New York and the orders of the Officers appointed over me, according to Law. I make this obligation freely, without any mental reservations or purpose of evasion, and that I will well and faithfully discharge the duties of an Officer in the New York Naval Militia of the State of New York on which I am about to enter, so help me God

(Signature of applicant)

HOR: _____

(Date of federal reserve enlistment expiration)

Email: _____

Phone Number(s): _____

Unit name/location: _____

Certificate of Enlistment

(To be completed by New York Naval Militia Headquarters)

I certify that the above individual was enlisted and enrolled in the service of the State of New York on this _____ day of _____, 20____.

(Signature of Certifying Officer)

(Name of Officer)

PERSONAL IDENTIFIER INFORMATION:

Name:	(LAST)	(FIRST, MI)	DOB:	
Address:	(MAILING)			
Address:	(PHYSICAL)			
Phone:	(MOBILE)		(ALTERNATE)	
E-mail:	(PRIMARY)		(SECONDARY)	
Marital Status:	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED/CIVIL UNION		Dependents Claimed:	

MILITARY INFORMATION:

Component:	<input type="checkbox"/> Coast Guard <input type="checkbox"/> Marine Corps <input type="checkbox"/> Navy			
UIC:	Unit:	Duty Station:		
Grade:	Rank/Rate:	Length in service:		
Status:	<input type="checkbox"/> DRILLING RESERVIST <input type="checkbox"/> RETIRED RESERVIST (Eligible for pay at age 60) <input type="checkbox"/> RETIRED MILITARY (Receiving military retirement pay) <input type="checkbox"/> OTHER (Amplify)			

Date of separation or retirement from federal component:

CIVILIAN EDUCATION:

College, and/or Professional/Trade School (Name & Location)	ATTENDED		DEGREE		MAJOR/MINOR/ FIELD OF STUDY
	FROM	TO	TITLE	DATE	

CIVILIAN OCCUPATION:

Employer:		Job Title:	
Address:		City:	
Phone:		Contact Name:	

CIVILIAN QUALIFICATIONS:

Personal Qualifications or Certifications: (Check all that apply)	<input type="checkbox"/> Boat Coxswain <input type="checkbox"/> CDL Class ____ <input type="checkbox"/> Chaplain / Clergy <i>Faith: _____</i> <input type="checkbox"/> Medical Doctor/DO <input type="checkbox"/> Dentist <input type="checkbox"/> EMT/Paramedic	<input type="checkbox"/> Diesel Mechanic <input type="checkbox"/> Firefighter <input type="checkbox"/> Police Officer <input type="checkbox"/> Translator <input type="checkbox"/> Attorney <input type="checkbox"/> Welder MIG/TIG <input type="checkbox"/> Chef/Cook	<input type="checkbox"/> Engine Mechanic <input type="checkbox"/> Physician's Assistant <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Nurse RN/LPN <input type="checkbox"/> Other (amplify):
----------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

MILITARY QUALIFICATIONS:

List all current military qualifications held: (MOS, NOBC, NEC, Designator, etc.)		Military qualifications (Continued):	
Code:	Title:	Code:	Title:

FOREIGN LANGUAGE FLUENCY:

FOREIGN LANGUAGE	LANGUAGE PROFICIENCY				FOREIGN LANGUAGE (CONTINUED)	LANGUAGE PROFICIENCY			
	SPEAK	WRITE	READ	LISTEN		SPEAK	WRITE	READ	LISTEN

DRIVER LICENSE INFORMATION:

ID#:		State:		Class:		Expiration Date:	
------	--	--------	--	--------	--	------------------	--

OTHER RELEVANT INFORMATION:

Signature:		Date:	
-------------------	--	--------------	--

1. This form will assist the New York Naval Militia to determine the various skills sets possessed by members of the force. This form asks for comprehensive information on both civilian and military-acquired skills that may prove beneficial to the Naval Militia.

2. Members are to complete this form and return to New York Naval Militia headquarters through their Reserve Unit Point of Contact, or fax directly to 518-786-4427. Enclose copies of certifications, qualifications, diplomas, to support the information provided.

3. Information provided by this form will be maintained in the New York Naval Militia database, and in the member's service record at headquarters.

New York Naval Militia (NYNM)	REPORT OF MEDICAL HISTORY AUTHORIZATION, CONSENT AND RELEASE	FOR OFFICIAL USE ONLY NYNM Form 93
------------------------------------------	-------------------------------------------------------------------------	---------------------------------------

NOTICE

The information requested below is required to provide the medical examiner an accurate history of illnesses and injuries that may affect the applicant's ability to perform the strenuous physical exercise and exposure to living and working environments that are a part of the New York Naval Militia. Also this information will be provided to medical examiners in case of injury or illness. **If taking medications at time of application, list in Block 6.**

THE INFORMATION YOU PROVIDE MUST BE ACCURATE AND COMPLETE. You are encouraged to consult your private medical provider regarding past illnesses.

1. UNIT INFORMATION

1a. Unit Name	1b. NYNM Region
----------------------	------------------------

2. PERSONAL INFORMATION

2a. Last Name	2b. First Name	2c. MI	2d. Blank
2e. Age	2f. Date of Birth	2g. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	2h. Emergency Person Contact Name and Phone Number
2i. Home Address		2j. City	
2k. State	2l. Zip Code	2m. Home Phone	2n. Date of Physical Examination (m/d/yyyy)

3. MEDICAL HISTORY (Mark each item "YES" or "NO" Every item marked YES must be fully explained in block 6: explain treatment to return member to medically fit for duty)

HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING CONDITIONS:	YES	NO		YES	NO
3a. Tuberculosis or live with someone with tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	3m. Head injury or concussion	<input type="checkbox"/>	<input type="checkbox"/>
3b. Chronic or recurrent abdominal or stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	3n. Seizures, convulsions, epilepsy, or fits	<input type="checkbox"/>	<input type="checkbox"/>
3c. Asthma or breathing problems related to exercise, pollen, etc.	<input type="checkbox"/>	<input type="checkbox"/>	3o. Car, train, sea, and/or air sickness	<input type="checkbox"/>	<input type="checkbox"/>
3d. Been prescribed or use an inhaler	<input type="checkbox"/>	<input type="checkbox"/>	3p. A period of unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>
3e. Loss of vision in either eye	<input type="checkbox"/>	<input type="checkbox"/>	3q. Heart trouble or murmur	<input type="checkbox"/>	<input type="checkbox"/>
3f. Loss of hearing or wear a hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	3r. Received counseling for emotional or behavior disorder	<input type="checkbox"/>	<input type="checkbox"/>
3g. Impaired use of arms, legs, hands, feet	<input type="checkbox"/>	<input type="checkbox"/>	3s. Eating disorder (bulimia, anorexia)	<input type="checkbox"/>	<input type="checkbox"/>
3h. Knee problems	<input type="checkbox"/>	<input type="checkbox"/>	3t. Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>
3i. Broken bones(s) (cracked or fractured)	<input type="checkbox"/>	<input type="checkbox"/>	3u. Frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>
3j. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	3v. Been hospitalized (<i>if yes, why, when, where</i>)	<input type="checkbox"/>	<input type="checkbox"/>
3k. Anemia (including sickle cell)	<input type="checkbox"/>	<input type="checkbox"/>	3w. Any illness or injury not mentioned above (<i>if yes, explain</i>)	<input type="checkbox"/>	<input type="checkbox"/>
3l. Dizziness or fainting spells (including after exercise)	<input type="checkbox"/>	<input type="checkbox"/>	3x. Advised to avoid certain physical activities (<i>if yes, explain</i>)	<input type="checkbox"/>	<input type="checkbox"/>

4. IMMUNIZATION RECORDS

IMMUNIZATIONS			
	Month/Year Given		Month/Year Given
Tetanus	____/____	Mumps	____/____
Diphtheria	____/____	Rubella	____/____
Pertussis	____/____	Polio	____/____
Measles	____/____	Chicken Pox	____/____
Small Pox	____/____	Influenza	____/____
		Tdap	____/____
		Hepatitis A	____/____
		Hepatitis B	____/____
		TB/PPD	____/____
		Anthrax	____/____

REPORT OF MEDICAL HISTORY

NYNM Form 93

5. ALLERGIES (Mark each item "YES" or "NO" Every item marked yes must be fully explained in block 5i)

DO YOU NOW HAVE ANY OF THE FOLLOWING ALLERGIES:	YES	NO		YES	NO
5a. Bee or Wasp Sting	<input type="checkbox"/>	<input type="checkbox"/>	5e. Latex	<input type="checkbox"/>	<input type="checkbox"/>
5b. Hay Fever or seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	5f. Any drug, E-mycin antibiotic, or sulfa allergies, list in Block 5i	<input type="checkbox"/>	<input type="checkbox"/>
5c. Insect Bites	<input type="checkbox"/>	<input type="checkbox"/>	5g. Other Allergies, list in Block 6	<input type="checkbox"/>	<input type="checkbox"/>
5d. Iodine/seafood	<input type="checkbox"/>	<input type="checkbox"/>	5h. Food allergies, list in Block 6	<input type="checkbox"/>	<input type="checkbox"/>

5i. Describe the allergic reaction and what condition occurs:

6. Remarks (Please include comments as required by Block 3. Also provide any other medical history that you or your physician deems important.)

List all current medications, including over-the-counter medications, vitamins, and supplements;

Social History:

Tobacco Use: Number of packs or dips per day: _____

Alcohol Use: Number of drinks per week (on average): _____

List all current medical restrictions:

Have there been any significant changes in your health since your last medical examination: NO YES. If YES, please describe:

7. AUTHORIZATION AND RELEASE

I certify that to the best of my knowledge the information provided is true and accurate and that I have disclosed all pertinent medical history.

8a. Member Name (Type or Print)

8b. Signature

8c. Date

New York Naval Militia (NYNM)	REPORT OF MEDICAL EXAM	FOR OFFICIAL USE ONLY NYNM Form 88
INSTRUCTIONS TO MEDICAL PROFESSIONAL		
<p>The applicant may be participating in strenuous activity, which may include exposure to extreme weather conditions, cold water, fatigue and remote locations. Please, complete the following items and summarize your findings in the section below. By your signature, you have determined that the applicant is fit for full duty in the New York Naval Militia.</p> <p>Medical examinations recorded on another agency or organizational record of medical examination form, with signature of licensed medical practitioner are acceptable in lieu of this completed form. Attach the completed other agency form to this form, and complete sections 1 and 2 below.</p> <p>Acceptance criteria for applicants to the New York Naval Militia include the ability to <u>FULLY</u> participate in militia activities. This includes strenuous physical exercise and activities. Defects that are cause for rejection of an applicant for actual enlistment or appointment into the naval service should be identified. Conditions that will or are likely to require treatment, particularly unresolved injuries and recurrent illness must be listed. The history of immunization should be verified to the satisfaction of the medical examiner. A licensed healthcare provider must complete this examination.</p>		
1. UNIT INFORMATION		
1a. Unit Name		1b. NYNM Region
2. PERSONNEL INFORMATION		
2a. Last Name		2b. First Name
		2c. MI
		2d. Blank
2e. Age	2f. Date of Birth (m/d/yyyy)	2g. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
2h. Emergency Contact Person Name and Phone Number		
2i. Home Address		2j. City
		2k. State
		2l. Zip Code + 4
2m. Home Phone	2n. Date of Physical Examination (DD MMM YY)	2o. Location of Physical Examination
3. CLINICAL EVALUATION		
	Normal	Abnormal
3a. Head, Face, Neck, and Scalp	<input type="checkbox"/>	<input type="checkbox"/>
3b. Nose	<input type="checkbox"/>	<input type="checkbox"/>
3c. Sinuses	<input type="checkbox"/>	<input type="checkbox"/>
3d. Ears – General (<i>Internal and External Canals</i>)	<input type="checkbox"/>	<input type="checkbox"/>
3e. Ear Drum (<i>Perforation</i>)	<input type="checkbox"/>	<input type="checkbox"/>
3f. Eyes- General	<input type="checkbox"/>	<input type="checkbox"/>
3g. Ophthalmoscopic	<input type="checkbox"/>	<input type="checkbox"/>
3h. Pupils (<i>Equality and Reaction</i>)	<input type="checkbox"/>	<input type="checkbox"/>
3i. Heart (<i>Thrust, Size, Rhythm, and Sounds</i>)	<input type="checkbox"/>	<input type="checkbox"/>
3j. Lungs and Chest	<input type="checkbox"/>	<input type="checkbox"/>
3k. Abdomen and Viscera (<i>Include Hernia</i>)	<input type="checkbox"/>	<input type="checkbox"/>
3l. External Genitalia (<i>Genitourinary</i>)	<input type="checkbox"/>	<input type="checkbox"/>
3m. Upper Extremities	<input type="checkbox"/>	<input type="checkbox"/>
3n. Lower Extremities	<input type="checkbox"/>	<input type="checkbox"/>
3o. Feet	<input type="checkbox"/>	<input type="checkbox"/>
3p. Spine and other Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
	Normal	Abnormal
3q. Mouth and Throat	<input type="checkbox"/>	<input type="checkbox"/>
3r. Vascular System (<i>Varicosities, etc.</i>)	<input type="checkbox"/>	<input type="checkbox"/>
3s. Prostate	<input type="checkbox"/>	<input type="checkbox"/>
3t. Testicular	<input type="checkbox"/>	<input type="checkbox"/>
3u. Anus and Rectum	<input type="checkbox"/>	<input type="checkbox"/>
3v. Endocrine System	<input type="checkbox"/>	<input type="checkbox"/>
3w. G-U System	<input type="checkbox"/>	<input type="checkbox"/>
3x. Skin, lymphatics	<input type="checkbox"/>	<input type="checkbox"/>
3y. Neurologic	<input type="checkbox"/>	<input type="checkbox"/>
Notes: (Describe abnormalities in detail. Continue in Section 6 or additional sheets as necessary.)		
4. LABORATORY FINDINGS (as clinically indicated)		
4a. Urinalysis (1) Albumin: _____ (2) Sugar: _____		4b. Blood (1) Hemoglobin: _____ (2) Hematocrit: _____
5. MEASUREMENTS AND OTHER FINDINGS		
5a. Height inches	5b. Weight lbs.	5c. Obese <input type="checkbox"/> Yes <input type="checkbox"/> No
5d. Pulse		5e. Blood Pressure (1) Systolic: _____ (2) Diastolic: _____
5f. Blank		5g. Wears Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No
		5h. Wears Contacts <input type="checkbox"/> Yes <input type="checkbox"/> No
		5j. Best/Corrected Vision (1) Left: 20/ _____ (2) Right: 20/ _____
		5i. Color Vision
		5k. Or valid NYS Driver License Number/Class
5l. Other Findings (if more room is needed, continue on reverse)		

Last Name	REPORT OF MEDICAL EXAM	NYNM Form 88 (Reverse)
6. NOTES, REMARKS, AND OTHER FINDINGS (Use additional sheets of paper if needed)		
ACCEPTANCE CRITERIA FOR APPLICANTS TO, AND CONTINUED SERVICE IN THE NEW YORK NAVAL MILITIA		
<p>A. Acceptance is based upon ability to participate in strenuous physical activity, (which may include exposure to extreme weather conditions, cold water, fatigue and remote locations) and the absence of contagious disease, illness, or history that will or is likely to require medical care or restriction of participation. All members must be able to run/walk one (1) mile in less than 20 minutes and be able to lift or carry up to 40 pounds on a frequent basis.</p> <p>B. Special attention should be given to orthopedic and cardiovascular conditions or complaints.</p> <p>C. There is no specific limit for vision. However, applicants who wear glasses or contact lenses but cannot participate in activities that require the removal of glasses (or contacts) should be reviewed on a case-by-case basis.</p> <p>D. Examining physicians may submit appropriate statements for consideration of acceptance, when the physician is of the opinion that the applicant will not encounter any restriction of participation in the program and that the condition in question does not present an unacceptable risk for aggravation or worsening as the result of participation in the activities of the New York Naval Militia.</p>		
7. ENDORSEMENT		
It is my professional medical opinion in accordance with the above criteria that the examinee is:		
<input type="checkbox"/> PHYSICALLY QUALIFIED: Fit for full duty in the New York Naval Militia		
<input type="checkbox"/> NOT PHYSICALLY QUALIFIED: NOT fit for full duty for reasons stated above in Block 6 (notes)		
7a. Name of Physician (Type or Print) or Physician's Stamp	7b. Signature	7c. Date (m/d/yyyy)