

Appendix C  
 NMSDF Application

NEW MEXICO STATE DEFENSE FORCE		FOR OFFICIAL USE ONLY (FOUO) SEE PRIVACY ACT STATEMENT IN AR 632-3					
Application for Appointment							
<b>SECTION I-PERSONAL INFORMATION</b>							
NAME (LAST, FIRST, MIDDLE)				SSN	HOME PHONE	US CITIZEN Y or N	
CURRENT ADDRESS (STREET, CITY, STATE, ZIP CODE)					CELL PHONE	SEX F M	BLOOD
HEIGHT	WEIGHT	EYES	HAIR	PHYSICAL LIMITATIONS			BIRTHDATE
MARITAL STATUS		NAME OF SPOUSE			# OF DEPENDANTS	EMAIL ADDRESS	
LANGUAGES		CIVIL/COURT CONVICTIONS					
<b>SECTION II-EDUCATION (High School, Trade Schools, College/University)</b>							
<b>SECTION III-PRIOR MILITARY SERVICE (Include all Branches &amp; Periods of Service, Attach DD 214 or Discharge Certificate)</b>							
BRANCH			GRADE	TYPE OF DISCHARGE	RESERVE OBLIGATION		
SECURITY CLEARANCE HELD				MILITARY DECORATIONS AND AWARDS			
<b>MILITARY EDUCATION COMPLETED</b>							
SCHOOL & LOCATION (City & State)				YEARS	QUALIFICATION AWARDED		
<b>SECTION IV-PERSONAL ASPIRATIONS FOR JOINING</b>							

## BACKGROUND INVESTIGATION AND DISCLOSURE REPORT

The Military Code of the State of New Mexico-Chapter 20, NMSA 1978 Compilation provides for:

The Department of Military Affairs (DMA) of the State of New Mexico, which consists of three military (components) division: (1) the Army National Guard, the Air National Guard, and the State Defense Force-Section 2-3-2 (A) NMSA 1978 compilation.

The State Defense Force (SDF), which is military component and military division of the Department of Military Affairs (DMA) of the State of New Mexico-Section 20-5-1 NMSA 1978 compilation.

The Adjutant General (TAG) of the State of New Mexico, who is a member of the Governor's Cabinet, military Chief of Staff to the Governor, and head of the Department of Military Affairs-Section 20-3-2-(B) NMSA 1978 compilation.

The Assistant Adjutant General (AAG) for the SDF Military division of DMA, who is, by virtue of his/her office, the commanding general of the SDF-Section 20-3-2 (H) NMSA 1978 compilation.

The commissioned military officers and warrant officers of the SDF, who are appointed and commissioned by the governor of the State of New Mexico-Section 20-5-3 (B) NMSA 1978 compilation.

### AUTHORIZATION FOR RELEASE OF INFORMATION AND BACKGROUND INVESTIGATION

I, the undersigned, am a candidate for appointment/enlistment in the State Defense force of New Mexico. I certify that I submitted my application with all the supporting documentation, to the Assistant Adjutant General (NMSDF) of the State of New Mexico. I understand that, before I can become a member in the State Defense Force, I must undergo a comprehensive background investigation.

Therefore:

I do hereby authorize the Office of the Governor of the State of New Mexico, the Office of the Adjutant General of the State of New Mexico, the office of the Assistant Adjutant General (NMSDF) of the State of New Mexico, the Department of Public Safety of the State of New Mexico, and their duly authorized representatives to conduct a comprehensive investigation and review of my background, including but not limited to: verification of my social security number, current and previous residences, job references, employment history, education, character references, and criminal records including traffic violations, DWI citations, drug arrests, arrest warrants and any other public records.

I authorize the complete release of information contained in files, records or data that pertain to me personally and that supports a background report on me. I understand that any decision made with regards to my application for appointment/enlistment in the State Defense Force will not be affected by the release of my place and the date of birth, unless I am under the age of 18 or over the age of 64 (without a waiver for the Adjutant General).

I hereby release the above government officials, military officers, and their duly authorized representatives from any and all liability for damages of whatever kind, which may at any time, result from this investigation. I understand that a copy of this authorization may be provided to the custodians of public records and files, provided that, if it is anyone other than the above named officials, I grant prior written approval. Information on this application and results of the background investigation will be maintained in confidence in accordance with local, state and federal status.

SIGNATURE OF APPLICANT	LAST NAME, FIRST, MIDDLE I		DATE
DATE OF BIRTH	PLACE OF BIRTH	SSN#	MILITARY SERVICE #
DRIVER'S LICENSE/STATE	DRIVERS	PRIOR MILITARY SERVICE BRANCH	DISCHARGE CERTIFICATE/TYPE
CURRENT RESIDENCE	LENGTH	CITY AND COUNTY	STATE AND ZIP CODE
DO NOT WRITE BELOW THIS LINE-FOR USE BY LAW ENFORCEMENT AGENCIES AND OFFICIALS			

**CERTIFICATIONS**

**THE UNDERSIGNED CERTIFY THAT:**

1. I am not a conscientious objector.
2. Have not used, purchased, possessed or sold harmful, habit forming or illegal drugs or chemicals, except as prescribed by a licensed physician.
3. I do not object to bearing arms.
4. I have not received treatment for alcohol abuse within the past year.
5. I have not received treatment for any mental health disorders except stated hereon.
6. I will wear the New Mexico State Defense Force uniform only as authorized and prescribed by regulations. I will comply with and fulfill the New Mexico Army National guard standards of cleanliness, good grooming, and appearance and will fulfill the obligation stated in the oath of office.
7. I have not been convicted of a felony or high misdemeanor, nor found guilty in a general court-martial.
8. The information given by me on this application is true, complete, and correct to the best of my knowledge and belief. I understand that I am being considered for appointment in the New Mexico State Defense Force based on the information provided on this document.

(Signature)	(SSN#)	(Date)

**BACKGROUND INVESTIGATION PRIVACY ACT STATEMENT**

THE PRIVACY ACT OF 1975 (5 U.S.C. 522)

1. The New Mexico State Defense Force is authorized to perform a background investigation on all applications for appointments.
2. Your approval and signing of this section of this application allows all federal, state, county, and city agencies to release information about you to the New Mexico State Defense Force to make a decision regarding this appointment.
3. You may refuse to approve and sign this section of the application; however, your refusal to approve and sign this section of the application could result in non-consideration or denial of your application.

I have read and understand the above, and hereby authorize any and all federal, state, and city agencies to release such information to the New Mexico Defense Force that may be in their possession about me and which is or may be relevant regarding appointment to the New Mexico state Defense Force.

(Signature)	(SSN#)	(Date)

<b>ADMINISTRATIVE AREA</b>

Appendix D Report of Medical History (DD Form 2807-1 with NMSDF Requirements in Block 30a)

**REPORT OF MEDICAL HISTORY**  
 (This information is for official and medically confidential use only and will not be released to unauthorized persons.)

OMB No. 0704-0413  
 OMB approval expires  
 Aug 31, 2014

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Information Management Division, 1155 Defense Pentagon, Washington, DC 20301-1155 (0704-0413). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

**PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.**

**PRIVACY ACT STATEMENT**

**AUTHORITY:** 10 U.S.C. 136, DoD Instruction 6130.03, and E.O. 9397, as amended (SSN).  
**PRINCIPAL PURPOSE(S):** The primary collection of this information is from individuals seeking to join the Armed Forces. The information collected on this form is used to assist DoD physicians in making determinations as to acceptability of applicants for military service and verifies disqualifying medical condition(s) noted on the prescreening form (DD 2807-2). An additional collection of information using this form occurs when a Medical Evaluation Board is convened to determine the medical fitness of a current member and if separation is warranted. Completed forms are covered by recruiting, medical evaluation board, and official military personnel file SORNs maintained by each of the Services.  
**ROUTINE USE(S):** The Blanket Routine Uses found at [http://privacy.defense.gov/blanket\\_uses.shtml](http://privacy.defense.gov/blanket_uses.shtml) apply to this collection.  
**DISCLOSURE:** Voluntary. However, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. An applicant's SSN is used during the recruitment process to keep all records together and when requesting civilian medical records. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status. The SSN of an Armed Forces member is to ensure the collected information is filed in the proper individual's record.

**WARNING:** The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a \$10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	2. SOCIAL SECURITY NUMBER	3. TODAY'S DATE (YYYYMMDD)
4.a. HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code)	5. EXAMINING LOCATION AND ADDRESS (Include ZIP Code)	
b. HOME TELEPHONE (Include Area Code)		

<b>X ALL APPLICABLE BOXES:</b>			7.a. POSITION (Title, Grade, Component)
6.a. SERVICE <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	6.b. COMPONENT <input type="checkbox"/> Regular <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	6.c. PURPOSE OF EXAMINATION <input type="checkbox"/> Enlistment <input type="checkbox"/> Medical Board <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Commission <input type="checkbox"/> Retirement <input type="checkbox"/> Retention <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> Separation <input type="checkbox"/> ROTC Scholarship Program	b. USUAL OCCUPATION

8. CURRENT MEDICATIONS (Prescription and Over-the-counter)	9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance)
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Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO	12. (Continued)	YES	NO
10.a. Tuberculosis	<input type="radio"/>	<input type="radio"/>	f. Foot trouble (e.g., pain, corns, bunions, etc.)	<input type="radio"/>	<input type="radio"/>
b. Lived with someone who had tuberculosis	<input type="radio"/>	<input type="radio"/>	g. Impaired use of arms, legs, hands, or feet	<input type="radio"/>	<input type="radio"/>
c. Coughed up blood	<input type="radio"/>	<input type="radio"/>	h. Swollen or painful joint(s)	<input type="radio"/>	<input type="radio"/>
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	<input type="radio"/>	<input type="radio"/>	i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	<input type="radio"/>	<input type="radio"/>
e. Shortness of breath	<input type="radio"/>	<input type="radio"/>	j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	<input type="radio"/>	<input type="radio"/>
f. Bronchitis	<input type="radio"/>	<input type="radio"/>	k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	<input type="radio"/>	<input type="radio"/>
g. Wheezing or problems with wheezing	<input type="radio"/>	<input type="radio"/>	l. Bone, joint, or other deformity	<input type="radio"/>	<input type="radio"/>
h. Been prescribed or used an Inhaler	<input type="radio"/>	<input type="radio"/>	m. Plate(s), screw(s), rod(s) or pin(s) in any bone	<input type="radio"/>	<input type="radio"/>
i. A chronic cough or cough at night	<input type="radio"/>	<input type="radio"/>	n. Broken bone(s) (cracked or fractured)	<input type="radio"/>	<input type="radio"/>
j. Sinusitis	<input type="radio"/>	<input type="radio"/>	13.a. Frequent indigestion or heartburn	<input type="radio"/>	<input type="radio"/>
k. Hay fever	<input type="radio"/>	<input type="radio"/>	b. Stomach, liver, intestinal trouble, or ulcer	<input type="radio"/>	<input type="radio"/>
l. Chronic or frequent colds	<input type="radio"/>	<input type="radio"/>	c. Gall bladder trouble or gallstones	<input type="radio"/>	<input type="radio"/>
11.a. Severe tooth or gum trouble	<input type="radio"/>	<input type="radio"/>	d. Jaundice or hepatitis (liver disease)	<input type="radio"/>	<input type="radio"/>
b. Thyroid trouble or goiter	<input type="radio"/>	<input type="radio"/>	e. Rupture/hernia	<input type="radio"/>	<input type="radio"/>
c. Eye disorder or trouble	<input type="radio"/>	<input type="radio"/>	f. Rectal disease, hemorrhoids or blood from the rectum	<input type="radio"/>	<input type="radio"/>
d. Ear, nose, or throat trouble	<input type="radio"/>	<input type="radio"/>	g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	<input type="radio"/>	<input type="radio"/>
e. Loss of vision in either eye	<input type="radio"/>	<input type="radio"/>	h. Frequent or painful urination	<input type="radio"/>	<input type="radio"/>
f. Worn contact lenses or glasses	<input type="radio"/>	<input type="radio"/>	i. High or low blood sugar	<input type="radio"/>	<input type="radio"/>
g. A hearing loss or wear a hearing aid	<input type="radio"/>	<input type="radio"/>	j. Kidney stone or blood in urine	<input type="radio"/>	<input type="radio"/>
h. Surgery to correct vision (RK, PRK, LASIK, etc.)	<input type="radio"/>	<input type="radio"/>	k. Sugar or protein in urine	<input type="radio"/>	<input type="radio"/>
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)	<input type="radio"/>	<input type="radio"/>	l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, Herpes, etc.)	<input type="radio"/>	<input type="radio"/>
b. Arthritis, rheumatism, or bursitis	<input type="radio"/>	<input type="radio"/>	14.a. Adverse reaction to serum, food, insect stings or medicine	<input type="radio"/>	<input type="radio"/>
c. Recurrent back pain or any back problem	<input type="radio"/>	<input type="radio"/>	b. Recent unexplained gain or loss of weight	<input type="radio"/>	<input type="radio"/>
d. Numbness or tingling	<input type="radio"/>	<input type="radio"/>	c. Currently in good health (If no, explain in Item 29 on Page 2.)	<input type="radio"/>	<input type="radio"/>
e. Loss of finger or toe	<input type="radio"/>	<input type="radio"/>	d. Tumor, growth, cyst, or cancer	<input type="radio"/>	<input type="radio"/>

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER
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Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO		YES	NO				
15.a. Dizziness or fainting spells	<input type="radio"/>	<input type="radio"/>	19. Have you been refused employment or been unable to hold a job or stay in school because of:	<input type="radio"/>	<input type="radio"/>				
b. Frequent or severe headache	<input type="radio"/>	<input type="radio"/>		a. Sensitivity to chemicals, dust, sunlight, etc.	<input type="radio"/>	<input type="radio"/>			
c. A head injury, memory loss or amnesia	<input type="radio"/>	<input type="radio"/>		b. Inability to perform certain motions	<input type="radio"/>	<input type="radio"/>			
d. Paralysis	<input type="radio"/>	<input type="radio"/>		c. Inability to stand, sit, kneel, lie down, etc.	<input type="radio"/>	<input type="radio"/>			
e. Seizures, convulsions, epilepsy or fits	<input type="radio"/>	<input type="radio"/>		d. Other medical reasons (If yes, give reasons.)	<input type="radio"/>	<input type="radio"/>			
f. Car, train, sea, or air sickness	<input type="radio"/>	<input type="radio"/>		20. Have you ever been treated in an Emergency Room? (If yes, for what?)	<input type="radio"/>	<input type="radio"/>			
g. A period of unconsciousness or concussion	<input type="radio"/>	<input type="radio"/>			21. 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.)	<input type="radio"/>	<input type="radio"/>		
h. Meningitis, encephalitis, or other neurological problems	<input type="radio"/>	<input type="radio"/>		22. Have you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give age at which occurred.)		<input type="radio"/>	<input type="radio"/>		
16.a. Rheumatic fever	<input type="radio"/>	<input type="radio"/>	23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)			<input type="radio"/>	<input type="radio"/>		
b. Prolonged bleeding (as after an injury or tooth extraction, etc.)	<input type="radio"/>	<input type="radio"/>				24. 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.)	<input type="radio"/>	<input type="radio"/>	
c. Pain or pressure in the chest	<input type="radio"/>	<input type="radio"/>					25. Have you ever been rejected for military service for any reason? (If yes, give date and reason for rejection.)	<input type="radio"/>	<input type="radio"/>
d. Palpitation, pounding heart or abnormal heartbeat	<input type="radio"/>	<input type="radio"/>						26. Have you ever been discharged from military service for any reason? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)	<input type="radio"/>
e. Heart trouble or murmur	<input type="radio"/>	<input type="radio"/>			27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? (If yes, specify what kind, granted by whom, and what amount, when, why.)				<input type="radio"/>
f. High or low blood pressure	<input type="radio"/>	<input type="radio"/>		28. Have you ever been denied life insurance?					<input type="radio"/>
17.a. Nervous trouble of any sort (anxiety or panic attacks)	<input type="radio"/>	<input type="radio"/>	29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)						<input type="radio"/>
b. Habitual stammering or stuttering	<input type="radio"/>	<input type="radio"/>				29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)			<input type="radio"/>
c. Loss of memory or amnesia, or neurological symptoms	<input type="radio"/>	<input type="radio"/>					29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)		<input type="radio"/>
d. Frequent trouble sleeping	<input type="radio"/>	<input type="radio"/>						29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)	<input type="radio"/>
e. Received counseling of any type	<input type="radio"/>	<input type="radio"/>			29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)				<input type="radio"/>
f. Depression or excessive worry	<input type="radio"/>	<input type="radio"/>		29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)					<input type="radio"/>
g. Been evaluated or treated for a mental condition	<input type="radio"/>	<input type="radio"/>	29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)						<input type="radio"/>
h. Attempted suicide	<input type="radio"/>	<input type="radio"/>				29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)			<input type="radio"/>
i. Used illegal drugs or abused prescription drugs	<input type="radio"/>	<input type="radio"/>					29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)		<input type="radio"/>
18. FEMALES ONLY. Have you ever had or do you now have:	<input type="radio"/>	<input type="radio"/>						29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)	<input type="radio"/>
a. Treatment for a gynecological (female) disorder	<input type="radio"/>	<input type="radio"/>			29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)				<input type="radio"/>
b. A change of menstrual pattern	<input type="radio"/>	<input type="radio"/>		29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)					<input type="radio"/>
c. Any abnormal PAP smears	<input type="radio"/>	<input type="radio"/>	29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)						<input type="radio"/>
d. First day of last menstrual period (YYYYMMDD)	<input type="radio"/>	<input type="radio"/>				29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)			<input type="radio"/>
e. Date of last PAP smear (YYYYMMDD)	<input type="radio"/>	<input type="radio"/>					29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)		<input type="radio"/>

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

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)

SOCIAL SECURITY NUMBER

**30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA** *(Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)*

**a. COMMENTS**

Additional Information required by the New Mexico State Defense Force to be completed by the Provider:

1. Blood Pressure: \_\_\_\_\_ Heart Rate: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

2. Brief description on examination of the following (use additional space below if necessary:)

2a. Cardiovascular System: \_\_\_\_\_

2b. Lungs: \_\_\_\_\_

2c. Abdomen: \_\_\_\_\_

2d. Extremities: \_\_\_\_\_

3. Listing of all medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Pertinent laboratory data (e.g. HgA1c): \_\_\_\_\_

b. TYPED OR PRINTED NAME OF EXAMINER *(Last, First, Middle Initial)*

c. SIGNATURE

d. DATE SIGNED  
*(YYYYMMDD)*