



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Public Health Service Commissioned Corps



## PRACTICE HOURS WAIVER REQUEST

(Clinical/Public Health Practice Hours)  
Privacy Act Notice is on the Second Page

### IDENTIFICATION

1. NAME (Last, First, Middle Initial)		2. GRADE/RANK	3. SERNO
4. ORGANIZATION	5. DUTY PHONE NUMBER	6. WORK EMAIL	
7. MOBILE NUMBER	8. CATEGORY/PROFESSIONAL DISCIPLINE	9. SPECIALTY	
10. REQUEST YEAR (yyyy) (calendar or contract year)		11. SUBMISSION DATE (mm/dd/yyyy)	
12. DO YOU RECEIVE SPECIAL PAY? (check all that apply) Category Incentive Pay (not including BCIP)      Retention Bonus		13. Anniversary Date (mm/dd)	

### 14. WAIVER TYPE

If additional actions are needed, please include the documents within this PDF.

UNIQUE DUTIES UNDER ADVERSE CONDITIONS (E.G. TRAVEL REQUIREMENTS OF 120 DAYS OR MORE DURING THE CALENDAR OR CONTRACT YEAR) (include travel documents signed by supervisor)

PERMANENTLY STATIONED OUTSIDE THE CONTINENTAL UNITED STATES (OCONUS) EXCEPT ALASKA AND HAWAII (include Personnel Orders indicating OCONUS Duty Station)

EXECUTIVE POSITION/FLAG OFFICER  
(include Personnel Orders indicating Executive-Level or Flag Officer Position)

FULL TIME INTRAMURAL OR EXTRAMURAL TRAINING PROGRAM THAT IS 6 MONTHS OR LONGER  
(include letter of support signed by Agency Liaison)

MEDICAL INCAPACITATION FOR OVER 6 MONTHS OF THE CALENDAR OR CONTRACT YEAR  
(include signed letter from your health care provider indicating that you are unable to perform clinical practice hours for 6 months or longer of the contract/calendar year of your request or, if applicable, your current MAB deployment waiver)

### 15. SYNOPSIS OF REQUEST

### 16. CERTIFICATION

I certify that I have read and understand CCI 241.01 and CCI 633.01, and I have read and agree to abide by the terms of the clinical practice hours as stated in the aforementioned Instructions and that the above information is true and correct. Further, I understand that making a false statement or claim against the U.S. Government is punishable by a fine, or imprisonment, or both. 18 U.S.C. §287; 18 U.S.C. §1001.

OFFICER'S PRINTED NAME

OFFICER'S SIGNATURE	DATE (mm/dd/yyyy)
---------------------	-------------------

### 18. OFFICER'S OPDIV/STAFFDIV/NON-HHS ORGANIZATION SUPERVISOR

PRINTED NAME	TITLE
SIGNATURE	DATE (mm/dd/yyyy)

(continued on next page)

---

## INSTRUCTIONS FOR COMPLETING FORM PHS-7088 PRACTICE HOURS WAIVER REQUEST (Clinical/Public Health Practice Hours)

CCI 241.01, "Readiness and Duty Requirements" and CCI 633.01, "Special Pays" requires officers to certify on an annual basis all practice hours provided for the purpose of clinical proficiency and readiness. In some instances, Officers may request to waive the submission of their practice hours. Officers are required to submit Form PHS-7088 (Page 1) in addition to any other documents specified on the form to request to waive the submission of their practice hours.

**Items 1 thru 7** Self-explanatory.

**Item 8** Enter the category/professional discipline consistent with current professional license (e.g., nurse, dentist, etc.).

**Item 9** Enter the clinical specialty designated for clinical proficiency or readiness if applicable (i.e., board certified specialties).

**Item 10** Provide the calendar or contract (only in the case of IP/RB recipients) year for which you are requesting a practice hours waiver. Your waiver must be requested for a certain year. You will put that year in this box. If you are requesting a multi-year waiver (only applicable in certain circumstances), you may put yyyy-yyyy (not to exceed 4 years) in this box.

**Item 11** This is the date you submitted your waiver request.

**Item 12** Check these boxes as applicable if you receive category Incentive Pay (excluding Board-Certified Incentive Pay) or a Retention Bonus. These may be left blank.

**Item 13** Effective date of Category Incentive Pay/Retention Bonus. If no IP/RB, Anniversary date is 12/31

**Item 14** Indicate the type of waiver you are requesting. If required, please include the requested additional documents to this PDF file so only one PDF file is submitted. PDF Portfolios are not accepted.

**Item 15** Write a synopsis of request. Your synopsis should answer the question "Why are you requesting a Practice Hours Waiver?"

**Item 16** To be completed by officer: Sign and date certification form.

**Item 17** To be completed by officer's Operating Division/Staff Division/Non-HHS Organization Supervisor: Electronic PIV/ CAC signatures preferred but may be hand signed. After all signatures are obtained, return Form PHS-7088 to officer and officer will submit via the Commissioned Corps submission process outlined in the Practice Hours Waiver FAQs.

---

## PRIVACY ACT NOTICE PHS COMMISSIONED CORPS PRACTICE HOURS CERTIFICATE (FORM PHS-7088)

**General:** This information is provided pursuant to the Privacy Act of 1974 (P.O. 93-579) for Public Health Service Commissioned Corps officers submitting Practice Hours.

**Records System:** 09-40-0001, "PHS Commissioned Corps General Personnel Records," HHS/PSC/HRS; 09-40-0002, "PHS Commissioned Corps Medical Records," HHS/PSC/HRS; 09-40-0003, "PHS Commissioned Corps Board Proceedings," HHS/PSC/HRS; 09-40-0004, "PHS Commissioned Corps Grievance, Investigatory and Disciplinary Files," HHS/PSC/HRS; 09-40-0011, "Proceedings of the Board for Correction of PHS Commissioned Corps Records," HHS/PSC/HRS; and 09-90-1402, "HHS Payroll Records," HHS.

**Authority for Collection of Information:** CCI 241.01 Readiness and Duty Requirements and 633.01 Special Pays, 42 U.S.C. 202 et seq. (PHS Act Sec 201 et seq.); and Executive Order 9397 (Numbering System for Federal Accounts Relating to Individual Persons)

**Purposes and Uses:** The purpose of this form is to document practice hours at a Department of Health and Human Services or other Federal/ Non-Federal Healthcare facility or deployment to meet the requirements for readiness and special pays (See CCI 633.01, "Special Pays," and CCI 241.01, "Readiness and Duty Requirements"). Disclosure: Voluntary; however, refusal to submit information requested on this form may negatively impact the officer's special pays and readiness and duty requirements (a condition of service). Officer's PHS serial number is required for identification purposes. The information also may be used for study purposes and/or collection of statistical data for reports to other Federal agencies and the Congress. It may also be used for other lawful purposes including collection of a debt owed the Federal Government, law enforcement, and litigation.

**Effect of Nondisclosure:** You are required to provide the information requested on this form to be eligible for certain special pays and/or to maintain readiness and duty requirements. Failure to supply complete and accurate information may result in delays and/or errors in determining eligibility for deployment and/or special pays and, therefore, result in administrative action or late payment or nonpayment, or because for refund of pay if you receive a pay based on erroneous information. All statements are subject to verification.