PIMA COUNTY
HUMAN RESOURCES

Last Name	*First Name*	*MI*	*Last Four Digits of SSN*

CLAIM FOR EMPLOYMENT PREFERENCE POINTS

For classified positions under the
PIMA COUNTY EMPLOYEE MERIT SYSTEMS
150 W. Congress, 4th Floor Tucson, AZ 85701
Phone: (520)724-8028 Fax: (520)770-4241 (secure fax)

Preference Points will be added to final scores of qualified applicants who wish to claim them for initial employment with Pima County Government. Maximum preference is 15 points and will apply only after an applicant has earned a passing score without preference. These preference points are for initial appointment/hire and are not applicable for current employees.

PLEASE COMPLETE THE APPROPRIATE SECTION FOR THE PREFERENCE(S) YOU ARE CLAIMING.

VETERAN: 5 points (A.R.S. § 38-492(A))

A veteran of the Armed Forces of the United States separated from the Armed Forces under honorable conditions following six months or more of active duty.

ELIGIBILITY verified through DD Form 214 or other acceptable proof.

Length of Active Duty: _____ *Years* _____ *Months* _____ *Days* Discharge Status: _____

Eligibility Verified: _____ *Human Resources Staff Signature* _____ *Date*

DISABLED VETERAN: 10 points (A.R.S. § 38-492(F))

An honorably separated veteran who served on active duty in the Armed Forces at any time and who has a service connected injury or is receiving compensation or disability retirement benefits under laws administered by the Veteran's Administration, Army, Navy, Air Force, Coast Guard or Public Health Service.

ELIGIBILITY verified through DD Form 214 AND letter from Veterans Administration that indicates veteran has a service connected injury or is receiving compensation or disability retirement benefits for a service-connected disability.

Eligibility Verified: _____ *Human Resources Staff Signature* _____ *Date*

ADDITIONAL CLAIM SECTIONS ON PAGE 2 AND PAGE 3

FOR HUMAN RESOURCES DEPARTMENT USE ONLY

V	DV	S OR SS	DP	NA	Total

Date Received _____ Date Posted: _____ Purge Date: _____

Last Name	*First Name*	*MI*	*Last Four Digits of SSN*

SPOUSE OR SURVIVING SPOUSE: 5 points (A.R.S. § 38-492 (E)

Spouse or Surviving Spouse of any of the following:

1. Any veteran who died of a service-connected injury.
2. Any member of the Armed Forces serving on active duty at the time of application who is listed by the Secretary of Defense of the United States in any of the following categories for not less than ninety days:
   A. Missing in action (MIA).
   B. Captured in the line of duty by a hostile force.
   C. Forcibly detained or interned in the line of duty by a foreign government or power.
3. A person who has a total, permanent disability resulting from a service-connected injury or any person who died while such disability was in existence.

Eligibility verified through Veterans Administration documents provided by the applicant from the VA which establishes eligibility and marital status.

Please check Appropriate circumstances

- ☐ Died of a service connected injury OR at the time of this application.
- ☐ Is missing in action.
- ☐ Has been captured in the line of duty by a hostile force.
- ☐ Has been forcibly detained or interned in the line of duty by a foreign government.
- ☐ Is totally, permanently disabled as a result of a service-connected injury.

Eligibility Verified: _____ _____

Human Resources Staff Signature *Date*

NATIVE AMERICAN: 5 points (Board of Supervisors Policy D21.4)

Applicant has attached a copy of his/her recognized, Tribal Identification Card that establishes membership in the tribe.

Eligibility Verified: _____ _____

Human Resources Staff Signature *Date*

Last Name	First Name	MI	Last Four Digits of SSN

DISABLED PERSON: 5 points (A.R.S. § 38-492 (B))

Anyone who has a physical or mental impairment that substantially limits one or more major life activities or has a record of such impairment or is regarded as having such an impairment.

Eligibility verified by the medical authority you indicate below.

I, _____, certify that I have a physical or mental impairment which limits my major life
Applicant Name

activity of _____. This impairment occurred _____ and has limited
List Major Life Activity Limited *Date*

my activity for _____ years _____ months

I AUTHORIZE THE MEDICAL AUTHORITY LISTED BELOW TO RELEASE SUCH INFORMATION NECESSARY TO SUBSTANTIATE MY CLAIM FOR PREFERENCE POINTS.

_____ _____
Applicant Signature *Date*

****

The name and address of the medical authority familiar with my impairment is:

_____
Name of Medical Provider

_____
Address of Medical Provider

THIS SECTION TO BE USED BY MEDICAL AUTHORITY NAMED ABOVE ONLY

If the applicant suffers from a physical or mental impairment that substantially limits a major life activity or major bodily function as defined by the Americans with Disabilities Act, then the Applicant should be considered disabled.

☐ I concur with this claim. ☐ I do not concur with this claim.

_____ _____
Signature/Title of Medical Authority *Date*

Eligibility Verified: _____ _____
Human Resources Staff Signature *Date*