

Prepared by: _____ Bldg/Room: _____ Phone: _____

REQUEST FOR APPROVAL OF OUTSIDE ACTIVITY*

(Ref.: HHS Standards of Conduct Regulations)

Initial Request
Revised Request
Renewal

1. Name (Last, First, Initial)	2. Organizational location (Operating Division, Bureau, Division)
3. Title of position	4. Grade and salary (Federal)
* 5. Name, address and business of person or organization for whom outside services will be performed	6. Location where services will be performed

7. Nature of activity (Indicate type of activity, e.g., teaching, consultative services, and give a full description of specific duties or services to be performed. Specify, when possible, the scheduled days of week and hours of day proposed activity will be performed.)

Supervisor's Name, Signature and Date:

8. Estimated time involved

a. Period covered	b. Estimated total time devoted to activity (If on a continuing basis, give estimated time per year)
From _____ To _____	

c. Will work be performed entirely outside usual working hours?
 Yes No If "NO," indicate estimated number of hours or days of absence from work

9. Do your official duties relate in any way to the proposed activity?
 No Yes (Describe)

* 10. If providing consultative or professional services, are your would-be associates receiving or will they seek, a grant or contract from a federal agency?
 No Yes (Describe)

11. Method or basis of compensation	Amount:	See Reverse	12. Will compensation be derived from a HHS grant or contract?
<input type="checkbox"/> Fee <input type="checkbox"/> Honorarium <input type="checkbox"/> Per Diem <input type="checkbox"/> Per Annum	<input type="checkbox"/> Royalty <input type="checkbox"/> Expenses <input type="checkbox"/> Other		<input type="checkbox"/> No <input type="checkbox"/> Yes (Describe)

13. This request is made with full knowledge of department and operating division policy and procedures on outside activities. The statements I have made are true, complete and correct to the best of my knowledge and belief.

14. Signature of employee	15. Date	16. Additional information attached
		<input type="checkbox"/> Yes <input type="checkbox"/> No

* 17. Action recommended by reviewing official

a. <input type="checkbox"/> Approval <input type="checkbox"/> Disapproval	b. Signature	c. Title	d. Date
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18. Action taken

a. <input type="checkbox"/> Approval <input type="checkbox"/> Disapproval	b. Signature	c. Title	d. Date
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* See reverse of form

INSTRUCTIONS

- * Item 5 - Self-Employment: If applicable, indicate self-employment, the type of service (as medical, legal, etc.), whether alone or with partners, giving their names, and, if providing professional services to a large number of clients or patients, estimate the total number rather than listing them separately.
 - * Item 10 - Federal Grants or Contracts Involved: Describe the Federal grants or contracts (type, granting or contracting department, etc.). Full details must be provided on any aspect of professional and consultative services which involves, directly or indirectly, the preparation of grant applications, contract proposals, program reports, and other material which are designed to become the subject of dealings between institutions and government units and the Federal Government.
 - * Item 16 - Attachments: Be sure to sign copies of all attachments submitted.
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- * ITEM 17 - COMMENTS OF REVIEWING OFFICIAL

COMPENSATION DETAILS: Provide type and amount, e.g., honorarium and expenses. For continuing activities, provide type and amount for the past 5 years, or since the activity began if less than 5 years.

Year	Comp Type	Amount Compensation	Amount Expenses

* ITEM 18 - REASON FOR DISAPPROVAL

* I VERIFY THAT THE EMPLOYEE WAS PROVIDED A COPY OF THE HHS FORM 520 NOTICE/REGULATION EXCERPTS (JANUARY 1999).	
Deputy Ethics Counselor/Designee	Date

* NIH addition to the form, per HHS DAEO Policy disseminated January 8, 1999, requiring distribution of the 2-page notice/excerpts with every approved HHS-520. (7/03)