

# PSC TRANSHARE APPLICATION

## (Update ONLY)

Return this completed form to:  
 D.C. and Baltimore Area Employees - 5600 Fishers Lane, Room 5B-07, Rockville, MD 20857  
 Region Employees - Region TRANSHARE Coordinator  
 Perry Point Employees - Director, Division of Supply Management  
**Questions? Call 301-443-2414**

1. Name--Last Name _____	First Name _____	Middle Initial _____
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2. Agency <input type="checkbox"/> PSC <input type="checkbox"/> FDA <input type="checkbox"/> IHS <input type="checkbox"/> OS <input type="checkbox"/> AOA <input type="checkbox"/> HRSA <input type="checkbox"/> SAMHSA <input type="checkbox"/> ACF <input type="checkbox"/> CMS <input type="checkbox"/> CDC	3. SSN _____ 4. Government e-mail address _____
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5. Sub Agency _____	6. Work Phone Number _____	7. Building/Room Number _____
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8. Monthly Actual Mass Transit or Vanpool Commute Cost ( <i>not including parking</i> ) _____	9. Smart Benefits Program <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Smart Card No. _____
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10. Mode of Transportation (*Check appropriate modes, include daily cost for each*):

Bus                       Train                       Vanpool Company \_\_\_\_\_  
 Metrorail                       Other \_\_\_\_\_

11. Home Address (*Street address, apartment number, city, county, state, and zip*)

Street / P.O. BOX \_\_\_\_\_ Apartment Number \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

12. Comments:

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**13. SIGNATURE AND CERTIFICATION**

I certify that: I am employed by the HHS; I will be using TRANSHARE fare for my daily commute to and from work; I will not transfer the fare to anyone else; I understand that I must surrender all HHS parking permits to participate in the PSC TRANSHARE Program; and to the best of my knowledge and belief, all of my statements are true, correct, complete, and made in good faith. A false, fictitious, or fraudulent certification will render me subject to criminal prosecution under U.S. Code, Title 18, Section 1001, civil penalty action providing for administrative recoveries of up to \$10,000 per violation, and/or agency disciplinary actions up to and including dismissal.

Applicant's Signature _____	Date _____
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**Privacy Act Statement:** This information is provided pursuant to 5 U.S.C. 552a (Privacy Act of 1974) for individuals supplying Information for inclusion in a system of records. The authority to collect the information requested on this form is derived from 5 U.S.C. 7905, "Programs to encourage commuting by means other than single-occupancy motor vehicles." The primary use of the information is by the PSC Administrative Operations Service staff to manage and evaluate participation in the PSC Transhare Program. Information from these records may be disclosed outside the Department as follows: to appropriate Federal, state or local agencies responsible for investigating, prosecuting, enforcing, or implementing statutes, rules, regulations or orders when HHS becomes aware of evidence of a potential violation of civil or criminal law; to a congressional office from the record of an individual in response to a verified inquiry from that congressional office made at the written request of that individual; to the Department of Justice (DOJ) where DOJ has agreed to represent the Federal government, HHS or employees of HHS in case of lawsuit; to a contractor when HHS contracts with a private firm for the purpose of collating, analyzing, aggregating, or otherwise refining records in this system; to officials of labor organizations recognized under 5 U.S.C. Chapter 71 when relevant and necessary to their duties of exclusive representation, concerning personnel policies, practices, and matters affecting working conditions; to organizations deemed qualified by the Secretary to carry out quality assessments or utilization review; and HHS may disclose statistical reports containing information from this system of records to city, county, state, and Federal government agencies (including the General Accounting Office). Furnishing the information on this form is entirely voluntary; however, failure to do so will result in ineligibility to participate in the PSC Transhare Program.

### FOR PARKING AND INFORMATION OFFICE USE ONLY

Daily commute cost:        \$ _____ Weekly commute cost:        \$ _____ Monthly commute cost:        \$ _____ Quarterly Allowance:        \$ _____	Authorized PSC Signature _____ Date _____ <hr/> PSC TRANSHARE Number _____
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