P & G Association Management
129 W. Lake Mead Suite 16
Henderson, NV 89015
Please email back to : jamie@pandgmanagement.com

FEDERAL EMPLOYEES CIVIL RELIEF ACT ELIGIBILITY VERIFICATION

As a employee of a Federal Agency, State Agency, or Indian Tribe, you are eligible for protection under AB 393 (2019) and the associated section of NRS 116. Please fill out the form below and indicate whether you are or not eligible for protection under the Federal Employee Civil Relief Act.

Unit Owners Name : _____

Unit Address: _____

Mailing Address, if different: _____

Email Address: _____ Phone: _____

Federal/State/Tribal Employer Contact Information:

Name of Contact/Manager/Supervisor: _____

Address of Place of Employment: _____

Telephone: _____

I am eligible for protection under the FECRA because I am :

____ A federal worker, as defined below

____ A state worker, as defined below

____ A tribal worker, as defined below

____ A household member

____ I am not eligible for protection under the FECRA

Federal Worker – is an employee of a federal agency or an employee of a contractor who has entered into contract with a federal agency.

State Worker – is an employee of a state agency or an employee of a contractor who has entered into contract with a state agency.

Tribal Worker – is an employee of a qualified Indian or tribe or an employee of a contractor who has entered into contract with a qualified Indian Tribe.

I attest by my signature below that the above information is true and correct to the best of my knowledge and belief. If eligible for protection under FECRA, I further attest by my signature below that I, as a person eligible under FECRA,am providing my own person identifying information in order to avail myself and/or my dependents of the protections of the FECRA or, if I am a household member of as defined above, that I have been authorized to provide the identifying information for this purpose.

I further agree that (1) upon request, I will provide additional information to the Association which may ne required to verify entitlement to protections under the FECRA; (2) the Association will use this information to verify eligibility both intially and periodically thereafter, and (3) when my or my dependents eligibilty for FECRA protection expires, I will notify the Association within fourteen days.

Signature: _____

Print Name: _____ Date:_____

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NEVADA SERVICEMEMBER CIVIL RELIEF ACT ELIGIBLITY VERIFICATION

Unit Owner's Name: _____

Unit Address: _____

Mailing Address, if Different: _____

Email Address: _____ Phone: _____

___ Initial here if you are **NOT** a Service Member or a Dependent of a Service Member. If you are **NOT** a Service Member, after you initial on the line, skip down to the bottom and sign and date.

If you are a Service Member or Dependent of a Service Member, CONTINUE BELOW:

Service Member's Name: _____

Service Member's Date of Birth: _____

Service Member's Social Security Number: _____

I am eligible for protection under the NVSCARA because I am :

___ A service member currently on active duty or deployment or in the period of one year immediately following the end of such active duty or deployment.

___ A dependent of such a service member. If I a dependent, I am the :

___ Spouse

___ Child, as defined in 38 USC 101 (4)

___ Individual for who the service member provided more than one-half of my support in the 180 days immediately proceeding in the application for relief.

I attest by my signature below that I, as the service member, am providing my own personal identifying information in order to avail myself and/or dependents of the protections of the NVSCRA or, if I am the dependent of the service member,that the service member has authorized me to provide the service member's personal identifying information for this purpose. I further agree that (1) upon request, I will provide additional information to the Association which may be required to verify entitlement to protections under the NVSCRA; (2) the Association wll use this information to verify eligibility both initially and periodically thereafter, and (3) when my dependents eligibility for NVSCRA protections expires, I will notify the Association within fourteen (14) days.

Signature: _____

Printed Name: _____ Date: _____