



MILITARY DEPARTMENT  
STATE OF SOUTH CAROLINA  
SOUTH CAROLINA STATE GUARD  
OLYMPIA ARMORY, 551 GRANBY LANE  
COLUMBIA, SOUTH CAROLINA 29201  
803-299-4238  
803-253-6210 Fax  
www.sg.sc.gov

Dear State Guard Applicant:

Thank you for your interest in the South Carolina State Guard. You have taken the first step toward becoming a member of one of our State's oldest military organizations. The State Guard is a part of the South Carolina Military Department and there are a number of qualifications that all new personnel must meet. Some of these requirements are as follows:

- Be between the ages of seventeen (17) years (with parent/guardian consent) and 71 years of age.
- A US citizen or a resident of South Carolina. Non US citizens must show proof of application for Citizenship
- Meet basic medical condition criteria. (Cannot have a medical condition that would endanger self or others).
- No record of drug or alcohol abuse.
- No visible tattoos on neck above the collar of the t-shirt or below the wristbone
- Meet Height and Weight requirements (Reference the Height/Weight chart included with this document See: Form 20/66 Record of Basic Data; Height/Weight Chart
- An Honorable or General Discharge (Under Honorable Conditions) if prior active or reserve military service
- Cannot be a current member of an active or reserve component of the US Armed Forces or of another State Defense Force.

**If you meet the membership requirements listed above, please complete the attached Record of Basic Data form and be prepared to submit all "REQUIRED" documents that apply. Your complete application will not be processed until all REQUIRED documents are submitted to SCSG Administrator's Office.**

- If prior Federal service – Copy of DD214, NGB 22 or discharge from the Reserves – REQUIRED
  - SCSG Form 20/66 – Record of Basic Data (enclosed) – REQUIRED
  - Copy of Diploma showing your highest educational achievement – REQUIRED
  - Copy of Social Security Card - REQUIRED
  - Copy of Driver's License or State Identification Card – REQUIRED
  - Copy of birth certificate (Current passport is acceptable) – REQUIRED
  - Applicants must complete / provide a criminal background check prior to acceptance into the SCSG - visit (fee may apply): <https://catch.sled.sc.gov> - REQUIRED
  - A Completed South Carolina State Guard Medical Service Inquiry Form – REQUIRED
  - Any special training documents or civilian licensed skills that you would like to be included in your Enlistment Packet i.e. CDL – OPTIONAL
- Do you read or speak any languages other than English? Or do you know American Sign Language. Please Explain:

How did you hear about the S.C. State Guard?

# SCSG Height/Weight Chart

(Rev Oct 2014)

**Male** [weight in pounds by age]

**Female** [weight in pounds by age]

Height	17-20	21-27	28-39	40+	Height	17-20	21-27	28-39	40+
<b>58</b>					<b>58</b>	139	141	142	144
<b>59</b>					<b>59</b>	144	154	146	148
<b>60</b>	152	156	159	161	<b>60</b>	148	149	151	153
<b>61</b>	156	160	164	166	<b>61</b>	152	154	155	157
<b>62</b>	161	164	168	170	<b>62</b>	156	158	160	162
<b>63</b>	165	169	173	175	<b>63</b>	161	163	164	166
<b>64</b>	170	174	178	180	<b>64</b>	165	167	169	171
<b>65</b>	175	179	183	185	<b>65</b>	170	172	174	176
<b>66</b>	180	183	188	190	<b>66</b>	175	176	178	181
<b>67</b>	185	189	194	196	<b>67</b>	179	181	183	186
<b>68</b>	190	194	199	201	<b>68</b>	184	186	188	191
<b>69</b>	195	199	204	206	<b>69</b>	189	191	193	196
<b>70</b>	200	205	209	212	<b>70</b>	194	196	198	201
<b>71</b>	205	209	214	217	<b>71</b>	199	201	203	206
<b>72</b>	210	215	220	223	<b>72</b>	204	206	208	211
<b>73</b>	215	220	225	228	<b>73</b>	209	211	214	217
<b>74</b>	221	226	231	234	<b>74</b>	214	217	219	222
<b>75</b>	226	232	237	240	<b>75</b>	220	222	224	228
<b>76</b>	232	237	243	246	<b>76</b>	225	227	230	233
<b>77</b>	238	243	249	252	<b>77</b>	230	233	235	239
<b>78</b>	243	249	253	258	<b>78</b>	236	238	241	245
<b>79</b>	249	255	261	264	<b>79</b>	241	244	247	250
<b>80</b>	254	260	267	270	<b>80</b>	247	250	253	256

Add 6 pounds per inch for males and 5 pounds for females over 80 inches in height.

## RECORD OF BASIC DATA

### APPLICANT INFORMATION

NAME: LAST		FIRST		MIDDLE or "NMN"	
SUFFIX:	GENDER (M or F): <b>M</b> <b>F</b>	NICKNAME:		BIRTH DATE (MM/DD/YYYY):	Last Four Digits of SSN:
COUNTRY OF CITIZENSHIP:	IF NOT U.S. CITIZEN, PLAN TO NATURALIZE: Y or N <b>Y</b> <b>N</b>		IF U.S. BIRTH, LOCATION:	STATE	CITY
RESIDENTIAL STREET ADDRESS:		CITY		STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT):		CITY		STATE	ZIP CODE
EMAIL:		CELL PH #	HOME PH #	Other Ph #	
HEIGHT (INCHES):	WEIGHT (LBS):	HAIR COLOR:	EYE COLOR:	BLOOD TYPE:	RACE:

### EMPLOYMENT INFORMATION

CURRENT EMPLOYER:		SUPERVISOR:		SUPV PH #:	
EMAIL:		WORK PH #	POSITION:	START DATE (MM/DD/YYYY):	
PLACE OF EMPLOYMENT STREET ADDRESS:		CITY		STATE	ZIP CODE:

### EMERGENCY CONTACT INFORMATION

NAME: LAST		FIRST		RELATIONSHIP:	
RESIDENTIAL STREET ADDRESS:		CITY:		STATE:	ZIP CODE:
CELL PH #	HOME PH #	EMAIL:			

### CIVILIAN EDUCATION (List most recent first):

SCHOOL/INSTITUTION	LOCATION (CITY, STATE)	YEARS ATTENDED (XX - XX)	DEGREE CONFERRED	EXPL NOTE, IF NEEDED

### MILITARY SERVICE INFORMATION

IF NONE, CHECK HERE:

TYPE	BRANCH	ACTIVE or RESERVE	YEARS SERVED (XX - XX)	DISCHARGE or RETIREMENT	DOCUMENT ATTACHED
FEDERAL		<b>A</b> <b>R</b>		<b>D</b> <b>R</b>	DD-214 <b>Y</b> <b>N</b>
NATIONAL GUARD		<b>A</b> <b>R</b>		<b>D</b> <b>R</b>	NGB-22 <b>Y</b> <b>N</b>
STATE GUARD		<b>A</b> <b>R</b>		<b>D</b> <b>R</b>	
OTHER (ROTC, CAP, etc)					

### ADDITIONAL INFORMATION

SPECIAL SKILLS, LICENSES, or CERTIFICATIONS:	ISSUING AUTHORITY or JURISDICTION:	DATE ISSUED:	EXPIRATION DATE:

NAME: LAST	FIRST	MIDDLE or "NMN"
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**LEGAL INFORMATION -- YOU MUST INITIAL YOUR ANSWERS**

**INITIAL BELOW:**

Have you ever been arrested for, charged with, or convicted of **ANY** offense (leave out traffic fines of less than \$150)? **If YES, Explain Below.** Y \_\_\_\_\_ N \_\_\_\_\_

Have you ever tried, used, sold, supplied, or possessed any narcotic (to include heroin or cocaine), depressant (to include Quaaludes), stimulant, hallucinogen (to include LSD or PCP), or cannabis (to include marijuana or hashish), or any mind( altering substance (to include glue or pain), or anabolic steroid, except as prescribed by a licensed physician? **If YES, Explain Below.** Y \_\_\_\_\_ N \_\_\_\_\_

Are you now or have you ever: (1) been a member of an organization dedicated to terrorism, either with an awareness of the organization's dedication to that end, or with the specific intent to further such activities; (2) knowingly engaged in any acts of terrorism (3) advocated any acts of terrorism or activities designed to overthrow the U.S. Government by force; (4) been a member of an organization dedicated to the use of violence or force to overthrow the U.S. Government, and which engaged in activities to that end with an awareness of the organization's dedication to that end or the specific intent to further such activities; (5) been a member of an organization that advocates or practices commission of acts of force or violence to discourage others from exercising their rights under the U.S. Constitution or any State of the U.S. with the specific intent to further such action; or (6) knowingly engaged in activities designed to overthrow the U.S. Government by force? **If YES, Explain Below.** Y \_\_\_\_\_ N \_\_\_\_\_

**ADDITIONAL INFORMATION THAT THE APPLICANT BELIEVES NECESSARY TO SUPPORT MEMBERSHIP IN S.C. STATE GUARD:**

**CERTIFICATION & SIGNATURE**

I authorize any law enforcement agency to release to any officer of the SC State Guard any record of criminal history on file concerning me. I certify that the above information is true, complete and accurate to the best of my knowledge and belief and is made in good faith. I understand that a knowing and willful false statement on this form can be punished by fine or imprisonment or both, (U.S. CODE, TITLE 18, SECTION 1001), and may lead to immediate discharge. **ELECTRONIC SIGNATURE AGREEMENT:** The SCSG asks that applicants complete SCSG form 20-66 and sign it electronically, thus replacing the manual/handwritten. Subsequent written signatures may be required prior to acceptance into the SCSG. By selecting the "I ACCEPT," you are signing this agreement electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten. **ACKNOWLEDGMENT:** My electronic signature is legally binding. please make the appropriate selection and provide your signature. **SELECT ONE.**

DATE (MM/DD/YYYY):	SIGNATURE:
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**SCSG OFFICE USE ONLY**

BOARD DATE:	RANK ASSIGNED:	UNIT ASSIGNED:	LINE NUMBER:	SCSG EMAIL:
DATE OF OATH:	REASON FOR REJECTION/DECLINE:			

**Application Submission Instructions**

Thank you for your interest in the South Carolina State Guard.

1. SAVE or PRINT this form as a PDF and then submit email to [SCSGApplications@tag.scmd.state.sc.us](mailto:SCSGApplications@tag.scmd.state.sc.us)
2. Please maintain a copy of this form for your personal records

**SOUTH CAROLINA STATE GUARD MEDICAL SERVICE INQUIRY**

Name: \_\_\_\_\_ SSN (Last 4) \_\_\_\_ \_

Address: \_\_\_\_\_ Civilian Occupation: \_\_\_\_\_

Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ Cell: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ Work: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Height (inches): \_\_\_\_\_ Weight: \_\_\_\_\_  
use drop down menu for DOB

**Medical History**

Allergies: \_\_\_\_\_

Glasses:  Yes  No

\_\_\_\_\_

Contacts:  Yes  No

\_\_\_\_\_

Hearing Aids:  Yes  No

Other: \_\_\_\_\_

\_\_\_\_\_

Blood Type: \_\_\_\_\_

Do you have a history of:

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Headaches                   | <input type="checkbox"/> Pneumonia                   | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Shortness of Breath         | <input type="checkbox"/> Ulcer(s)                    | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Glaucoma             |
| <input type="checkbox"/> Heart Palpitations          | <input type="checkbox"/> GI Disorder(s)              | <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Epilepsy             |
| <input type="checkbox"/> Heart Murmur                | <input type="checkbox"/> Lactose Intolerance         | <input type="checkbox"/> Osteoarthritis             | <input type="checkbox"/> Bleeding Disorder    |
| <input type="checkbox"/> Heart Attack                | <input type="checkbox"/> Gallbladder Disease         | <input type="checkbox"/> Hypertension (High B/P)    | <input type="checkbox"/> Kidney Disease       |
| <input type="checkbox"/> Chest Pain                  | <input type="checkbox"/> Prostate Disease            | <input type="checkbox"/> Depression                 | <input type="checkbox"/> Thyroid Disorder     |
| <input type="checkbox"/> Dizziness/Fainting          | <input type="checkbox"/> GYN Disease/Disorder        | <input type="checkbox"/> Gout                       | <input type="checkbox"/> Mental Health Issues |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Bowel Irregularities        | <input type="checkbox"/> Stroke                     | <input type="checkbox"/> TB                   |
| <input type="checkbox"/> Allergies/Hay Fever         | <input type="checkbox"/> Hearing Loss                | <input type="checkbox"/> Chronic infectious disease | <input type="checkbox"/> Cancer               |
| <input type="checkbox"/> Bronchitis                  | <input type="checkbox"/> Tinnitus (ringing in ears ) | <input type="checkbox"/> HIV                        | <input type="checkbox"/> Shoulder Problems    |
| <input type="checkbox"/> Knee or Hip Problems        | <input type="checkbox"/> Back Problems               |   |   |

Other : \_\_\_\_\_

Tobacco use:      Yes      No                      Smoke      Smokeless      Vapor

Alcohol use: How many drinks do you have in a week? \_\_\_\_\_

Do you have sleep problems?    Yes    No    Trouble going to sleep or staying asleep?    Yes    No

Excessive sleepiness during the day?  Yes  No Sleep Apnea?  Yes  No Do you use a CPAP?  Yes  No

Exercise Routine:

- No exercise plan
- Less than 3 x per week
- 3 x per week for more than 30 minutes
- More than above

Nutrition:

Do you have appetite problems?  Yes  No

Special Diet: \_\_\_\_\_

Do you feel you are "fit":  Yes  No Do you need help starting a fitness plan:  Yes  No

Do you have contact /exposure to blood / body fluids at your civilian jobsite:  Yes  No

Living Will:  Yes  No

Immunizations:  Flu  Hep B  Pneumonia  Tetanus  Shingles

Family physician Name/Phone: \_\_\_\_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Next of Kin (NOK) Name/Phone: \_\_\_\_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Other Phone Numbers: \_\_\_\_\_

Activity Restrictions: \_\_\_\_\_

Hospitalizations/Surgeries in past 24 months:  No  Yes- Explain:

Fractures in past 24 months:  No  Yes- Explain: \_\_\_\_\_

Medications (prescribed and over-the-counter): \_\_\_\_\_

Remarks:

SIGNATURE: \_\_\_\_\_ PRINT LAST NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Office use only

Category A

Category B

Category C

FULLY DEPLOYABLE

DEPLOY W/ RESTRICTIONS

NON-DEPLOYABLE