Released under the John F Kennedy Assassination Records Collection Act of 1992 (44 USC 2107 Note). Case#:NW 68261 Date: 19-01-2022

Assassination Records Review Board Final Determination Notification

AGENCY : HSCA

RECORD NUMBER : 180-10068-10324

RECORD SERIES : STAFF PAYROLL RECORDS

AGENCY FILE NUMBER :

December 8, 1995

Status of Document: Postponed in Part

Number of releases of previously postponed information: 8

Reason for Board Action: The Review Board's decision was premised on several factors including: (a) the significant historical interest in the document in question; (b) the absence of evidence that the release of the information would cause harm to the United States or to any individual.

Number of Postponements: 4

Postponements: All the postponements in this document represent Social Security numbers.

Reason for Board Action: The text is redacted because the public disclosure of the redaction could reasonably be expected to constitute an unwarranted invasion of personal privacy, and that invasion of privacy would be so substantial that it outweighs the public interest.

Substitute Language: SSN

Date of Next Review: 2017

Board Review Completed: 10/24/95

Released under the John F. Kennedy Assassination Records Collection Act of 1992 44 USC 2107 Note). Case#:NW 88326 Date: 2025

"Diff Files" for NARA 2025 Documents Release JFK Assassination Records

Generated using diff-pdf and OpenCV.
Thanks to the Mary Ferrell Foundation and
The Black Vault for their archiving work.

maryferrell.org theblackvault.com github.com/vslavik/diff-pdf opencv.org This file highlights differences between the 2025 release, and previous releases.

Red: Newly revealed in 2025.

Blue: Present in earlier releases, but not in 2025.

Black Unchanged between versions.

For Original Documents visit: archives.gov/research/jfk/release-2025

Notes:

Black text on a blue background inidcates content that was previously redacted using black ink.

I did my best to be accurate in revealing what is new, but please confirm with the original sources where accuracy is essential.

Created by: x.com/hlywdufo

JFKdiffs.com

Date: 08/20/93

Page:1

JFK ASSASSINATION SYSTEM

IDENTIFICATION FORM

AGENCY INFORMATION

AGENCY : HSCA

RECORD NUMBER: 180-10068-10324

RECORDS SERIES : STAFF PAYROLL RECORDS

AGENCY FILE NUMBER:

DOCUMENT INFORMATION

ORIGINATOR: HSCA

FROM:

TO:

TITLE:

DATE: 12/29/77

PAGES: 8

SUBJECTS:

HSCA, ADMINISTRATION

COLLINS, WENDY S.

DOCUMENT TYPE : PRINTED FORM

CLASSIFICATION : U

RESTRICTIONS : 3

CURRENT STATUS : P

DATE OF LAST REVIEW: 07/07/93

OPENING CRITERIA:

COMMENTS:

Box #:1.

LOUIS STOKES, OHIO, CHAIRMAN

RICHARDSON PREYER, N.C.
WALTER E. FAUNTROY, D.C.
YVONNE BRATHWAITE BURKE, CALIF.
CHRISTOPHER J. DODD, CONN.
HAROLD E. FORD, TENN.
FEOYD J. FITHIAN, IND.
ROBERT W. EDGAR, PA.

SAMUEL L. DEVINE, OHIO STEWART B. MCKINNEY, CONN. CHARLES THONE, NEBR. HAROLD S. SAWYER, MICH.

(202) 225-4624

Select Committee on Assassinations

U.S. House of Representatives 3369 House Office Building, ANNEX 2 WASHINGTON, D.C. 20515

December 5, 1978

The Honorable Frank Thompson, Jr. Chairman
Committee on House Administration
U. S. House of Representatives
Washington, D. C. 20515

Dear Mr. Chairman:

Effective December 1, 1978, the official duty station of Ms. Wendy Collins has been changed from Washington, D. C. to Pittsford, Vermont.

This change will remain in effect through the balance of the 95th Congress.

LOUIS STOKES

Chairman

LS:th

NW 88326

Docld:32243290 Page 3

PAYROLL AUTHORIZATION FORM

(Please Use Typewriter or Ballpoint Pen)

U.S. HOUSE OF REPRESENTATIVES Washington, D.C. 20515

(Any erasures, corrections, or changes on this form must be initialed by the authorizing official.)

To the Clerk of the House of Representatives:

I hereby authorize the following payroll action:

Employee Name (First-Middle-Last)	Effective Date
Hendy S. Collins	Jecemer 20, 1978
Employee Social Security Number	Type of Action
024-44-5103	☐ Appointment
Employing Office or Committee/Subcommittee	☐ Salary Adjustment☐ Title Change
	☐ Termination (At close of business on effective date)
Assasaine Cions	☐ Leave without pay (Beginning with effective date above and end
•	close of businessSpecify Date
(If type of action is an Appointment, Salary Adjustment, or Title Ch	ange, complete appropriate information below.)
Position Title	Gross Annual Salary*
* If employee is a civil service annuitant (includes U.S. House of Representatives), the	gross annual salary shown should include the annuity received by the emp
plus the salary received from the employing office.	,
If Committee Employee, complete appropriate item below.)	
1. ☐ Standing Committee: Staff—☐ Clerical or ☐ Professi	onal.
2. Special (Investigative staff of Standing Committee) or	Select Committee: Authority—H. Res of congre
3. Joint Committee.	
3. Joint Committee.	
3. ☐ Joint Committee. If Employee of an Officer of the House, complete item below.)	
3. Joint Committee. If Employee of an Officer of the House, complete item below.) Position Number	Step
3. □ Joint Committee. (If Employee of an Officer of the House, complete item below.) Position Number	Step
 Joint Committee. If Employee of an Officer of the House, complete item below.) Position Number If applicable, Level_ I certify that this authorization is not in violation relatives. 	of 5 U.S.C. 3110(b), prohibiting the employment
 Joint Committee. (If Employee of an Officer of the House, complete item below.) Position Number If applicable, Level_ I certify that this authorization is not in violation relatives. 	Step of 5 U.S.C. 3110(b), prohibiting the employment
3. ☐ Joint Committee. (If Employee of an Officer of the House, complete item below.) Position Number	of 5 U.S.C. 3110(b), prohibiting the employment
3. Joint Committee. If Employee of an Officer of the House, complete item below.) Position Number	of 5 U.S.C: 3110(b), prohibiting the employment (Signature of Authorizing Official) (Type or print name of Authorizing Official)
3. Joint Committee. (If Employee of an Officer of the House, complete item below.) Position Number	of 5 U.S.C: 3110(b), prohibiting the employment (Signature of Authorizing Official) (Type or print name of Authorizing Official)
3. Joint Committee. (If Employee of an Officer of the House, complete item below.) Position Number	of 5 U.S.C. 3110(b), prohibiting the employment (Signature of Authorizing Official) (Type or print name of Authorizing Official) (Title-If Member, District and State)
3. Joint Committee. (If Employee of an Officer of the House, complete item below.) Position Number	of 5 U.S.C: 3110(b), prohibiting the employment (Signature of Authorizing Official) (Type or print name of Authorizing Official) (Title-If Member, District and State)
3. Joint Committee. (If Employee of an Officer of the House, complete item below.) Position Number	StepStep
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3. Joint Committee. (If Employee of an Officer of the House, complete item below.) Position Number	of 5 U.S.C. 3110(b), prohibiting the employment (Signature of Authorizing Official) (Type or print name of Authorizing Official) (Title-If Member, District and State) Index the House Classification Act and for Committee enformmittee on the Budget, and the Joint Committees, mu
3. Joint Committee. (If Employee of an Officer of the House, complete item below.) Position Number	(Signature of Authorizing Official) (Type or print name of Authorizing Official) (Title—If Member, District and State) Index the House Classification Act and for Committee encommittee on the Budget, and the Joint Committees, mu
3. Joint Committee. If Employee of an Officer of the House, complete item below.) Position Number	Step
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PAYROLL AUTHORIZATION FORM

(Please Use Typewriter or Ballpoint Pen)

U.S. HOUSE OF REPRESENTATIVES Washington, D.C. 20515

(Any erasures, corrections, or changes on this form must be initialed by the authorizing official.)

To the Clerk of the House of Representatives:

I hereby authorize the following payroll action:

Employee Name (First-Middle-Last)	Effective Date
wendy S. Collins	Pecemier 29, 1977
Employee Social Security Number	Type of Action
024=34=5153	⊠%Appointment
	☐ Salary Adjustment
Employing Office or Committee/Subcommittee	☐ Title Change
Assassinations	 □ Termination (At close of business on effective date) □ Leave without pay (Beginning with effective date above and ending close of business
	Specify Date
(If type of action is an Appointment, Salary Adjustment, or Title Cha	ange, complete appropriate information below.)
Position Title	Gross Annual Salary*
Roscarca Attorney	812,000
* If employee is a civil service annuitant (includes U.S. House of Representatives), the g	
plus the salary received from the employing office.	
(If Committee Employee, complete appropriate item below.)	
1. ☐ Standing Committee: Staff—☐ Clerical or ☐ Profession	nal.
2. 🖾 Special (Investigative staff of Standing Committee) or S	Select Committee: Authority—H. Res. 6 of Congress
3. Joint Committee.	,
(If Employee of an Officer of the House, complete item below.)	
Position Number	Step
I certify that this authorization is not in violation	
relatives.	of 5 U.S.C. 3110(b), prohibiting the employment o
relatives.	of 5 U.S.C. 3110(b), prohibiting the employment o
relatives.	of 5 U.S.C. 3110(b), prohibiting the employment o
relatives. Date	of 5 U.S.C. 3110(b), prohibiting the employment o
Date	of 5 U.S.C. 3110(b), prohibiting the employment o (Signature of Authorizing Official) (Type or print name of Authorizing Official)
Date	of 5 U.S.C. 3110(b), prohibiting the employment o
Telatives. Date	of 5 U.S.C. 3110(b), prohibiting the employment o (Signature of Authorizing Official) (Type or print name of Authorizing Official) (Title-If Member, District and State) der the House Classification Act and for Committee em-
Date	(Signature of Authorizing Official) (Type or print name of Authorizing Official) (Title—If Member, District and State) Ider the House Classification Act and for Committee emommittee on the Budget, and the Joint Committees, must
Compared to the Committee on House Administration.	of 5 U.S.C. 3110(b), prohibiting the employment o (Signature of Authorizing Official) (Type or print name of Authorizing Official) (Title-If Member, District and State) der the House Classification Act and for Committee em-
Date	of 5 U.S.C. 3110(b), prohibiting the employment of (Signature of Authorizing Official) (Signature of Authorizing Official) (Type or print name of Authorizing Official) (Title-If Member, District and State) Ider the House Classification Act and for Committee emporamittee on the Budget, and the Joint Committees, must Chairman, Committee on House Administration
Total Committee Chairman or Ranking Minority Member) (If appropriate, signature of Subcommittee Chairman or Ranking Minority Member) (Type or print name and title of above official) All appointments and salary adjustments for employees unployees, except those of the Committee on Appropriations, the Committee approved by the Committee on House Administration. APPROVED:	(Signature of Authorizing Official) (Signature of Authorizing Official) (Type or print name of Authorizing Official) (Title-If Member, District and State) Ider the House Classification Act and for Committee emommittee on the Budget, and the Joint Committees, must Chairman, Committee on House Administration
Type or print name and title of above official) All appointments and salary adjustments for employees unployees, except those of the Committee on Appropriations, the Cobe approved by the Committee on House Administration. APPROVED: Office of Finance use only:	(Signature of Authorizing Official) (Type or print name of Authorizing Official) (Title—If Member, District and State) (Inder the House Classification Act and for Committee emormmittee on the Budget, and the Joint Committees, must Chairman, Committee on House Administration ID Benefits

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	LICALTH						
	FEDER	BENEFITS REGIST ALEMPLOYEES HEALTH BEN ead instructions on ba	EFITS PROGRA	M A		22933820	
	TO EMPLOYING OFFICE: SHOW OLD CARRIER'S CONTROL NUMBER ONLY IF ELECTION IS TO CAENROLLMENT OR TO CHANGE OPTIONS OR TYPE OF ENROLLMENT IN THE SAME PLAN.					Old Carrier's Control No.	
PART A		(Use numbers)					
ALL WHO REGIS- TER MUST FILL	4. YOUR MAILING ADDRESS (NUMBER	UR MAILING ADDRESS (NUMBER AND STREET)				Yes 1 No 2	
IN THIS PART.	(CITY) (STATE)	(ZIP CODE)	5	SOCIAL SECURITY ACCOUNT NUMBER			
	WASHINGTON D.	IMPORTANT		27-44-5	169		
THE FAMILY ENRO	AN EMPLOYEE OR A MEMBER OF HIS FAMIL OLLMENT OF ANOTHER FEDERAL OR DISTF OF BE CANCELED OR CHANGED TO SELF ONLY CANNOT ELECT A FAMILY ENROLLMENT U	Y TO BE COVERED UNDER MOR RICT OF COLUMBIA EMPLOYEE . SIMILARLY, IF A FAMILY MEN NLESS THE FAMILY MEMBER C	OR ANNUITAN IBER LISTED BY ANCELS HIS (OF	T YOU MUST REGISTER YOU IN PART B IS COVE HER) ENROLLMENT.	R NOT	TO ENROLL OR THE OTHER HROUGH HIS (OR HER) OWN EE BACK OF PAGES 2 AND 3.	
PART B	 I elect to enroll in a health benefits pla share of the cost of the enrollment. (C 	n as shown below. I authorize opy the information requested	deductions from below from bac	my salary, compensati k page of brochure of t	on, or a he plan	annuity to cover my you select.)	
FILL IN THIS PART IF YOU WISH TO ENROLL OR CHANGE	Blue Cross/Blue Benefit Plan	Shield Servi		TION (HIGH OR LOW)		OLLMENT CODE NUMBER.	
YOUR ENROLL MENT IN A HEALTH BENE- FITS PLAN.	 In space below list all eligible family 22, including (a) legally adopted chi parent-child relationship. Include also is incapable of self-support. (Attach PARENTS OR OTHERS WHO ARE ARE DEPENDENT ON YOU AND A 	members without exception: I Idren and (b) stepchildren; for o any unmarried child over 22 a doctor's certificate for a diss NOT ELIGIBLE FAMILY ME	ster children, ar who became dis	nd illegitimate children abled before age 22 and 2 or over, if one is not	who li d who, l already	ive with you in a regular because of the disability, on file.) DO NOT LIST	
If enrollment is for Self Only,	NAMES OF FAMILY MEMBERS	DATE OF BIRTH (Month, Day, Year)	NAMES	OF FAMILY MEMBERS		DATE OF BIRTH (Month, Day, Year)	
answer item 1. If enrollment is	Wife or Husband	1			: •	6	
for Self and Family, also an swer item 2		2				7	
IF YOU ARE		3				8	
CHANGING YOUR		4			•	9	
ALSO FILL IN PART D		5			10		
PART C	PLACE AN "X" IN ITEM 1 OR 2 WHICHEVER 1. I ELECT NOT TO ENROLL IN A PLAN UNI	DER THE FEDERAL		CANCEL MY PRESENT-	ENROL	LMENT UNDER THE	
PART IF YOU WISH NOT TO	EMPLOTEES HEALTH BENEFITS FROOM				nrollment Codé Number		
ENROLL OR IF					If you elect to cancel be sure to read		
CANCEL YOUR ENROLLMENT.	ANSWER ITEMS 1.2. AND 3 TO SHOW ENRO	ALLENT CODE OF WAR	D AND SUICIBIL	TV FOR CHANGE		Cancellation of Enroll- ient" on back of page 3.	
PART D	1. ENROLLMENT CODE NUMBER OF PRESENT PLAN	2. NUMBER OF EVENT V	VHICH PERMITS	CHANGE: 3. DATE OF	EVEN	T WHICH PERMITS CHANGE.	
PART, AS WELL AS PART B, TO CHANGE YOUR	UP FRESENT FLAN	(See table oil back of page /	Tot proper numb		IONTH	DAY YEAR	
REGISTRATION.				WARNING	Any ir	ntentional false statement	
PART E	1.1 0 00 00			in this application	on or is a	wilful misrepresentation violation of the law f not more than \$10,000	
TER MUST FILL IN THIS PART.	(VOUPSIGNATURE DO NOT PE	nin Aug 5	7 19 78		tofi	not more than 5 years,	
	1. NAME AND ADDRESS (INCLUDING ZIP C	ODE) OF EMPLOYING OFFICE		2. DATE RECEIVED EMPLOYING OFFI		3. EFFECTIVE DATE OF ELECTION	
PART F	U.S. House of Repre	sentatives					
TO BE COMPLETED BY AGENCY	Office of Finance, N	Washington, D.C.	20515	4. PAYROLL OFFICE	NO.	5. SF 2811 REPORT NO.	
J. Adelioi	(SIGNATURE OF AUTH	ORIZED AGENCY OFFICIAL)		0000483	2		
REMARKS FOR USE ONLY BY AGENCY.							

NW 88326 Docld:32243290 Page 6

Page 1 — To Payroll Office

Standard Form No. 2809
U.S. Civil Service Commission,
FPM Supplement 890-1

The state of the s	If typewriter is not available, bear down with ball-point pen	to make legible of	opies.
	HEALTH BENEFITS REGISTRATION FO FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (Read instructions on back of page 3.)	ORM	22933820
	TO EMPLOYING OFFICE: SHOW OLD CARRIER'S CONTROL NUMBER ONLY IF ELECTIONS OF TYPE OF ENROLLMENT IN THE SAME P	TION IS TO CANCEL	Old Carrier's Control No
PART A	1. NAME (LAST)	ATE OF BIRTH (Use numbers)	3. ARE YOU NOW MARRIED?
ALL WHO REGIS	4. YOUR MAILING ADDRESS. (NUMBER AND STREET)	NTH DAY YEAR	Yes 1 1
TER MUST FILL IN THIS PART.		DCIAL SECURITY	6. SEX MALE 1
	WASHINGTON D.C. 20007 02	14-614-5163	FEMALE 2
THE EARTH VENIOR	IMPORTANT IN EMPLOYEE OR A MEMBER OF HIS FAMILY TO BE COVERED UNDER MORE THAN ONE ENRO LLMENT OF ANOTHER FEDERAL OR DISTRICT OF COLUMBIA EMPLOYEE OR ANNUITANT Y BE CANCELED OR CHANGED TO SELF ONLY. SIMILARLY, IF A FAMILY MEMBER LISTED BY YO CANNOT ELECT A FAMILY ENROLLMENT UNLESS THE FAMILY MEMBER CANCELS HIS (OR HE	U IN PART B IS COVERED T ER) ENROLLMENT. ALSO S	FHROUGH HIS (OR HER) OWN SEE BACK OF PAGES 2 AND 3.
PART B	I elect to enroll in a health benefits plan as shown below. I authorize deductions from m share of the cost of the enrollment. (Copy the information requested below from back p OPTIC	ago or browners - in-	ROLLMENT CODE NUMBER
PART IF YOU WISH TO ENROLL	Plan.	IGH	101.
OR CHANGE YOUR ENROLL MENT IN A HEALTH BENE- FITS PLAN.	2. In space below list all eligible family members without exception: List your wife or hu 22, including (a) legally adopted children and (b) stepchildren, foster children, and parent-child relationship. Include also any unmarried child over 22 who became disable is incapable of self-support. (Attach a doctor's certificate for a disabled child age 22 of PARENTS OR OTHERS WHO ARE NOT ELIGIBLE FAMILY MEMBERS. THEY WARE DEPENDENT ON YOU AND ARE LISTED.	led before age 22 and who	, because of the disability, y on file.) DO NOT LIST EFITS, EVEN IF THEY
If enrollment is	NAMES OF FAMILY MEMBERS (Month, Day, Year) NAMES O	F FAMILY MEMBERS	DATE OF BIRTH (Month, Day, Year)
for Self Only, answer item 1. If enrollment is	Wife or Husband		[6]
for Self and Family, also an swer item 2.	2		
IF YOU ARE	3		8
CHANGING YOUR ENROLLMENT ALSO FILL IN	4		9
PART D.	PLACE AN "X" IN ITEM 1 OR 2 WHICHEVER APPLIES.		
PART C FILL IN THIS PART IF YOU WISH NOT TO ENROLL OR IF YOU WISH TO CANCEL YOUR ENROLLMENT	1. I ELECT NOT TO ENROLL IN A PLAN UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM Present Enroll	b.,	you elect to cancel e sure to read Cancellation of Enroll- nent" on back of page 3.
PART D	ANSWER ITEMS 1, 2, AND 3 TO SHOW ENROLLMENT CODE BEING CHANGED AND ELIGIBILIT 1. ENROLLMENT CODE NUMBER 2. NUMBER OF EVENT WHICH PERMITS CI (See table on back of page 2 for proper number	HANGE. 3. DATE OF EVE	NT WHICH PERMITS CHANGE.
PART, AS WELL AS PART B, TO CHANGE YOUR REGISTRATION.	OF PRESENT CAN	MONT	H DAY YEAR
PART E	1, 10/11	in this application of relative thereto is punishable by a fine	intentional false statement or wilful misrepresentation a violation of the law of not more than \$10,000
TER MUST FILL IN THIS PART.	(YOUR SIGNATURE DO NOT PRINT) HUS 5 19 FT	or both (18 U.S.C.	
	1. NAME AND ADDRESS (INCLUDING ZIP CODE) OF EMPLOYING OFFICE	2. DATE RECEIVED IN EMPLOYING OFFICE	3. EFFECTIVE DATE OF ELECTION
PARTF	U.S. House of Representatives		
TO BE COMPLETED BY AGENCY	Office of Finance, Washington, D.C. 20515	4. PAYROLL OFFICE NO	5. SF 2811 REPORT NO.
	(SIGNATURE OF AUTHORIZED AGENCY OFFICIAL)	00004832	
REMARKS FOR USE ONL			

BY AGENCY. NVV 88326— Docld:3224329014Page 7

If typewriter is not available, bear down with ball-point pen to make legible copies. New Carrier's Control No. HEALTH BENEFITS REGISTRATION FORM FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (Read instructions on back of page 3.) Old Carrier's Control No. TO EMPLOYING OFFICE: SHOW OLD CARRIER'S CONTROL NUMBER ONLY IF ELECTION IS TO CANCEL ENROLLMENT OR TO CHANGE OPTIONS OR TYPE OF ENROLLMENT IN THE SAME PLAN 3. ARE YOU NOW MARRIED? (MIDDLE INITIAL) (Use numbers) PART A - Wendy DAY : YEAR 4. YOUR MAILING ADDRESS (NUMBER AND STREET) ALL WHO REGIS-TER MUST FILL IN THIS PART. 5 SOCIAL SECURITY ACCOUNT NUMBER IMPORTANT IT IS ILLEGAL FOR AN EMPLOYEE OR A MEMBER OF HIS FAMILY TO BE COVERED UNDER MORE THAN ONE ENROLLMENT. IF YOU ARE ALREADY COVERED THROUGH THE FAMILY ENROLLMENT OF ANOTHER FEDERAL OR DISTRICT OF COLUMBIA EMPLOYEE OR ANNUITANT YOU MUST REGISTER NOT TO ENROLL OR THE OTHER ENROLLMENT MUST BE CANCELED OR CHANGED TO SELF ONLY. SIMILARLY, IF A FAMILY MEMBER LISTED BY YOU IN PART B IS COVERED THROUGH HIS (OR HER) OWN ENROLLMENT, YOU CANNOT ELECT A FAMILY ENROLLMENT UNLESS THE FAMILY MEMBER CANCELS HIS (OR HER) ENROLLMENT. ALSO SEE BACK OF PAGES 2 AND 3. I elect to enroll in a health benefits plan as shown below. I authorize deductions from my salary, compensation, or annuity to cover my PART B share of the cost of the enrollment. (Copy the information requested below from back page of brochure of the plan you select.) 🛴 FILL IN THIS ENROLLMENT CODE NUMBER OPTION (HIGH OR LOW) PART IF YOU WISH TO ENROLL ORCHANGE 2. In space below list all eligible family members without exception: List your wife or husband first, then your unmarried children under age 22; including (a) legally adopted children and (b) stepchildren, foster children, and illegitimate children who live with you in a regular parent-child relationship. Include also any unmarried child over 22 who became disabled before age 22 and who, because of the disability, is incapable of self-support. (Attach a doctor's certificate for a disabled child age 22 or over, if one is not already on file.) DO NOT LIST PARENTS OR OTHERS WHO ARE NOT ELIGIBLE FAMILY MEMBERS. THEY WILL NOT RECEIVE BENEFITS, EVEN IF THEY ARE DEPENDENT ON YOU AND ARE LISTED. YOUR ENROLL-MENT IN A HEALTH BENE-FITS PLAN. DATE OF BIRTH DATE OF BIRTH NAMES OF FAMILY MEMBERS NAMES OF FAMILY MEMBERS (Month, Day, Year) If enrollment is (Month, Day, Year) for Self Only, Wife or answer item 1. 1 6 Husband If enrollment is for Self and .2 Family, also an swer item 2. 3 IF YOU ARE CHANGING YOUR 9. 4 ENROLLMENT ALSO FILL IN 10 5 PART D. PLACE AN "X" IN ITEM 1 OR 2 WHICHEVER APPLIES: PART C I ELECT TO CANCEL MY PRESENT ENROLLMENT UNDER THE CODE NUMBER SHOWN BELOW I ELECT NOT TO ENROLL IN A PLAN UNDER THE FEDERAL FILL IN THIS PART IF YOU WISH NOT TO ENROLL OR IF Present Enrollment Code Number If you elect to cancel YOU WISH TO be sure to read CANCEL YOUR ENROLLMENT "Cancellation of Enrollment" on back of page 3. ANSWER ITEMS 1, 2, AND 3 TO SHOW ENROLLMENT CODE BEING CHANGED AND ELIGIBILITY FOR CHANGE: PART D ENROLLMENT CODE NUMBER 2. NUMBER OF EVENT WHICH PERMITS CHANGE. 3. DATE OF EVENT WHICH PERMITS CHANGE. FILL IN THIS (See table on back of page 2 for proper number PART, AS WELL AS PART B, TO MONTH YEAR CHANGE YOUR REGISTRATION. WARNING.—Any intentional false statement PART E in this application or wilful misrepresentation relative thereto is a violation of the law ALL WHO REGISpunishable by a fine of not more than \$10,000. TER MUST FILL or imprisonment of not more than 5 years, IN THIS PART. or both (18 U.S.C. 1001.) (YOU'R SIGNATURE DO NOT PRINT) DATE RECEIVED IN EMPLOYING OFFICE EFFECTIVE DATE OF ELECTION 1. NAME AND ADDRESS (INCLUDING ZIP CODE) OF EMPLOYING OFFICE PART F U.S. Rouse of Representatives fiffice of Finance, Washington, D.C. 2002 TO BE 5. SF 2811 REPORT NO. 4. PAYROLL OFFICE NO. COMPLETED BY AGENCY 00000852 (SIGNATURE OF AUTHORIZED AGENCY OFFICIAL) REMARKS FOR USE ONLY BY AGENCY.

NW 88326-Docld:322432901 Page 8

		FEDERA	BENEFITS REGIST IL EMPLOYEES HEALTH BEN Lad instructions on ba	NEFITS PROGR	IAM	22933820	
		TO EMPLOYING OFFICE: SHOW OF ENROLLMENT OR TO CHANGE OP				Old Carrier's Control No.	
PART A	1. NAME		RST) (MIDI	DLE INITIAL)	2. DATE OF BIRTH (Use numbers)	3. ARE YOU NOW MARRIED?	
ALL WHO REGISTER MUST FILL	4. YOUR		ND STREET)		MONTH DAY YEA	Yes 1 No 2*	
	(CITY)	(STATE)	(ZIR CODE)		5. SOCIAL SECURITY CACCOUNT NUMBER	6. SEX MALE 1	
THE FAMILY ENRO ENROLLMENT MUS	OLLMENT T BE CAN	OYEE OR A MEMBER OF HIS FAMILY OF ANOTHER FEDERAL OR DISTRI CELED OR CHANGED TO SELF ONLY. ELECT A FAMILY ENROLLMENT UN	CT OF COLUMBIA EMPLOYEE SIMILARLY IF A FAMILY MEN	OR ANNUITA	NT YOU MUST REGISTER N	OT TO ENROLL OR THE OTHER	
PART B		ect to enroll in a health benefits plan e of the cost of the enrollment. (Co					
FILL IN THIS PART IF YOU WISH TO ENROLL O.R. C. H.A. N. G. E.	SH4500	OF PLAN		C	PTION (HIGH OR LOW)	ENROLLMENT CODE NUMBER	
YOUR ENROLL- MENT IN A HEALTH BENE- FITS PLAN.	22, pare is in PAI	space below list all eligible family m including (a) legally adopted child ent-child relationship. Include also ncapable of self-support: (Attach a RENTS OR OTHERS WHO ARE N E DEPENDENT ON YOU AND AR	ren and (b) stepchildren, for any unmarried child over 22 doctor's certificate for a disa IOT ELIGIBLE FAMILY ME	ster children, a who became d	and illegitimate children wi isabled before age 22 and w 22 or over if one is not alro	ho live with you in a regular who, because of the disability,	
If enrollment is for Self Only,		NAMES OF FAMILY MEMBERS	DATE OF BIRTH (Month, Day, Year)	NAME	S OF FAMILY MEMBERS	DATE OF BIRTH (Month, Day, Year)	
answer item 1. If enrollment is	Wife or Husband		1			[6	
for Self and Family, also an swer item 2:			2				
FYOU ARE			3			8	
CHANGING YOUR			4			9	
ALSO FILL IN PART D.			5			10	
PART C	1. PELEC	N."X" IN ITEM 1 OR 2 WHICHEVER A CT NOT TO ENROLL IN A PLAN UNDE OYEES HEALTH BENEFITS PROGRAM	R THE FEDERAL	2. LELECT TO	O CANCEL MY PRESENT EN	ROLLMENT UNDER THE	
PART IF YOU WISH NOT TO ENROLL OR IF				1 - F	INTER SHOWN BELOW:		
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REMARKS FOR USE ONLY BY AGENCY.							

2809-115-01

Page 4 - To Enrollee

Standard Form No. 2809 U.S. Civil Service Commission FPM Supplement 890-1 November 1972

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District of Columbia (or State of).
do solemnly swear (or affirm)—
(1) That ☑ I am a citizen of the United States; ☐ if in the service on the date of enactment of the latest General Government Matters Appropriation Act, and being eligible for citizenship, I had theretofore filed a declaration of intention to become a citizen; ☐ I owe allegiance to the United States; ☐ I am an alien from Poland or the Baltic countries lawfully admitted to the United States for permanent residence;
☐ I am a citizen of the Republic of the Philippines; ☐ I am a national of a country allied with the United States in the current defense effort;
(2) That my acceptance and holding of office or employment with the U.S. House of Representatives does not or (if this affidavit is executed by me prior to my acceptance of such office or employment) will not constitute a violation of the first section of the Act of August 9, 1955 (5 U.S.C. 7311), which reads as
ollows: No person shall accept or hold office or employment in the Government of the United States or any agency thereof, including wholly owned Government corporations, who— (1) advocates the overthrow of our constitutional form of government in the United States; (2) is a member of an organization that advocates the overthrow of our constitutional form of government in the
United States, knowing that such organization so advocates; (3) participates in any strike or asserts the right to strike against the Government of the United States or such
agency; or (4) is a member of an organization of Government employees that asserts the right to strike against the Government of the United States or such agencies, knowing that such organization asserts such right;
(3) That I am receiving a pension, annuity, or retired pay from the United States covernment (if so, please furnish source and claim number);
(Name and location of administering agency) (Claim number) (4) That this Payroll Information Form and Personnel Affidavit is complete, true, and correct;
(5) That I will support and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties of the office on which I am about to enter; So help the God. Subscribed and sworn to before me this State of Allstuck J Allegue Notary Public. State of Allstuck J Allegue Notary Public.
NOTARY SEAL My commission expires 9-15-82

U.S. House of Representatives

OFFICE OF THE CLERK

OFFICE OF FINANCE

IMPORTANT NOTICE TO EMPLOYEE

Newly employed personnel must execute the attached combined PAYROLL INFORMATION FORM and PERSONNEL AFFIDAVIT properly and submit them to the Office of Finance, where a Notary Public is on duty to perform this service without charge. DO NOT SIGN PERSONNEL AFFIDAVIT UNTIL BEFORE A NOTARY.

Currently employed personnel wishing to make changes in their records need only complete the pertinent section of the PAYROLL INFORMATION FORM, indicate their employing office, and affix their signature. Please be certain that information is legible enough for the Finance Office to identify the individual making the change.

DETACH AND RETAIN THIS NOTICE

Salary payments are made by check monthly and mailed to the address designated on the Payroll Information Form. Checks are disbursed from the Office of Finance to normally reach the addressee on the last working day of each month.

For additional information, contact the Office of Finance, 263 Cannon Office Building, Telephone Extension 56515 or 57064.

EMPLOYEE BENEFITS

RETIREMENT: An employee of the House of Representatives is eligible to join the Federal Civil Service Retirement System. Participation is voluntary, and action to elect retirement coverage may be initiated at any time by completing the appropriate section of the Payroll Information Form. Once an election is filed and the normal deduction of $7\frac{1}{2}$ percent of the gross salary commences, the employee cannot discontinue deductions so long as he is continuously employed. (Note: Legislative employees are not covered by the Social Security Act.)

LIFE INSURANCE: An employee is automatically covered under the Federal Employees' Group Life Insurance Act unless he waives or subsequently cancels such coverage by filing the required waiver form with the Office of Finance. The insurance coverage is \$10,000; or an amount equal to the gross annual salary, rounded to the next higher thousand dollars (if the salary is not a multiple of a thousand dollars), plus an additional two thousand dollars; whichever is the greater. Additional optional insurance coverage in the amount of \$10,000 is also available.

HEALTH BENEFITS: The Federal Employees' Health Benefits Program is available on a voluntary basis with costs partly financed by the Government. Within 31 days after the effective date of appointment, every employee must register to enroll in a plan or not to enroll. Future opportunities to enroll or to change the type of enrollment are shown in the enclosed pamphlet. Also enclosed is the necessary registration form, Standard Form 2809.

U.S. SAVINGS BONDS: Monthly deductions for bonds in regular bond denominations may be authorized. Authorization cards are available in the Finance Office.

WORK INJURY BENEFITS: An employee injured or incurring disease as a result of performance of duty is entitled to medical care and monetary benefits under the provisions of the Federal Employees' Compensation Act. In instances where such injury or disease is fatal, the employee's family is entitled to monetary benefits. The Compensation Act is administered by the Bureau of Employees' Compensation, U.S. Department of Labor. Forms for filing notices of injury and claims for compensation are available in the Office of Finance or from any Postmaster.

UNEMPLOYMENT COMPENSATION: An employee may under certain circumstances be entitled to unemployment compensation if discharged or otherwise separated from his employment. The compensation is usually payable by the State (including the District of Columbia) in which the employee had his last service. However, a claim for benefits may be filed in the local office nearest the employee's residence. If an employee is discharged for misconduct, quits voluntarily without good cause, or refuses a suitable job without good cause, then there is a period of disqualification which varies from State to State. The amount of payments and period of time payable also varies from State to State.

16---82058-1

M E M O R A N D U M

TO: Thomas Howarth, Budget Officer Elizabeth Berning, Chief Clerk

FROM: I. Charles Mathews, Special Counsel

DATE: December 19, 1977

RE: Ms. Wendy Collins

Please be advised that Ms. Wendy Collins has accepted the position of Senior Attorney Researcher with the Select Committee on Assassinations. Her effective starting date will be December 29, 1977 and her starting salary will be \$18,000.00.

Your full cooperation will be appreciated in familiarizing her with staff procedures and welcoming her aboard.

ICM:jl

MEMORANDUM

TO: ALL STAFF

RE: Payroll Certification

The <u>Regulations</u> and <u>Accounting Procedures</u> for Allowances and <u>Expenses of Committees</u>, <u>Members and Employees of the U.S. House of Representatives</u> require that, among other things, the Committee's monthly payroll certification include the relationship, if any, of each employee to any current Member of Congress. This certification is signed monthly by our Chairman.

The following are the relationships to be included in the certification:

father	nephew	brother-in-law
mother	niece	sister-in-law
son	husband	stepfather
daughter	wife	stepmother
brother	father-in-law	stepbrother
sister	mother-in-law	stepsister
uncle	son-in-law	half-brother
aunt	daughter-in-law	half-sister
first cousin		

Please complete the appropriate portion below, sign and date this form, which will then become a part of your permanent personnel file. If this status changes, you must notify the Committee's Budget Office immediately of the change.

I am no	t related	to any cu	ırrent	(95th Con	gress) M	Member of	Congress.
			(95th	Congress)	Member	of Congre	ss.

Words Sullis
Signature of Employee

29 Dec 77