

President's Management Council
INTERAGENCY ROTATION PROGRAM

The PMC Interagency Rotation Program enables emerging Federal leaders to expand their leadership competencies, broaden their organizational experiences, and foster networks they can leverage in the future.

Employee Statement of Interest

TO BE COMPLETED BY POTENTIAL ROTATIONS PROGRAM PARTICIPANT:

Name:			
Department/Agency:			
Component:		Functional Area:	
Email Address:		Phone Number:	
Current Title:		Current Security Level or Clearances	
GS Level:		Location/Address:	
Supervisor Name:		Supervisor Email:	
Supervisor Title:		Supervisor Phone:	
Brief Description of Current Role (major/core duties):			
Brief Bio/Description of Professional Background:			

Developmental Goals: Please identify 2-3 Executive Core Qualification (ECQ) Competencies you aim to develop and provide additional input. For more information about the ECQ Competencies, please visit: www.opm.gov/ses/recruitment/ecq.asp.

ECQs (check all that apply): *Please provide comments on your developmental goals related to this assignment:*

Leading Change

Leading People

Results Driven

Business Acumen

Building Coalitions

Please provide information about your career objectives and the steps you have taken to work toward them:

How would this opportunity contribute to your short-term performance and long-term career goals?

Do you require any reasonable accommodations? *If yes, please explain.*

Are there any special requirements associated with your job series? *If yes, please explain.*

I understand this program's requirements and am prepared to engage in a 6-month rotation at another agency:

Employee's Signature

Date

Supervisor Approval

TO BE COMPLETED BY SUPERVISOR:

Employee strengths:

Employee career development needs:

Based on this individual's strengths and development needs, what type of work might be most beneficial? (For example, a project focused on a technical area, a leadership competency, a function/process, etc.) Why?

I support this individual's interest in this program:

YES NO

I recommend this individual for this program:

YES NO

This person is available for a 6-month interagency rotation:

YES NO

Supervisor's Signature

Date

TO BE COMPLETED BY COMPONENT MANAGEMENT (DEPUTY ASSISTANT SECRETARY or EQUIVALENT):

I support this employee's participation in a 6-month interagency rotation:

YES NO

Comments (optional):

Deputy Assistant Secretary or Equivalent Signature

Date