MEMORANDUM FOR THE ARMY NATIONAL GUARD OFFICE OF THE CHIEF SURGEON (ARNG-CSG), 111 S. GEORGE MASON RD. ARLINGTON, VA, 22031-1373

SUBJECT: Request for Health Professions Officer (HPO) Board Certified Pay (BCP)

_____

Last Name First Name Rank SSN

1. In consideration of payment of BCP under title 37 USC §335 and DoDI 6000.13, I have read the current U.S. Army National Guard (ARNG) Army Medical Department (AMEDD) Officer Selected Reserve Incentive Program (SRIP) and ARNG Health Professions Officer Incentive Pay and Board Certification Pay policies and I qualify for the requested BCP. I understand the appropriate Army National Guard officials must verify and approve this agreement before payment will be authorized.

2. Conditions of the agreement.

a. This agreement is for the current Fiscal Year (FY), and will automatically continue to subsequent years as long as all conditions of this agreement and all eligibility criteria are satisfied.

b. I am assigned in a valid ARNG Selected Reserve (SELRES) position in my primary Area of Concentration (AOC) _____. My primary AOC is reflected in IPPS-A, and matches the specialty for which the BCP is being paid during the agreement period.

c. I am currently credentialed, expiration date_____, and hold current certifications and registrations, in accordance with AR 40-68, and applicable interim changes, to perform duties without prejudicial restriction to the standards of the specialty for which the award is made.

d. I must maintain a current, valid, unrestricted state license, current certification, registration, and additional credentials, or privileges required to perform the duties in the specialty for which the incentive is authorized under the provisions of AR 40-68, and with applicable interim changes. I will keep my license and credentials current during the BCP agreement.

e. I currently hold and will continue to maintain Diplomate, certification, or board status in the professional board of my designated health professions clinical specialty (AOC) for the duration of this agreement.

Board Name: _____

Board Effective Date: _____

Board Expiration Date: _____

f. The period of continuous SELRES that I agree to serve under this agreement will be effective:_____

g. I understand in consideration of my entering into this BCP agreement, the ARNG agrees to pay BCP at the annual rate of $_____. It is paid at the 1/30th prorated amount of the monthly rate during performance of Inactive Duty Training (IDT), Active Duty Training (ADT), or any authorized equivalent or rescheduled duties in pay status, and subject to the availability of funds, and applicable State and Federal taxes for the life of this agreement.

h. I understand my BCP will expire when my Diplomate, certification, or board expires unless I submit my recertification documentation with a new BCP agreement. I am responsible to repay all payments received, beginning on the day after the expiration date of my Diplomate, certification, or board status. Additionally, it is my responsibility to inform to initiate stop-payment and recoupment action upon loss of

eligibility, loss of license, or loss of certification that terminates this agreement, payments received during the ineligible period will be recouped.

i. I understand I must be a Satisfactory Participant and meet ALL requirements in this agreement and per the guidelines of the ARNG Health Professions Officer Special and Incentive Pay Plan at the time the IDT or ADT duties are performed in order to receive BCP. I must meet all eligibility criteria at the time the duty is performed. Retroactive BCP is not authorized

j. I understand failure to fulfill the conditions specified in this agreement may result in termination of the agreement and the repayment of any unearned portion of BCP. Reasons for termination include, but are not limited to: loss of privileges, court- martial conviction, violations of the Uniform Code of Military Justice, failure to maintain required certification or licensure, unprofessional conduct, failure to demonstrate proficient medical skill, or reasons that are in the best interest of the Army. The Program Director, ARNG-CSG is the termination authority.

3. DISCLOSURE: Voluntary, however, failure to provide this information may result in non-verification of agreement and special pay could be affected.

SIGNATURE:_____

NAME:

RANK:

SSN:

DATE:

APPROVAL AUTHORITY AND VERIFICATION – Officer meets all qualifying criteria for the category of special pay indicated on this agreement and is endorsed (CIRCLE ONE):

APPROVED / DISAPPROVED (If DISAPPROVED, state reason)

SIGNATURE:_____

NAME:

RANK/CORPS:

TITLE:

UNIT:

(APPROVAL AUTHORITY)