Line of Duty Checklist

Full Name:		DODI	

Rank:		MOS:		Date of Injury	

Unit Address:	

************Submit all supporting documents listed below with this checklist*************

EMERGENCY CARE	Required Actions	Completed by:
The **Medical Incident Packet** is taken to the **Emergency Dept.** / **Urgent Care** by Soldier and NCO.	The **UNIT** completes lines 1 through 8 on the DA Form 2173 prior to sending the Soldier to **Emergency Dept.** / **Urgent Care**	
Memo for Emergency Medical Treatment Payment Instructions	Provide this letter of instructions to the medical facility billing representative.	
Unit completes DHA-GL Medical Eligibility Request Worksheet 1 (MMSO1)	The MMSO1 must be submitted through eMMPS/MEDCHART within 5 business days from date of injury.	
DD Form 2870- Provide a signed copy to the medical facility (OR) Have Soldier complete facility Medical Record Release	Soldier completes blocks 1-4. Unit completes blocks 6 and 9. Enter ER Facility Name in block 6. Unit contact info in block 6a-d. Soldier signs/dates block 11 and 13 Unit will retain one copy and provide one copy to the facility.	
NEXT ACTIONS	**Required Actions**	**Completed by:**
DA Form 4856-Counseling	Unit will counsel the Soldier on expectations and requirements for initiating an LOD and seeking medical treatment.	
Soldier Rights and Warnings	Soldier must complete this form to initiate a LOD claim and indicate if they **DO/DO NOT** wish to make a statement. **Must be signed by officer**.	
Disability Counseling Form	Soldier must sign this counseling form in addition to the DA Form 4856	
DA Form 2823- Sworn Statement (if applicable)	If the Soldier indicated, they wanted to make a statement on the Soldier Rights and Warnings this form is required for the LOD. **The form must be signed by Person Administering Oath.**	
MEDICAL DOCUMENTS	Soldiers will provide all **Clinical** medical documents concerning their injuries, illnesses, and diseases. They must keep the unit informed of all medical appointments and changes in their condition.	
Duty Status.	The Unit will provide documentation that the Soldier was on military orders or in a duty status. i.e., DA Form 1379, Title 32, or Title 10 orders.	
FOLLOW-UP CARE	**Required Actions**	**Completed by:**
Unit completes a Pre-Authorization Request for Medical Care DHA-GL Worksheet-02 (MMSO2). Making sure the Soldier is not inside 50-mile catchment area.	The MMSO2 must be submitted through eMMPS/MEDCHART.	
Soldier registers with TRICARE.	The Soldier receives notification of MMSO2 was approved. The Soldier then registers with Humana beneficiary self-service portal at: https://infocenter.humana-military.com/beneficiary/service/Registration/Registration	
Soldier provides Medical Treatment Payment Instructions to provider.	Provide this letter of instructions to the medical facility billing representative.	

STATEMENT OF MEDICAL EXAMINATION AND DUTY STATUS
(Required for Line of Duty Investigation)

For use of this form, see AR 600-8-4, the proponent agency is DCS, G-1.

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 U.S. Code 1201, Retirement, Chapter 61, Retirement or Separation for Physical Disability; and Title 10 U.S. Code 1203, Separation for Physical; AR 600-8-4, Line of Duty, Policy, Procedures, and Investigations and EO 9397 (as amended).

PRINCIPAL PURPOSE: To provide information regarding a Soldier's status when injury, illness, disease or death occurs. It tracks and ensure Soldiers are receiving proper benefits and proper institutions/agencies are notified regarding payment and benefits. For additional information see the System of Records Notice A0608-8-1b AHRC, Line of Duty Investigations. https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570057/a06008-1b-ahrc.aspx/

ROUTINE USES: There are no specific routine uses anticipated for this form; however it may be subject to a number of proper and necessary routine uses identified in the system of records notice(s) specified in the purpose Statement above.

DISCLOSURE: Voluntary, however, failure to provide the information will interfere with the proper adjudication of the Soldier's case in the best interest of the Soldier and the United States Army.

1. THRU:	2. TO:	3. FROM:
JFHQ-Georgia Army National Guard 1000 Halsey Ave. Bldg. 408 Marietta, GA. 30060	National Guard Bureau 111 S. George Mason Dr. Arlington, Virginia 22204	

4. NAME OF SOLDIER EXAMINED *(Last, First, Middle Initial)*	5. SSN	6. GRADE

7. UNIT OF ASSIGNMENT ADDRESS:	8. ACCIDENT/INCIDENT INFORMATION
	a. Date/Time: _____ b. Location: _____

SECTION I - TO BE COMPLETED BY ATTENDING PHYSICIAN OR HOSPITAL PATIENT ADMINISTRATOR (UA/READINESS/SARC'S MAY COMPLETE WITH SUBSTANTIATING MEDICAL RECORDS)

9. SOLDIER WAS: ☐ OUT PATIENT ☐ ADMITTED ☐ DEAD ON ARRIVAL

10. ☐ HOSPITAL NAME _____

11. ☐ HOUR/DATE EXAMINED _____

12. NATURE AND EXTENT OF ☐ INJURY ☐ ILLNESS ☐ DISEASE ☐ RESULTING IN DEATH *(Explain) (OR HISTORY OF THE DISEASE)*

13. ICD-10 CODE: _____

14. MEDICAL OPINION: **(Lines 15-23 Must be completed by a Physician, Physician Assistant or Nurse Practitioner)** (UA/Readiness/SARC's may complete with substantiating medical records)

15. SOLDIER ☐ WAS ☐ WAS NOT UNDER THE INFLUENCE OF ☐ ALCOHOL ☐ DRUGS *(Specify)*: _____ ☐ UNKNOWN

16. DRUGS OR ALCOHOL ☐ MAY ☐ MAY NOT HAVE RESULTED IN THE SOLDIERS INJURY, ILLNESS, DISEASE OR DEATH ☐ UNKNOWN

17. BLOOD TEST MADE? ☐ YES ☐ NO (If Yes: No. of MG ALCOHOL/100 ML BLOOD _____) ☐ UNKNOWN

DRUG SCREEN DONE? ☐ YES (Attach results) ☐ NO

18. INJURY ☐ IS ☐ IS NOT LIKELY TO REQUIRE FOLLOW-ON CARE. ☐ UNKNOWN

19. INJURY ☐ IS ☐ IS NOT LIKELY TO RESULT IN A CLAIM AGAINST THE GOVERNMENT FOR FUTURE MEDICAL CARE ☐ UNKNOWN

20. DID INJURY ILLNESS OR DISEASE EXIST PRIOR TO SERVICE? ☐ YES ☐ NO (ONLY CAN BE DETERMINED BY A PHYSICIAN, PA, or NP). ☐ UNKNOWN

21. CONDITION EXISTED PRIOR TO START OF CURRENT DUTY? ☐ YES ☐ NO (ONLY CAN BE DETERMINED BY A PHYSICIAN, PA, or NP). ☐ UNKNOWN

22. TYPED OR WRITTEN NAME OF PROVIDER/SARC/UA/READINESS	23. SIGNATURE	24. DATE

SECTION II - TO BE COMPLETED BY THE IMMEDIATE COMMANDER OR SARC

25. NAME OF SOLDIER EXAMINED *(Last, First, Middle Initial)*	26. SSN	27. GRADE

28. DUTY STATUS: ☐ PRESENT ☐ EXCUSED 29. ABSENT WITHOUT LEAVE (DOCUMENTED?) ☐ YES ☐ NO 30. SOLDIER WAS INJURED IN AUTHORIZED TRAVEL STATUS PER JTR ☐ YES ☐ NO	31. DATE AND TIME OF DUTY	32. DUTY STATUS LOCATION

33. SOLDIER WAS ON FEDERAL ORDERS: ☐ 30 DAYS OR LESS ☐ > 30 DAYS

34. SOLDIER WAS IN INACTIVE DUTY TRAINING STATUS: ☐

DATE/TIME IDT BEGAN: _____ ENDED: _____

35. SOLDIER DIED OF INJURIES RECEIVED PROCEEDING DIRECTLY:

☐ TO ☐ FROM ☐ DURING TRAINING ☐ NA

36. DETAILS OF INCIDENT - REMARKS *(If additional space is needed, attach enclosures as necessary).*

37. FORMAL LINE OF DUTY INVESTIGATION REQUIRED ☐ YES ☐ NO *(*NOTE-An informal investigation can only result in an ILD finding)*

38. INJURY IS TO HAVE BEEN INCURRED IN LINE OF DUTY (*Not applicable on deaths)* ☒ YES ☐ NO

39. NAME/GRADE OF IMMEDIATE/UNIT COMMANDER OR SARC	40. SIGNATURE	41.DATE

DEPARTMENTS OF THE ARMY
GEORGIA ARMY NATIONAL GUARD
JOINT FORCE HEADQUARTERS
1000 HALSEY AVENUE, BUILDING 408
MARIETTA, GEORGIA 30060-4277

NGGA-PEM 23 JUNE 2023

SUBJECT: Emergency Medical Treatment of a Georgia Army National Guard Soldier

1. Use the following instructions to obtain payment for the Emergency Medical Treatment provided. The Defense Health Agency-Great Lakes (DHA-GL/MMSO) authorizes Emergency Medical care for any Army National Guard Soldiers that have been injured in Line of Duty. No deductible or copay is required.

2. For services rendered, please mail all claims to the address listed below using a UB04 or HCFA1500. **DO NOT enter the claim electronically**, as it will be denied. The Soldier will often not be eligible in the TRICARE/ DEERS electronic billing system due to their “Line of Duty” status. **It is imperative that the claim be mailed as directed**.

3. Mail MEDICAL CLAIMS to: TRICARE East Region Claims Department, P.O. Box 7981, Madison, WI 53707-7981. Phone: 800-444-5445.4.

4. Upon receipt, TRICARE will verify the Soldier’s eligibility with DHA-GL and upon confirmation they will pay the claim. It will take 30-60 days to receive an Explanation of Benefits.
.

5. Prescription medication listed on the current Tricare formulary are covered but require pre-payment and a reimbursement request by the Soldier.

5. For questions, or concerns, please contact the undersigned. Thank you in advance.

Frank Durst
DHA-GL Program Manager
GAARNG
678-569-5150

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.
This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY NUMBER
4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)* ☐ OUTPATIENT ☐ INPATIENT ☐ BOTH	

SECTION II - DISCLOSURE

6. I AUTHORIZE _____ TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a. NAME OF PERSON OR ORGANIZATION TO RECEIVE MY MEDICAL INFORMATION	b. ADDRESS *(Street, City, State and ZIP Code)*
c. TELEPHONE *(Include Area Code)*	d. FAX *(Include Area Code)*

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*
☐ PERSONAL USE ☐ CONTINUED MEDICAL CARE ☐ SCHOOL ☐ OTHER *(Specify)*
☐ INSURANCE ☐ RETIREMENT/SEPARATION ☐ LEGAL

8. INFORMATION TO BE RELEASED

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION ☐ DATE *(YYYYMMDD)* ☐ ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE: ☐ AUTHORIZATION REVOKED	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:	

Reset

DEVELOPMENTAL COUNSELING FORM

For use of this form, see ATP 6-22.1; the proponent agency is TRADOC.

PRIVACY ACT STATEMENT

AUTHORITY: 5 USC 301, Departmental Regulations, 10 USC 3013, Secretary of the Army.

PRINCIPAL PURPOSE: These records are created and maintained to manage the member's Army and Army National Guard service effectively, to document historically a member's military service,and safeguard the rights of the member and the Army.

NOTE: For additional information, see the System of Records Notice A0600-8-104b AHRC, https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570051/a0600-8-104b-ahrc/.

ROUTINE USE(S): There are no specific routine uses anticipated for this form; however, it may be subject to a number of proper and necessary routine uses identified in the system of records notice specified in the purpose statement above.

DISCLOSURE: Disclosure is voluntary.

PART I - ADMINISTRATIVE DATA

Name *(Last, First, MI)*	Rank/Grade	Date of Counseling

Organization	Name and Title of Counselor

PART II - BACKGROUND INFORMATION

Purpose of Counseling: *(Leader states the reason for the counseling, e.g. Performance/Professional/Event-Oriented counseling, and include the leader's facts and observations prior to the counseling.)*

Approach: ☐ Non Directive ☐ Combined ☐ Directive

Type of Counseling: ☑ General Form ☐ Professional Growth ☐ Performance ☐ Event Oriented

Soldier's Responsibility in the LOD Process

PART III - SUMMARY OF COUNSELING

Complete this section during or immediately subsequent to counseling.

Key Points Discussion:

On _____, you suffered an injury/illness while in a duty stats. IAW AR 600-8-4, a DA 2173 (LOD) will be processed on your behalf to protect your interest and the interests of the US Government in entitlement to medical care.

1) _____IT IS YOUR RESPONSIBILITITY TO PROVIDE TO THE UNIT ALL MEDICAL BILLS AND DOCUMENTATION.

2) _____You will sign a "Release of Information" from the facility that you are seen by, releasing all pertinent information based on the injury you sustained to:

3) _____You have until the next scheduled Drill Assembly to present to the Unit all Medical Documentation. This documentation is very important in order to process the DA 2173 in a timely manner and to prevent any unnecessary debt to be incurred by you, the Soldier.

4) _____In the event that you do not provide the Required Medical Documentation, your DA 2173 (LOD) may be Administratively Closed. If the DA 2173 is administratively closed, no further action will be processed on your behalf. It will then be YOUR responsibility to provide any additional documentation to Medical Actions and a Memorandum requesting that your LOD be reopened.

5) _____In the event that you, the Soldier, have made diligent attempts to receive all required Medical Documentation and have not received it, you will notify the Unit and we will assist with acquiring the documentation from the Medical Facility you were seen by, and no action will be taken against you.

6) _____Once the required documentation is received, any limiting profiles will be turned over to the State MEDCOM and you will be issued a profile on a DA 3349. The unit will help to facilitate this by sending all documentation to the State MEDCOM on your behalf.

7) _____IT IS MANDATORY that you follow the Treatment Plan provided to you by the Physician or Physicians (i.e. use of crutches, wearing of a brace etc.) If you are found not following the Limitations of your profile or DA 3349, you will be in direct violation and could possibly face punishment or a loss of your profile.

OTHER INSTRUCTIONS

This form will be destroyed upon: reassignment *(other than rehabilitative transfers)*, separation at ETS, or upon retirement. For separation requirements and notification of loss of benefits/consequences see local directives and AR 635-200.

Plan of Action *(Outlines actions that the subordinate will do after the counseling session to reach the agreed upon goal(s). The actions must be specific enough to modify or maintain the subordinate's behavior and include a specified time line for implementation and assessment (Part IV below).*

I will provide to the unit all Medical Bills and Documentation by the next schedule Unit Training Assembly.

I will sign a "Release of Information" from the facility that you are seen by, releasing all pertinent information based on the injury you sustained to:

In the event that I do not provide the Required Medical Documentation, my DA 2173 (LOD) may be Administratively Closed. If the DA 2173 is administratively closed, no further action will be processed on my behalf.

In the event that I have made diligent attempts to receive all required Medical Documentation and have not received it, I will notify the Unit ASAP so that they can assist me with acquiring these documents to support my LOD.

_____ IT IS MANDATORY that I follow the Treatment Plan provided to me by the Physician or Physicians (i.e. use of crutches, wearing of a brace etc.) If I am found not following the limitations of my profile or DA 3349, I will be in direct violation and could possibly face punishment or a loss of my profile.

Session Closing: *(The leader summarizes the key points of the session and checks if the subordinate understands the plan of action. The subordinate agrees / disagrees and provides remarks if appropriate.)*

Individual counseled: ☐ I agree ☐ disagree with the information above.

Individual counseled remarks:

I will provide all necessary documentation to ensure the completion of my LOD, and payment of medical bills. If I do not provide these documents, the bills will become my responsibility.

Signature of Individual Counseled:	DATE *(YYYMMDD)*

Leader Responsibilities: *(Leader's responsibilities in implementing the plan of action.)*

Signature of Counselor:	Date *(YYYMMDD)*

PART IV - ASSESSMENT OF THE PLAN OF ACTION

Assessment: *(Did the plan of action achieve the desired results? This section is completed by both the leader and the individual counseled and provides useful information for follow-up counseling.)*

SIGNATURES

Note: Both the counselor and the individual counseled should retain a record of the counseling.

Counselor:	Individual Counseled:	Date of Assessment *(YYYMMDD)*:

Note: Both the counselor and the individual counseled should retain a record of the counseling.

I, _____ informed
INVESTIGATING OFFICER NAME, RANK, SSN
_____ on _____ of his/her rights, and
SOLDIER NAME, RANK, SSN
that he/she does not have to make any statement relating to the origin, incurrence or aggravation of any injury or medical problem incurred while in a duty status. The soldier understood his/her rights.

_____
INVESTIGATING OFFICER SIGNATURE

_____
RANK

I, _____ have been advised this date that I am not required by law to make any statement relating to origin, incurrence, or aggravation of any injury or medical problem incurred while in a duty status. I understood my right and elected to:

___ Make a Statement.

___ Not Make a Statement

_____
SOLDIER'S SIGNATURE

_____
DATE

DISABILITY COUNSELING STATEMENT

I understand, to be eligible for continuance of pay and allowances while disabled from an injury/aggravation/illness/disease incurred in line of duty: (Soldier **MUST** initial to the left of EACH item to confirm their acknowledgement and understanding.)

1. ____I must properly notify my unit when in need of any medical or hospital care required as the result of this line of duty injury/illness.

2. ____**I cannot seek private medical or hospital care for this line of duty injury/illness without first requesting and receiving approval from my unit (the request will be processed by my unit for final approval through State Headquarters to Defense Health Agency IAW AR 600-8-4).**

3. ____I must report for any medical appointment scheduled by my unit or by the doctor treating my condition.

4. ____I must cooperate fully with the medical personnel providing treatment and follow their course of treatment.

5. ____I must furnish to my unit, upon completion of each of my medical appointments, documentation on the results of that appointment.

6. ____I must provide copies of my pay stubs if I work or receive sick or vacation pay. This statement will include amount received from each income protection plan/policy.

7. ____If I am employed during this period I must provide the following: Soldier's Claim Form – Employed.

(1) Provide copies of my pay stubs.

(2) Provide a statement as to whether I have one or more income protection plans and the amount of funds received from each, on a daily basis.

8. ____If I am self employed during this period I must provide the following: DA Form 7574 Self-Employed.

(1) Provide a statement of income.

(2) Provide a statement as to whether I have one or more income protection plans and the amount of funds received from each, on a daily or monthly basis.

(3) Provide a copy of my latest Internal Revenue Service tax forms to include Schedule "C" and all attachments.

DISABILITY COUNSELING STATEMENT (continued)

9. ____If I am unemployed I will provide a statement indicating I have not earned any income from any source. (DA Form 7574)

10. ____Any money received by me from an insurance company (Third Party Claim) will be reported through channels to the State Judge Advocate.

11. ____I cannot expect any incapacitation benefits until my unit has received the approval Line of Duty. This may be six weeks after the Investigation is initiated and forwarded from my unit. Questions regarding this Line of Duty will be addressed thru my chain of command.

12. ____I understand that I am not on active duty while receiving incapacitation compensation. I will not accrue leave nor receive active duty retirement points for the duration of this period and will not receive ADT/IDT/AT pay with incapacitation benefits.

13. ____I authorize and request the Veteran's Administration, my civilian physician, the civilian hospital providing my medical care, or any other facility providing care release any and all medical records, examinations, treatments, and summaries to my State Adjutant General and unit.

I understand that failure to fulfill the above requirements may result in termination of my entitlements to pay and allowances and medical care for this disability. The penalty for willfully making a false claim is a maximum fine of $10,000, imprisonment for 5 years, or both. (U.S. Code, Title 18, Section 287, 1001)

Signature of Service Member: _____ Date: _____

Signature of Counselor: _____ Date: _____

Printed Name and Rank of Counselor: _____

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is PMG.

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, USC Section 301; Title 5, USC Section 2951; E.O. 9397 Social Security Number (SSN).

PRINCIPAL PURPOSE: To document potential criminal activity involving the U.S. Army, and to allow Army officials to maintain discipline, law and order through investigation of complaints and incidents.

ROUTINE USES: Information provided may be further disclosed to federal, state, local, and foreign government law enforcement agencies, prosecutors, courts, child protective services, victims, witnesses, the Department of Veterans Affairs, and the Office of Personnel Management. Information provided may be used for determinations regarding judicial or non-judicial punishment, other administrative disciplinary actions, security clearances, recruitment, retention, placement, and other personnel actions.

DISCLOSURE: Disclosure of your SSN and other information is voluntary.

1. LOCATION	2. DATE *(YYYYMMDD)*	3. TIME	4. FILE NUMBER

5. LAST NAME, FIRST NAME, MIDDLE NAME	6. SSN	7. GRADE/STATUS

8. ORGANIZATION OR ADDRESS

9.
I, _____, WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

10. EXHIBIT	11. INITIALS OF PERSON MAKING STATEMENT	PAGE 1 OF 2 PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF_____ TAKEN AT _____ DATED _____

THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT, AND PAGE NUMBER MUST BE INDICATED.

STATEMENT OF _____ TAKEN AT _____ DATED _____

9. STATEMENT *(Continued)*

AFFIDAVIT

I, _____ , HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1, AND ENDS ON PAGE 2 . I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

_____
(Signature of Person Making Statement)

WITNESSES:

_____

_____

_____
ORGANIZATION OR ADDRESS

_____

_____

_____
ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this _____ day of _____ , _____

at _____

_____
(Signature of Person Administering Oath)

_____
(Typed Name of Person Administering Oath)

_____
(Authority To Administer Oaths)

INITIALS OF PERSON MAKING STATEMENT