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: _____