COMMANDER MEMO TEMPLATE

DEPARTMENT OF THE ARMY
(LETTERHEAD)

(OFFICE SYMBOL) **DATE**

MEMORANDUM FOR ***Incapacitation Review Board Authority (insert Command, Office Symbol, Address)***

SUBJECT: Recommendation to **APPROVE/DENY TIER (1 or 2)** Incapacitation (INCAP) Pay for **RANK, FIRST, MI. LAST NAME, (Last Four SSN)** for claim periods **YYYMMDD** to **YYYMMDD**

1. Request **(approval/denial)** of the attached application for Tier **(1/2)** INCAP Pay for claim periods **XX MMM YYYY** through **XX MMM YYYY.** This request ***(DOES/DOES NOT)*** exceed the six month statutory limit for INCAP pay.

2. This request is based on an approved **(Formal or Informal)** Line of Duty (LOD) determination for **(insert ILD condition)**, an **(injury, illness, or disease)** that occurred on **(date of ILD condition)** while on **(insert training order type or duty status).** Address his duty performance and readiness status – has the SM attended BA since the injury, are they currently receiving care, is a fit for duty exam required/necessary. Address the Soldier's attendance history. Justify any duty perform; request ETP for MDRP(s) with supporting documents.

3. Address previous approved/paid INCAP periods. ***RANK LAST NAME was previously approved and paid XX months of TIER X INCAP pay for claims XX MMM YYYY to XX MMM YYYY in the gross amount of $$$.*** Address any update to profile (temporary or permanent profile) or enrollment into IDES. Discuss issues with either of these processes. ***SM received a permanent profile on XX MMM YYYY and is pending enrollment into the IDES. He is being case managed by the ARMMC as of XX MMM YYYY and we are awaiting a MEBTO date.***

4. Address requested TIER status. His inability to perform military duties: ***Pursuant to his DA 3349 (Physical Profile) and due to his ILD condition, RANK LAST NAME was put on a six week convalesce period and is unable to perform any military duties from XX MMM YYYY through XX MMM YYYY. He is expected to return to duty on XX MMM YYYY and will be re-evaluated on XX MMM YYYY.*** Address his demonstrated loss of earned income; discuss limitations, timeframe to recover, etc. ***Pursuant to his Medical Treatment Plan and employer documentation, RANK LAST NAME is unable to return to his civilian employment during this requested claim period. His expected return to work date is XX MMM YYYY. He was previously earning $$$ a month and is currently losing $$$ a monthly due to his ILD condition. After a review of his DA 3349, he is able to perform military duties and will attend battle assembly.***

5. I have personal reviewed the circumstances surround this case and firmly believe it meets the criteria established by law for entitlement and is in the best interest of fairness and equity for the Secretary of the Army and the Soldier.

6. For additional information, please contact ***(insert appropriate POC) NAME, Position Title, Phone Number and Email.***

FOR THE ***(INSERT APPROPRIATE AUTHORITY LINE if applicable):***

4 Encls **(SIGNATURE BLOCK)**
1. LOD Determination
2. DA Forms 7574, 7574-1, 7574-2
3. Medical Documentation
4. Financial Documentation

CF:
IRB Authority (OFFICE SYMBOL/POC)
AR G1 (DAAR-HR/MAJ Dawn M. Williams)