

ADMINISTRATIVE REMARKS

Entry Type: Reserve Incapacitation Benefits (RIB-2)
 Reference: Reserve Policy Manual, COMDTINST M1001.28 (Series)
 Responsible Level: Unit
 Entry: _____

1. _____ (Date) Counseled this date regarding my request for reserve incapacitation benefits in the form of Medical Hold orders.
2. _____ (Initials) I understand I may be authorized medical care for an injury/illness/disease incurred or aggravated in the line of duty on _____ (DDMMYY) while performing _____ (Type of Duty) at _____ (Unit).
3. _____ (Initials) If authorized Medical Hold orders, I understand that I will receive active duty pay and allowances for the duration of orders. I further understand that while on orders I must report to the duty location designated by my command daily, unless I have an authorized absence.
4. _____ (Initials) I understand that CG-PSC-RPM, in it's role as Benefits Issuing Authority, may terminate my Medical Hold orders when I am found Available for Full Duty (AFFD) or earlier if it is determined to be medically appropriate.
5. _____ (Initials) I have been advised of the requirement to submit an updated Physician Report form from my designated medical provider every 30 days to CG-PSC-RPM-3 via my command. I understand that failure to do so may result in the termination of benefits.
6. _____ (Initials) I have been advised that my medical care/treatment will be coordinated through my servicing clinic.
7. _____ (Initials) I understand that my request for Medical Hold orders will not be considered until this signed acknowledgement is received by CG-PSC-RPM-3.

Select one option below:

- A. _____ (Initials) If my request is approved, I consent to being retained on active duty and understand the requirements and provisions as set forth.
- B. _____ (Initials) I do not consent to being retained on Medical Hold orders. I understand that by declining, I will not receive medical care/treatment or compensation.

My current contact information is:

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____
 Email: _____

 (Signature of Member / Date)

 (Signature of Counselor / Date)

 (Printed Name of Counselor)

1. NAME OF PERMANENT UNIT		2. NAME OF UNIT PREPARING THIS FORM	
3. NAME OF MEMBER (Last, First, MI)		4. EMPLOYEE ID NUMBER.	5. GRADE/RATE
		6. PAGE 7	