

ADMINISTRATIVE REMARKS

Entry Type: Reserve Incapacitation Benefits (RIB-3)
 Reference: Reserve Policy Manual, COMDTINST M1001.28 (Series)
 Responsible Level: Unit
 Entry: _____

1. _____ Counseled this date regarding my request for reserve incapacitation benefits in the form of Active Duty
 (Date) for Health Care (ADHC) orders issued under authority of 10 U.S.C. 12322.
2. _____ I understand I may be authorized medical care for an injury/illness/disease incurred or aggravated in the
 (Initials) line of duty on _____ while performing _____ at _____.
 (DDMMYY) (Type of Duty) (Unit)
3. _____ If authorized ADHC orders, I understand that I will receive active duty pay and allowances for the
 (Initials) 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. _____ I understand that CG-PSC-RPM, in it's role as Benefits Issuing Authority, may terminate my ADHC
 (Initials) orders when I am found Available for Full Duty (AFFD) or earlier if it is determined to be medically
 appropriate.
5. _____ I have been advised of the requirement to submit an updated Physician Report form from my designated
 (Initials) 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. _____ I have been advised that my medical care/treatment will be coordinated through my servicing clinic.
 (Initials)
7. _____ I understand that my request for ADHC orders will not be considered until this signed acknowledgement
 (Initials) is received by CG-PSC-RPM-3.

Select one option below:

- A. _____ If my request is approved, I consent to being retained on active duty and understand the requirements
 (Initials) and provisions as set forth.
- B. _____ I do not consent to being retained on ADHC orders. I understand that by declining, I will not
 (Initials) 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