SOLDIER'S ACKNOWLEDGEMENT OF INCAPACITATION PAY COUNSELING

For use of this form, see DA PAM 135-381; the proponent agency is DCS, G-1.

(TO BE COMPLETED BY SOLDIER AND WITNESSED BY COMMANDER *(See NOTE below)*)

I, _____ request incapacitation pay. I fully understand and agree to the following:

(Printed name and rank)

1. That this claim for incapacitation pay cannot be processed if proper documentation is not provided by me.

2. Any payments may be reduced by reportable earned income received from any other source.

3. That I may have to repay any monies received if a later determination is made that I was not entitled to them.

4. That if I am determined unfit for military duty, I WILL NOT perform Inactive Duty Training *(drills)* or Annual Training or any other form of active duty during the period of time I am drawing incapacitation pay. This may result in my not earning a qualifying *(good)* year for retirement purposes. My unit will assist me if requested for other ways to earn points.

5. That I must receive written or verbal authorization from a military medical facility or authorized government representative BEFORE obtaining medical treatment from any civilian source or that I will be personally responsible for any charges incurred.

6. That I must submit to all medical treatment and report for medical fitness examinations and that failure to do so can result in termination or a deduction of incapacitation pay. It is my responsibility to provide all medical documentation to my unit following medical appointments associated with my injury/illness/disease. Failure to submit all medical treatment documentation including reporting for medical examinations, Physical Therapy or follow up appointments will cause a delay or cancellation of my extension of incapacitation pay.

7. That in signing this form I hereby voluntarily grant permission, in relevant part IAW the Privacy Act, 37 USC § 204 and 10 USC § 3013 to provide the government with information regarding my nonmilitary "earned income" and employment status and all medical information related to the injury, illness, or disease identified above for the purpose of substantiating the claim. I recognize that failure to provide this information will result in no payment being made.

AS THE INDIVIDUAL MAKING THE CLAIM, I UNDERSTAND THAT I AM RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION PROVIDED.

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. In relevant part, the maximum penalty for knowingly making a false claim is imprisonment for 5 years and a fine. (18 USC § 287)

SOLDIER'S SIGNATURE/DATE: _____

WITNESSED BY: _____

(COMMANDER'S PRINTED NAME, RANK, SIGNATURE AND DATE)

(NOTE: Commander must witness and sign. At JFHQ/USARC/RRC/MSC/UNIT level, the commander or individuals with "FOR THE COMMANDER" signature authority may sign.)

DA Form 7574-2 must be completed and submitted with initial Incapacitation Pay Monthly Claim Form *(DA Form 7574)*