DEPARTMENT OF HOMELAND SECURITY
U.S. COAST GUARD

ADMINISTRATIVE REMARKS

PRIVACY ACT STATEMENT

Pursuant to 5 U.S.C. §552a(e)(3), this Privacy Act Statement serves to inform you of why DHS is requesting the information on this form.

AUTHORITY: 14 U.S.C. § 505

PURPOSE: To document a USCG service member's achievements, accomplishments, Uniform Code of Military Justice (UCMJ) infraction(s), or any other USCG military pay or personnel activity.

ROUTINE USES: Authorized USCG officials will use this information to validate a USCG service member's achievements, accomplishments, UCMJ infraction(s) or any other USCG military pay or personnel activity. Any external disclosures of information within this record will be made in accordance with DHS/USCG-014, Military Pay and Personnel, 76 Federal Register 66933 (October 28, 2011).

CONSEQUENCES OF FAILURE TO PROVIDE INFORMATION: Providing this information is voluntary. However, failure to provide this information may result in a delay in administrating this form.

Entry Type: Reserve Incapacitation Benefits (RIB-2)
Reference: Reserve Duty Status and Participation Manual, COMDTINST M1001.2;
Reserve Policy Manual, COMDTINST M1001.28 (Series)
Responsible Level: Unit or SPO
Entry: I, _____, was counseled on _____ regarding my request for reserve incapacitation benefits in the form of Medical Hold (MH) orders.

1. _____ (Initials) I understand I may be authorized medical care for an injury/illness/disease incurred or aggravated in the line of duty on _____ while performing Select One: at _____.

2. _____ (Initials) I understand that if my MH request is approved, I will receive active duty pay and allowances for the duration of my orders. I also understand I must report to the duty location designated by my command, unless I have an authorized absence.

3. _____ (Initials) I understand that CG-PSC-RPM, as the Benefits Issuing Authority, may terminate my MH orders when I am found Available for Full Duty (AFFD) for my military duties or earlier if it is determined to be medically appropriate.

4. _____ (Initials) I have been advised of the requirement to submit an updated Physician Report form (CG-6300A) 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.

5. _____ (Initials) I have been advised that my medical care/treatment will be coordinated through my servicing clinic.

6. _____ (Initials) I understand that my request for MH orders will not be considered until this signed acknowledgment 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 MH orders. I understand that by declining, I will not receive medical care / treatment or compensation through the Coast Guard incapacitation system.

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

Scan original into member's OMPF