

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-3)

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 Active Duty for Health Care (ADHC) orders issued under authority of 10 U.S.C. 12322.

1. \_\_\_\_\_ I understand I may be authorized medical care for an injury/illness/disease incurred or aggravated in the line of  
(Initials) duty on \_\_\_\_\_ while performing \_\_\_\_\_ at \_\_\_\_\_.
2. \_\_\_\_\_ I understand that if my ADHC request is approved, I will receive active duty pay and allowances for the duration of my  
(Initials) orders. I also understand I must report to the duty location designated by my command, unless I have an authorized absence.
3. \_\_\_\_\_ I understand that CG-PSC-RPM, as the Benefits Issuing Authority, may terminate my ADHC orders when I am found  
(Initials) Available for Full Duty (AFFD) for my military duties or earlier if it is determined to be medically appropriate.
4. \_\_\_\_\_ I have been advised of the requirement to submit an updated Physician Report form (CG-6300A) 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.
5. \_\_\_\_\_ I have been advised that my medical care/treatment will be coordinated through my servicing clinic.  
(Initials)
6. \_\_\_\_\_ I understand that my request for ADHC orders will not be considered until this signed acknowledgment is received by  
(Initials) 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 and  
(Initials) provisions as set forth.
- B. \_\_\_\_\_ I do not consent to being retained on ADHC orders. I understand that by declining, I will not receive medical care /  
(Initials) 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**