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-5)
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 a Notice of Eligibility (NOE) for authorized evaluation purposes only.

1. _________ (Initials) I understand that the requested NOE is for medical evaluation only and DOES NOT authorize medical care or treatment of any kind. I understand if I receive medical care or treatment I will be financially responsible for all costs incurred for such care and/or treatment unless prior approval is received from CG-PSC-RPM-3.
2. _________ (Initials) I understand that although my Evaluation Only NOE request may be approved, I am not eligible for Incapacitation Pay.
3. _________ (Initials) I understand that Evaluation Only NOE recipients may request a TONO for travel and transportation expenses associated with their Evaluation Only NOE.
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 my Evaluation Only NOE benefits.
5. _________ (Initials) I have been advised that all medical evaluation will be coordinated through my servicing clinic.
6. _________ (Initials) I understand that my request for an Evaluation Only NOE 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 accept receipt of subject Evaluation Only NOE and understand the requirements and provisions as set forth.

B. _________ (Initials) I decline receipt of subject Evaluation Only NOE. I understand that by declining, I will not receive the required medical evaluation.

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