

DEVELOPMENTAL COUNSELING FORM

For use of this form, see ATP 6-22.1; the proponent agency is TRADOC.

PRIVACY ACT STATEMENT

AUTHORITY: 5 USC 301, Departmental Regulations, 10 USC 3013, Secretary of the Army.

PRINCIPAL PURPOSE: These records are created and maintained to manage the member's Army and Army National Guard service effectively, to document historically a member's military service, and safeguard the rights of the member and the Army.

NOTE: For additional information, see the System of Records Notice A0600-8-104b AHRC, <https://dpcl.dod.mil/Privacy/SORNSIndex/DOD-wide-SORN-Article-View/Article/570051/a0600-8-104b-ahrc/>.

ROUTINE USE(S): There are no specific routine uses anticipated for this form; however, it may be subject to a number of proper and necessary routine uses identified in the system of records notice specified in the purpose statement above.

DISCLOSURE: Disclosure is voluntary.

PART I - ADMINISTRATIVE DATA

Name (Last, First, MI)	Rank/Grade	Date of Counseling
Organization	Name and Title of Counselor	

PART II - BACKGROUND INFORMATION

Purpose of Counseling: (Leader states the reason for the counseling, e.g. Performance/Professional/Event-Oriented counseling, and include the leader's facts and observations prior to the counseling.)

Approach: Non Directive Combined Directive

Type of Counseling: General Form Professional Growth Performance Event Oriented

SUBJECT: Line of Duty Investigation Information and Procedures

MAIN OBJECTIVES: Inform Soldier of their rights, responsibilities, expectations, and unit points of contact regarding the Line of Duty Investigation Procedures

PART III - SUMMARY OF COUNSELING

Complete this section during or immediately subsequent to counseling.

Key Points Discussion:

You sustained an injury / illness / disease while in a (circle one and initial) IDT / ADT / ADOS / AT / RMA / IADT / FTNGD-OS / T-10 status.

If the situation allows, you are required to seek medical treatment, evaluation, and follow-on care at a Military Treatment Facility (MTF). Should you elect to seek care at a non-MTF, you may be responsible for costs associated with seeking care.

You are required to report your injury to your Company Commander (_____) and encouraged to remit a completed copy your DA Form 2173 (Statement of Medical Evaluation and Duty Status), completed by the attending physician/hospital patient administrator NLT 5 days after sustaining the injury. It is encouraged that you include a copy of your relevant medical records with the DA Form 2173. Failure to notify your command within the required time will impede the timely processing of any potential Line of Duty (LOD) Investigation and other administrative actions necessary to ensure you can receive any required follow-on care at government expense. Should you neglect to report your injury in a timely manner, you have 180 calendar days from the end of the qualified duty status to request an LOD determination for the purpose of determining eligibility for medical and dental treatments and incapacitation pay entitlements.

You are encouraged to provide a verbal or written statement detailing the events leading up to your injury/illness/disease, however you are within your legal rights to decline to do so.

Please note, incurring an injury during an "authorized status" does not necessarily support a determination that the injury/illness/disease was sustained "In the Line-Of-Duty" in and of itself.

OTHER INSTRUCTIONS

This form will be destroyed upon: reassignment (other than rehabilitative transfers), separation at ETS, or upon retirement. For separation requirements and notification of loss of benefits/consequences see local directives and AR 635-200.

Plan of Action (Outlines actions that the subordinate will do after the counseling session to reach the agreed upon goal(s). The actions must be specific enough to modify or maintain the subordinate's behavior and include a specified time line for implementation and assessment (Part IV below).)

1. I understand that am encouraged to seek medical care at a Military Treatment Facility (MTF), if the situation allows. Should I opt to seek care at a non-MTF (unless authorized with a MMSO-01 or MMSO-02), I may be held financially responsible for expenses incurred as they are related to my injury/illness/disease.

2. I will provide a copy of my DA Form 2173 (section I completed by the attending physician or hospital patient administrator) to my Company Commander NLT 5 days following the incident.

3. I have been encouraged to provide copies of my relevant medical records as supporting documentation regarding the injury/illness/disease I sustained and the care I received NLT 5 days following the incident.

4. I have been informed of my right to decline to provide a statement or written correspondence detailing the events leading up to my injury/illness/disease.

5. I understand that incurring an injury during an "authorized status" does not necessarily support a determination that the injury/illness/disease was sustained "In the Line-Of-Duty" in and of itself.

6. I understand failure to notify my command within the suggested time will impede the timely processing of any potential Line of Duty (LOD) Investigation and other required administrative actions. I have 180 days from the end of the qualified duty status to request a LOD determination for the purpose of determining eligibility for medical and dental treatments and incapacitation pay entitlements.

7. A request for a LOD determination does not automatically entitle me to receive treatment. I will be instructed, in WRITING, by my assigned Medical Case Manager to attend any scheduled follow-on appointments related to the initiating injury/illness/disease.

Session Closing: (The leader summarizes the key points of the session and checks if the subordinate understands the plan of action. The subordinate agrees / disagrees and provides remarks if appropriate.)

Individual counseled: I agree disagree with the information above.

Individual counseled remarks:

As the individual making the claim, I understand I am responsible for the accuracy of the information provided. I also understand failure to fulfill the above requirements may result in the termination of any Line of Duty (LOD) Investigation or subsequent administrative actions. The penalty for willfully making a false claim is punishable by a maximum fine of \$10,000, imprisonment for five (5) years, or both.

Signature of Individual Counseled:	DATE (YYYYMMDD):
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Leader Responsibilities: (Leader's responsibilities in implementing the plan of action.)

1. I will inform the above Soldier of all upcoming suspense dates to ensure the timely submission of this request.

2. I will abide by HIPAA and U.S. Privacy Laws with regards to the handling of the above Soldier's medical records and administrative documents.

Signature of Counselor:	Date (YYYYMMDD):
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PART IV - ASSESSMENT OF THE PLAN OF ACTION

Assessment: (Did the plan of action achieve the desired results? This section is completed by both the leader and the individual counseled and provides useful information for follow-up counseling.)

SIGNATURES

Counselor:	Individual Counseled:	Date of Assessment (YYYYMMDD):
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Note: Both the counselor and the individual counseled should retain a record of the counseling.