(Updated 20260911)

RESERVE COMPONENT (RC) STATEMENT OF ELIGIBILITY FOR HEALTHCARE EVALUATION AND TREATMENT

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C 136, Under Secretary of Defense for Personnel and Readiness; 10 U.S.C. 1074, Medical and dental care for members and certain former members; and DoWI 1241.01, Reserve Component (RC) Line of Duty Determination for Medical and Dental Treatments and Incapacitation Pay Entitlements.
PURPOSE: To provide required information for Reserve Component Service Member's (RCSM) to obtain medical and dental treatment for an injury, illness, or disease that was incurred or aggravated while in a qualified duty status and that is not the result of gross negligence or misconduct.
ROUTINE USES: Disclosure of records are generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended. To permit the disclosure of records to the HHS and its components, other federal agencies, and academic institutions for the purposes of public health activities and conducting research, including to facilitate collaborative research activities. Additional routine uses are listed in the applicable System of Records Notice, EDHA 07, Military Health Information System at: **https://pclt.defense.gov/Portals/140/Documents/Privacy/SORNs/DHA/EDHA-07.pdf**
DISCLOSURE: Voluntary; however, failure to complete the form may result in inability to obtain medical and dental treatment and evaluation or submit through the appropriate Defense Health Agency (DHA) office for medical and dental treatment with a civilian provider using the Supplemental Health Care Program.

1. NAME AND GRADE OF RC SERVICE MEMBER (RCSM) *(Last, First, and Middle Initial)*	2. DOD ID NUMBER	3. DATE OF BIRTH *(YYYYMMDD)*

4. RCSM RESIDENTIAL ADDRESS, PHONE NUMBER, EMAIL ADDRESS	5. BRANCH OF SERVICE
☐ same as home of record _____ Miles from Military Medical Treatment Facility	☐ USAR ☐ USNR ☐ USMCR ☐ USAFR ☐ ARNG ☐ ANG ☐ USCGR ☐ USSF

6. RC SERVICE MEMBER (RCSM) DUTY STATUS

ORDERS ☐ 30 DAYS OR LESS ☐ FUNERAL HONORS

INACTIVE DUTY TRAINING: DATE/TIME BEGAN: _____ END: _____

7. ORGANIZATION/UNIT NAME/ADDRESS/PHONE

8. DETAILS OF INCIDENT - REMARKS *(If additional space is needed, continue on reverse and/or attach enclosures as necessary.)*

DESCRIPTION OF ACCIDENT/INCIDENT OR ILLNESS:

Date/Time: _____ Location: _____ OCCURRED: DIRECTLY ☐ TO ☐ FROM ☐ DURING Duty

9. DATE *(YYYYMMDD)*	10. NAME OF COMMANDER OR DESIGNEE AND CONTACT INFORMATION THAT CAN VERIFY DETAIL AND DUTY STATUS

11. SIGNATURE

COMPLETED BY MILITARY TREATMENT FACILITY OR CIVILIAN PROVIDER OR SUPPORT STAFF

12. NAME and LOCATION OF HOSPITAL OR TREATMENT FACILITY ☐ CIVILIAN ☐ MILITARY

13. HOUR AND DATE EXAMINED: _____	14. RCSM WAS:	15. MEDICAL RECORDS
NATURE AND EXTENT OF ☐ INJURY ☐ ILLNESS ☐ DISEASE	☐ ADMITTED	☐ ATTACHED
CONDITION EXISTED PRIOR TO START OF CURRENT DUTY? ☐ YES ☐ NO	☐ OUTPATIENT	☐ TRANSMITTED ELECTRONICALLY

16. ICD 10 CODE (S) / DIAGNOSIS:

17. MEDICAL OPINION ***(Must be completed by a Physician, Physician Associate or Nurse Practitioner)***

a. RCSM ☐ **WAS** ☐ **WAS NOT** UNDER THE INFLUENCE OF ☐ ALCOHOL ☐ DRUGS *(Specify)* _____ ☐ UNKNOWN

b. DRUGS OR ALCOHOL ☐ **MAY** ☐ **MAY NOT** HAVE RESULTED IN THE RCSM INJURY, ILLNESS, DISEASE ☐ UNKNOWN

BLOOD TEST DONE? ☐ **YES** ☐ **NO** (If Yes: Number of MG ALCHOL/100 ML BLOOD: _____)

DRUG SCREEN DONE? ☐ **YES** *(attach results)* ☐ **NO** ☐ UNKNOWN

c. INJURY ☐ **IS** ☐ **IS NOT** LIKELY TO REQUIRE FOLLOW-ON CARE. ☐ UNKNOWN

Expected Follow-On Care or Evaluation: _____

18. DATE *(YYYYMMDD)*	19. NAME, GRADE, CREDENTIALS OF PROVIDER OR SUPPORT STAFF COMPLETING (13-17).	20. SIGNATURE

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ADDITIONAL SPACE *(if needed)*