CERTIFICATION OF ELIGIBILITY
HEALTH PROFESSIONALS BOARD
CERTIFICATION PAY (BCP) FOR RESERVE
COMPONENT (All AFSCs -- Non-Flight Surgeons)[1]

1. ACKNOWLEDGMENT

I,_____hereby apply for participation in the Reserve Component BCP Program for Health Professions Officers in the in the Selected Reserve of the United States Air Force (USAF) under the authority of 37 USC § 335g. In support of this application, I acknowledge the following:

1.1. I meet the following eligibility criteria:

1.1.1. I am serving in an active status in the medical specialty (AFSC)[2] of the board certification.

1.1.2. I am entitled to basic pay under 37 USC § 204 or compensation under 37 USC § 206.

1.1.3. I possess a current valid and unrestricted health professional license(s)/certification and such additional credentials and privileges as required to practice in my area of specialty.

1.1.4. I am not receiving any BCP for the same skill and period of service under 37 USC § 353.

1.1.5. I possess a post-baccalaureate degree in a clinical specialty or acceptable post-Master's certificate.

1.1.6. I am certified by a professional board in the designated health profession clinical specialty identified in Attachment 1 of the Reserve Component Health Professions Special & Pay (HPS&I) Pay Plan.

1.2. I understand that the Reserve Component BCP Program shall apply to me, as follows:

1.2.1. I shall be entitled during the period of certification of eligibility to BCP based on an annual amount of $_____pro-rated at the rate of 1/30th of the monthly rate for any period in which I am entitled to basic pay pursuant to 37 USC § 204 or 37 USC § 206. I understand this payment shall be based on my duties performed in the specialty. This certification of eligibility shall apply for 1 year from the date of the member's signature. I further certify that I performed eligible duty for pay on these dates:

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[1] Certification of eligibility is to be used for all AFSCs except: 48A, 48G, and 48R

[2] IAW the Reserve Component HPS&I Pay Plan, BCP amounts for clinical specialty are listed in Attachment 1 (refer to applicable tables)

_____ (list dates).

1.2.2. I understand if my qualifying certification expires, it is my responsibility to inform ARPC/DPA to initiate stop-payment and recoupment action. I am responsible to repay all payments received beginning on the day after the expiration date of my qualifying certification status. Loss of eligibility, loss of license, or loss of certification terminates this certificate of eligibility and payments received during the ineligible period will be recouped immediately. Separation/assignment from the SELRES will terminate this certification of eligibility.

1.3. I understand that my entitlement under this program continues unless or until I do one of the following:

1.3.1. Fail to maintain a current or unrestricted valid health professional license(s)/certification, and such additional credentials and privileges as required to practice in my area of specialty.

2. UNDERSTANDING

I have read this document in its entirety and understand that the statements herein constitute all promises, representations concerning my BCP entitlement. No other promise, representation, or commitment has been made to me under this certification of eligibility.

3. AUTHENTICATION

3.1. Name and grade of applicant_____

3.2. Signature of applicant and date_____

HQ ARPC/DP:

3.3. Name and grade of Service representative_____

3.4. Signature and date_____