INCENTIVE PAY/BCP APPLICATION
(Complete fully and submit to HQ ARPC/DPAMM)

NAME: RANK: SSN: AFSC:

E-MAIL: HOME PH: WORK PH: .

IMA ***Traditional Unit Reservist*** ***ANG*** (mark one please)

Pay Office Location _____ POC: _____

AUTHORITY*: Title 37 U.S.C. 335 Special bonus and incentive pay authorities for officers in Reserve health profession. Fiscal Year Health Professions Special and Incentive (HPS&I) Pay Plan.* ***PURPOSE****: To authorize health professional special pays.* ***ROUTINE USES****: None.* ***DISCLOSURE****: Disclosure of SSN is voluntary. However, this form will not be processed without your SSN, since the Air Force identifies members by SSN for pay purposes.*

I hereby request Health Professions (HP) Officer Special Pays under the authority above.

INCENTIVE PAY (IP): Paid in monthly increments for HP officers performing duty. IP payment and amounts are based on the Active Component (AC) FY19 HPS&I Pay Plan for the clinical Air Force Specialty.

I hereby certify that:

_____ I am entitled to basic pay under 37 USC 204 or 37 USC 206 (IDTs and active duty).

_____ I have executed a written agreement (attachment from current FY pay plan).

_____ I am fully qualified and serving in the AFSC for which IP will be paid.

I qualify for IP for AFSC: _____ for the amount of: $_____

BOARD CERTIFICATION PAY (BCP): Paid in monthly increments for HP officers performing duty. BCP amounts are based on the Active Component (AC) FY19 HPS&I Pay Plan for the clinical Air Force Specialty.

I hereby certify that:

_____ I am entitled to basic pay under 37 USC 204 or 37 USC 206 (IDTs and active duty).

_____ I am serving in the specialty for which BCP is being paid.

_____ I have a post-baccalaureate degree in the clinical specialty or acceptable post-Master's certificate.

_____ I am certified by a professional board in a designated HP clinical specialty as identified in the current HPS&I Pay Plan.

_____ I possess and will maintain a current, valid, unrestricted license (or an approved waiver) and such credential and privileges as required to practice in my area of specialty.

I qualify for BCP for AFSC: _____ for the amount of: $ _____

CONDITIONS OF APPLICATION. I understand that:

a. The appropriate Air Force officials must approve this application.

b. My entitlement to any of the above special pays under this application will terminate for any of the following reason: The Surgeon General so directs for reasons that include, but are not limited to, military or medical unprofessional conduct, substandard performance (includes de-credentialing matters or suspension/loss of clinical privileges), incompetence, noncompliance with Air Force standards, Courts Martial convictions, UCMJ violations, failure to maintain a current, unrestricted license, or reasons that are in the best interest of the Air Force.

c. I am entitled to IP/BCP only for the actual period of IDTs/active duty and must refund any amount in excess of that entitlement.

_____ _____

(Member's Signature/Rank/SSN) (Date)

Attachments:

1. Copy of current, valid, unrestricted state medical license and board certification, as applicable
2. Written Agreement for BCP (if applicable)
3. Written Agreement for IP (if applicable)
4. Post-baccalaureate degree in clinical specialty or acceptable post-Master's Certificate (if requesting BCP)

Note: this application cannot be processed without the above attachments.

1st Indorsement, Program Manager (IMAs only) or Unit Commander (as applicable)

MEMORANDUM FOR: HQ ARPC/DPAMM
Attention: Special Pay Manager
18420 E Silver Creek Ave Bldg 390 MS68
Buckley AFB CO 80011

Recommend approval / disapproval.

This member is eligible as indicated above for applicable special pays. I have verified the information contained in this application. I certify that member possesses a current, valid, unrestricted State medical license and this member is in compliance with the conduct, competence, and standards expected by the Air Force.

_____ _____

Signature of Program Manager or Unit Commander (Date)

_____ _____

Printed Name/Rank of PM/CC Unit Phone Number

_____ _____

PM/CC E-mail Address Unit Designation