SAMPLE MEMBER REQUEST FOR RETROACTIVE RB/IP

 7220

 Date

From: LCDR John L. Doe, MC, USN

To: BUMED, Director, Total Force

Via: Commanding Officer, Naval Hospital, Guam

Subj: REQUEST FOR RETROACTIVE ACTIVE DUTY AGREEMENT FOR HEALTH PROFESSIONS OFFICER RETENTION BONUS/INCENTIVE PAY (RB/IP)

Ref: (a) OPNAVINST 7220.17A

 (b) NAVADMIN (current FY)

1. I hereby apply for Retention Bonus and Incentive Pay (RB/IP) effective \_\_\_\_\_\_\_\_\_\_\_\_\_\_, for the Health Professions Officer (HPO) specialty of \_\_\_\_\_\_\_\_\_\_\_\_ per references (a) and (b).

2. If my application for RB/IP is approved, I agree to not tender a resignation or request release from active duty that would become effective during this RB/IP service obligation. This obligation shall be for a period of \_\_ years beyond any existing active military service obligation for education or training. This obligation entitles me to Retention Bonus (RB) of $\_\_\_\_\_\_\_ and Incentive Pay (IP) of $\_\_\_\_\_\_\_\_\_\_\_\_\_ per year for \_\_ years as a “Specialty Requesting For”.

3. I understand, and agree to be bound by the provisions of this agreement and references (a) and (b) relating to termination of payments to be made under this agreement, termination of this service obligation and the circumstances under which recoupment of sums paid by the Government may be required. Specifically, I understand that per references (a) and (b), Chief, BUMED may terminate at any time my entitlement to RB/IP. Reasons for termination include but are not limited to loss of privileges, Courts Martial convictions, violations of the Uniform Code of Military Justice, failure to meet or maintain eligibility requirements, or for reasons that are in the best interest of the Navy.

4. I understand that BUMED, Director, Total Force shall validate my eligibility for RB/IP. If it is determined that I do not meet the eligibility requirements, this application shall be returned with no action taken and I may reapply at a later date if eligibility changes.

5. I understand that BUMED, Director, Total Force shall validate the total amount of RB/IP for which I am qualified and determine my RB/IP service obligation. If it is determined that the amount of RB/IP due or the RB/IP service obligation differs from what I calculated, I (shall/shall not) accept the determination of BUMED, Director, Total Force. If I do not accept such determination, I shall notify BUMED, Director, Total Force in writing within ten days of receipt. My application shall be returned with no action taken, and I will be free to reapply at a later date.

Subj: REQUEST FOR ACTIVE DUTY AGREEMENT FOR HEALTH PROFESSIONS

 OFFICER RETENTION BONUS/INCENTIVE PAY (RB/IP)

6. I understand that this contract is binding upon my acceptance of the approved agreement approval and receipt of the first payment. The fiscal year this RB/IP contract is effective shall determine my Incentive Pay (IP) dollar amount for the duration of the RB/IP contract.

7. The following information is provided and certified to be true and accurate.

 Most Recent Training Completion Date: YYMMDD

 Specialty for which request is made: YYMMDD

 Obligated Service Date for Education or Training: YYMMDD

 Name of Special Pay Coordinator:

 Telephone Number for Special Pay Coordinator:

 E-mail address for Special Pay Coordinator:

 Unit Identification Code (UIC):

 J. L. DOE