

VOLUNTEER ASSISTANT INFORMATION SHEET

1. Information. WWR has agreed to fund an Individual Travel Authorization (ITA) for you while you help care for your Marine. This ITA is approved with the understanding that you are serving as a Volunteer Assistant for the Federal Government. Procedures for requesting ITAs and authorized expenses are provided in this Policy Letter.

2. Requesting ITAs. The Patient Affairs Team (PAT) where your Marine is located will assist you with completing the ITA request. This request is approved by the Wounded Warrior Regiment in 30 day increments.

3. Information

a. Your Marine is authorized only one Volunteer Assistant at a time. See WWR Policy Letter 3-09, paragraph 4c, for exceptions to having two Volunteer Assistants assigned.

b. Only one round trip to and from your residence is authorized per individual.

c. While in a Volunteer Assistant status, you will be receiving per diem. The per diem allowance is a daily allowance that is paid instead of the actual expenses for lodging, meals, and related incidental expenses (M&IE). The per diem allowance is distinguished from transportation and other miscellaneous travel expenses and covers charges, including taxes and service charges applicable. The following types of expenses are authorized:

(1) Lodging. The term "lodging" includes expenses for overnight sleeping facilities and personal use of the room during the daytime. It does not include accommodations on airplanes, trains, buses, or vessels. Such cost is included in the transportation cost and is not considered a lodging expense.

(2) Meals. Includes the cost of breakfast, lunch, dinner, and all taxes; specifically excluded are alcoholic beverages and entertainment expenses, and any expenses incurred for other persons.

(3) Incidental Expenses. Expenses that are not reimbursable include:

(a) Fees and tips to bellhops, housekeepers, porters, and baggage persons in hotels, stewards or flight attendants and others on vessels and hotel servants.

(b) Service charges for fans, air conditioners, and heaters furnished in rooms when the charges are not included in the room rate.

(c) Telegrams and telephone calls necessary to reserve lodging accommodations.

(d) Mailing costs associated with filing travel vouchers and payment of Government Travel Charge Card bills.

(e) Local transportation, including usual tips, between places of lodging or duty and place where meals are taken, when not otherwise reimbursable under Chapters 3 and 4, Part F of the JFTR.

(4) Lodging Other than Motel/Hotel. If you will be leasing an apartment, house, or trailer, a lease agreement must be submitted. The lease must provide the time period that the lease is in effect, the monthly lease amount, and other items included in the lease. A receipt for payment of the lease must be submitted with the lease. The lease must be submitted with each partial settlement.

(5) Allowable Expenses

(a) Parking space fees.

(b) Appropriate and necessary furniture, such as stove, refrigerator, chairs, tables, beds, sofas, television, and vacuum cleaner. Some rental agreements include options-to-buy clauses that result in the renter owning the rental items listed in the lease. A traveler may be reimbursed for the cost of such a rental agreement (i.e., cost of furniture rental as part of the lodging cost) while in a traveler status if the traveler has no other choice but to enter into such an agreement. However, if the traveler exercises the purchase option, the amount that is being credited toward the purchase must be returned to the Government by the traveler if paid to the traveler as part of the travel claim settlement.

(c) Connection, use, and disconnection cost of utilities, including electricity, natural gas, water, fuel oil, and sewer charges.

(d) Dumping fees.

(e) Shower fees.

(f) Maid fees and cleaning charges.

(g) Monthly telephone use fees (does not include installation charges and unofficial long distance calls). When a personally owned cellular phone is used in lieu of an installed phone, the monthly cell phone fee may not be claimed.

(i) The costs of special user fees such as cable TV charges and plug-in charges for automobile head bolt heaters, if ordinarily included in the price of a hotel/motel room in the area concerned.

d. You must complete a supplemental travel voucher every 30 days. Your PAT representative will assist you with completing this voucher.

e. You must also complete a final travel voucher when you complete your travel back to your residence.

4. Any questions regarding your orders or travel vouchers, please contact your PAT representative.

ACKNOWLEDGEMENT:



Volunteer Assistant



PAT Representative



UNITED STATES MARINE CORPS
 WOUNDED WARRIOR BATTALION-EAST
 PSC BOX 20008
 CAMP LEJEUNE, NORTH CAROLINA 28542-0008

IN REPLY REFER TO:
 7200
 OIC
 15 JUN 15

MEMORANDUM

From: (Attending Physician/Surgeon)
 To: Officer in Charge, Marine Detachment BETHESDA

Subj: COMPETENT MEDICAL AUTHORITY CERTIFICATION FOR REQUEST FOR NON-MEDICAL ATTENDANT ORDERS

1. Marine's Information

<u>LCPL</u>	<u>SMITH</u>	<u>JOHN</u>	<u>A</u>	<u>123-45-6789</u>
Rank	LName	FName	MI	SSN

2. Request Non-Medical Attendant orders for the below named family member to assist with the recovery of the above named Marine who is receiving outpatient treatment at WRAMMC BETHESDA for rehabilitation.

<u>SMITH</u>	<u>JANE</u>	<u>B</u>	<u>987-654321</u>
LName	FName	MI	SSN

3. If the Marine is able to independently perform activities of daily living (ADL), no non-medical assistance is required. Assistance is needed if one or more ADLs are checked. Which of the following functions cannot be INDEPENDENTLY performed by the Marine?

- Bathing Dressing Toileting Eating Continence
 Transfer Other _____

4. Provide Marine's diagnosis, prognosis, and the projected duration of the Non-Medical Attendant:

- a. Diagnosis: TBI
 b. Prognosis: GDDP
 c. Duration of Non-Medical Attendant: 180 Days _____ Weeks _____ Months

5. Member requires more than one Non-Medical Attendant: Yes No

If yes, provide justification: _____

6. Casualty Status: VSI SI NSI

Subj: COMPETENT MEDICAL AUTHORITY CERTIFICATION FOR REQUEST FOR NON-MEDICAL ATTENDANT ORDERS

7. The point of contact for this Memorandum is Rank FName MI. LName at (xxx) xxx-xxxx.

Bob Brown / LT
Printed Physician's Name/Rank

~~~~~  
Physician's Signature

555-525-1234  
Phone Number

\* Letter must be signed by a physician.

\* The request and recommendation for more than one NMA shall be submitted to the WWR Headquarters (S-1) in writing, signed by the attending physician/surgeon, and the military medical facility commander, clearly outlining the necessity of the NMAs.

WWBn-E OIC Non-Medical Attendant Acknowledgement

Location: WALTER REED DET, WWBn East

Patient Name: LCPL JOHN SMITH

Date Marine counseled on the Non-Medical Attendant Program: 20150615

I have confirmed that the following have been verified:

- Request for Non-Medical Attendant meets the rules and regulations per the JTFR.
- A Non-Medical Attendant is required and recommended by a competent medical authority.
- Non-Medical Attendant has been briefed on the Volunteer Agreement and is authorized reimbursable expenses.
- That the Non-Medical Attendant has not executed orders prior to the approval by appropriate authority.

OIC Signature: 

Date: 20150615

**VOLUNTEER AGREEMENT FOR**

**APPROPRIATED FUND ACTIVITIES**       **NONAPPROPRIATED FUND INSTRUMENTALITIES**


**PART I - GENERAL INFORMATION**

|                                                                                                                                                                 |                                                                         |                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------|
| <b>1. TYPED NAME OF VOLUNTEER</b> <i>(Last, First, Middle Initial)</i><br>SMITH, JANE B                                                                         |                                                                         | <b>2. YEAR OF BIRTH</b><br>1985   |
| <b>3. INSTALLATION</b><br>WRNNMC BETHESDA, MD                                                                                                                   | <b>4. ORGANIZATION/UNIT WHERE SERVICE OCCURS</b><br>WWBN-E DET BETHESDA |                                   |
| <b>5. PROGRAM WHERE SERVICE OCCURS</b><br>WOUNDED WARRIOR*                                                                                                      | <b>6. ANTICIPATED DAYS OF WEEK</b><br>7                                 | <b>7. ANTICIPATED HOURS</b><br>24 |
| <b>8. DESCRIPTION OF VOLUNTEER SERVICES</b><br>CARE AND ASSISTANCE FOR WUNDED/INJURED/ ILL MARINE <u>LCPL JOHNA. SMITH 6789</u><br>(RANK FNAME MI LNAME LAST 4) |                                                                         |                                   |

**PART II - VOLUNTEER IN APPROPRIATED FUND ACTIVITIES**

**9. CERTIFICATION**

I expressly agree that my services are being provided as a volunteer and that I will not be an employee of the United States Government or any instrumentality thereof, except for certain purposes relating to compensation for injuries occurring during the performance of approved volunteer services, tort claims, the Privacy Act, criminal conflicts of interest, and defense of certain suits arising out of legal malpractice. I expressly agree that I am neither entitled to nor expect any present or future salary, wages, or other benefits for these voluntary services. I agree to be bound by the laws and regulations applicable to voluntary service providers and agree to participate in any training required by the installation or unit in order for me to perform the voluntary services that I am offering. I agree to follow all rules and procedures of the installation or unit that apply to the voluntary services I will be providing.

|                                                                                                                         |                                              |                                  |
|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|----------------------------------|
| <b>a. SIGNATURE OF VOLUNTEER</b><br> | <b>b. DATE SIGNED (YYYYMMDD)</b><br>20150615 |                                  |
| <b>10.a. TYPED NAME OF ACCEPTING OFFICIAL</b><br><i>(Last, First, Middle Initial)</i>                                   | <b>b. SIGNATURE</b>                          | <b>c. DATE SIGNED (YYYYMMDD)</b> |

**PART III - VOLUNTEER IN NONAPPROPRIATED FUND INSTRUMENTALITIES**

**11. CERTIFICATION**

I expressly agree that my services are being provided as a volunteer and that I will not be an employee of the United States Government or any instrumentality thereof, except for certain purposes relating to compensation for injuries occurring during the performance of approved volunteer services and liability for tort claims as specified in 10 U.S.C. Section 1588(d)(2). I expressly agree that I am neither entitled to nor expect any present or future salary, wages, or other benefits for these voluntary services. I agree to be bound by the laws and regulations applicable to voluntary service providers, and agree to participate in any training required by the installation or unit in order for me to perform the voluntary services that I am offering. I agree to follow all rules and procedures of the installation or unit that apply to the voluntary services that I am offering.

|                                                                                       |                                  |                                  |
|---------------------------------------------------------------------------------------|----------------------------------|----------------------------------|
| <b>a. SIGNATURE OF VOLUNTEER</b>                                                      | <b>b. DATE SIGNED (YYYYMMDD)</b> |                                  |
| <b>12.a. TYPED NAME OF ACCEPTING OFFICIAL</b><br><i>(Last, First, Middle Initial)</i> | <b>b. SIGNATURE</b>              | <b>c. DATE SIGNED (YYYYMMDD)</b> |

**PART IV - TO BE COMPLETED AT END OF VOLUNTEER'S SERVICE BY VOLUNTEER SUPERVISOR**

|                                                                               |                 |                |                 |                      |                                           |
|-------------------------------------------------------------------------------|-----------------|----------------|-----------------|----------------------|-------------------------------------------|
| <b>13. AMOUNT OF VOLUNTEER TIME DONATED</b>                                   |                 |                |                 | <b>14. SIGNATURE</b> | <b>15. TERMINATION DATE</b><br>(YYYYMMDD) |
| <b>a. YEARS</b> <i>(2,087 hours=1 year)</i>                                   | <b>b. WEEKS</b> | <b>c. DAYS</b> | <b>d. HOURS</b> |                      |                                           |
| <b>16.a. TYPED NAME OF SUPERVISOR</b><br><i>(Last, First, Middle Initial)</i> |                 |                |                 | <b>b. SIGNATURE</b>  | <b>c. DATE SIGNED (YYYYMMDD)</b>          |

**MANPOWER AND RESERVE AFFAIRS DEFENSE TRAVEL SYSTEM REQUEST FOR INFORMATION**

(Read Privacy Act Statement before signing)

**PRIVACY ACT STATEMENT**

In accordance with the Privacy Act of 1974 (Public Law 93-579), this notice informs you of the purpose for collection of information on this form. Please read it before completing the form.

**AUTHORITY:** 5 U.S.C. 5707 and implementing Federal Travel Regulation, 41 CFR 300-304, 5 U.S.C. 5738, E.O. 11609, 36 CFR 13747 (1971), 31 U.S.C. 1348, Public Law 107-56 Sec. 326. and E.O. 9397 (SSN).

**PRINCIPAL PURPOSE** To assemble in one system information to provide government agencies with (1) Necessary information on the commercial travel and transportation payment and expense control system which provides travelers charge cards and the agency an account number for official travel and related travel expenses on a worldwide basis; (2) attendant operational and control support, and (3) management information reports for expense control purposes. The information collected on this form will be filed within a Privacy Act Systems of Records collection governed by Privacy Act System of Records Notice GSA/GOVT-3, which can be downloaded at [http://privacy.defense.gov/govwide/gsa\\_govt-3.shtml](http://privacy.defense.gov/govwide/gsa_govt-3.shtml).

**RETENTION AND SAFEGUARDS:** Paper records are stored in lockable file cabinets or secured rooms. Electronic records are protected by passwords, access codes, and entry logs. There is restricted access to credit card account numbers, and information is released only to authorized users and officials on a need-to-know basis. Records are filed by name, Social Security Number, and/or credit card number. Records are kept for 3 years and then destroyed, as required by the General Records Retention Schedules issued by the National Archives and Records Administration (NARA).

**ROUTINE USES:** To various officials outside the Department of Defense specifically identified as a Routine Use in Privacy Act System of Records Notice GSA/GOVT-3 for the stated specific purpose in addition to those set out in the blanket routine uses established by the Department of Defense Privacy Office and posted at <http://www.defenselink.mil/privacy/notices/blanket-uses.html>.

**DISCLOSURE:** Providing information on this form is mandatory. Failure to furnish personally identifiable information may negate the application.

|                     |                     |          |                     |
|---------------------|---------------------|----------|---------------------|
| SSN:<br>987-65-4321 | First Name:<br>JANE | MI:<br>B | Last Name:<br>SMITH |
|---------------------|---------------------|----------|---------------------|

Organization/Branch:  
WOUNDED WARRIOR BATTALION - EAST, DET BETHESDA

|                                     |                                                                                     |                       |               |
|-------------------------------------|-------------------------------------------------------------------------------------|-----------------------|---------------|
| Work E-Mail:<br>JSMITH123@gmail.com | Gender:<br><input type="checkbox"/> Male <input checked="" type="checkbox"/> Female | Civ/Mil Grade:<br>CIV | Rank:<br>LCPL |
|-------------------------------------|-------------------------------------------------------------------------------------|-----------------------|---------------|

|                              |                   |              |                    |
|------------------------------|-------------------|--------------|--------------------|
| Home Address:<br>123 MAIN ST | City:<br>QUANTICO | State:<br>VA | Zip Code:<br>22134 |
|------------------------------|-------------------|--------------|--------------------|

|                                 |                                                         |
|---------------------------------|---------------------------------------------------------|
| Home Phone #:<br>(555) 123-4554 | Emergency Name and Phone #:<br>JOE SMITH (555) 123-5445 |
|---------------------------------|---------------------------------------------------------|

|                                  |                                     |
|----------------------------------|-------------------------------------|
| Duty Station:<br>WRNMMC BETHESDA | Reporting Unit Code (RUC):<br>30002 |
|----------------------------------|-------------------------------------|

|                                                                  |                           |
|------------------------------------------------------------------|---------------------------|
| Duty Station Address:<br>8901 ROCKVILLE PIKE, BETHESDA, MD 20889 | Work Phone #:<br>555-6123 |
|------------------------------------------------------------------|---------------------------|

|                                  |                         |
|----------------------------------|-------------------------|
| Government Charge Card #:<br>N/A | Expiration Date:<br>N/A |
|----------------------------------|-------------------------|

|                                                                                        |                                 |                      |
|----------------------------------------------------------------------------------------|---------------------------------|----------------------|
| <input checked="" type="checkbox"/> Checking<br>OR<br><input type="checkbox"/> Savings | 9 Digit Routing #:<br>987654321 | Account #:<br>111123 |
|----------------------------------------------------------------------------------------|---------------------------------|----------------------|

|                                                                                                   |                          |
|---------------------------------------------------------------------------------------------------|--------------------------|
| Signature:<br> | Date Signed:<br>20150615 |
|---------------------------------------------------------------------------------------------------|--------------------------|



## VOLUNTEER ASSISTANT CHECKLIST

(Read Privacy Act Statement before completing)

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### MEMBER'S INFORMATION

|                                                                                                                      |                                  |                 |                                                 |                      |
|----------------------------------------------------------------------------------------------------------------------|----------------------------------|-----------------|-------------------------------------------------|----------------------|
| 1. Name<br>SMITH, JOHN                                                                                               |                                  | 2. Rank<br>LCPL | 3. Last 4 SSN/MOS<br>6789/0311                  | 4. Date<br>15-Jun-15 |
| 5. EAS<br>06-Jun-16                                                                                                  | 7. Home of Record<br>QUANTICO VA |                 | 8. Name of Hospital/Location<br>WRNMMC BETHESDA |                      |
| 6. Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                       |                                  |                 |                                                 |                      |
| 9. Member's Status? <input type="checkbox"/> NSI <input type="checkbox"/> VSI <input checked="" type="checkbox"/> SI |                                  |                 |                                                 |                      |

### ATTENDANT'S INFORMATION

|                                                              |  |                                                                                                           |                                                                           |
|--------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|
| 10. Name of Attendant<br>JANE SMITH                          |  | 11. Final ITO Closed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Date: 15-May-15 | 12. <input checked="" type="checkbox"/> NMA <input type="checkbox"/> VNMA |
| 13. Address of Attendant<br>123 MAIN ST<br>QUANTICO VA 22134 |  | 14. Destination<br>BETHESDA MD                                                                            |                                                                           |
| 15. Date of Birth (MM/DD/YYYY) 01/01/1985                    |  |                                                                                                           |                                                                           |

\* Please fill out page 2 if requesting more than one NMA \*

|                                                                                                                                     |                                                                                                                                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 16. Does it meet JFTR rules and regulations? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                    | 29. Orders issued by Regiment? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                            |
| 17. Letter from competent medical authority? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                    | 30. Advance required? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                     |
| 18. DTS profile completed for traveler? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                         | 31. Estimated cost of trip:                                                                                                                                                   |
| 19. Number of days requested: 180                                                                                                   | 32. Lodging provided? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                     |
| 20. Estimated start date: JUN 15, 2015                                                                                              | Meals provided? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                           |
| Estimated end date: DEC 12, 2015                                                                                                    | Location of lodging:                                                                                                                                                          |
| 21. Attendant briefed on authorized reimbursable expenses? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No      | Mode of travel from HOR? <input checked="" type="checkbox"/> POV <input type="checkbox"/> BUS                                                                                 |
| 22. Part I and Blocks 10a and 10b are complete on DD Form 2793? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> TRAIN <input type="checkbox"/> AIR <input type="checkbox"/> OTHER                                                                                    |
| 23. Attendant signed DD Form 2793? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                              | 33. Any expenses claimed over \$75 and all lodging and rental car expenses, if applicable, are submitted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 24. Request reviewed by Regiment's Medical Officer? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No             | 34. Travel voucher submitted upon completion of service? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                  |
| 25. SNM's EAS/ECC verified within MCTFS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                        | 35. Convalescent leave dates:                                                                                                                                                 |
| 26. Commanding Officer/Designated Official approved? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No            | Convalescent leave location:                                                                                                                                                  |
| 27. Authorization initiated by WWBn-E through DTS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No              | 36. Additional information:                                                                                                                                                   |
| 28. Transportation acquired through DTS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                        |                                                                                                                                                                               |

Signature of OIC/Designated Representative: \_\_\_\_\_ 20150615

Signature of Battalion Commanding Officer/Designated Representative: \_\_\_\_\_ 20150615

