RANK FIRST NAME LAST NAME EDIPI MOS

SECTION / BILLET SPONSOR: \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_\_\_ LODGING LOC: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADMNINSTRATIVE REQUIREMENTS:**

ORDERS START DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ORDERS END DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IDT/APD START DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ IDT/APD END DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARE IDTS SCHEDULED IN DMM? YES / NO GTCC HOLDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ACTIVE? YES/ NO

ANNUAL AUDIT DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CEI DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY CARE PLAN DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CRCR CERT DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY RESIDENCE VALIDATED: YES / NO VALIDATION DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SERCURITY CLEARANCE: \_\_\_\_\_\_\_\_\_\_\_\_\_ EXP DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RLO REPRESENTATIVE SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TRAINING REQUIREMENTS:**

PFT DATE: \_\_\_\_\_\_\_\_\_ CFT DATE: \_\_\_\_\_\_\_\_\_\_\_ HT/WT: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

CYBER AWARENESS DATE: \_\_\_\_\_\_\_\_\_\_ DERIVATIVES TRAINING DATE (EVERY 2 YRS): \_\_\_\_\_\_\_\_\_

SAPR TRAINING DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_ LEAVE AND LIBERTY BRIEF: \_\_\_\_\_\_\_\_\_ RLO BRIEF: \_\_\_\_\_\_\_\_\_\_\_

I have received and understand the overview of the Marine Corps SAPR Program.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL REQUIREMENTS:**

PHA DATE: \_\_\_\_\_\_\_\_\_ HIV DATE: \_\_\_\_\_\_\_\_\_\_ DENTAL CLASS: \_\_\_\_\_\_\_\_\_\_

ALL IMA MARINES WILL REPORT TO BUSH MEDICAL CLINIC AND VALIDATE THEIR MEDICAL READINESS AND IMMUNIZATIONS. ALL PERSONNEL SHOULD BRING A COPY OF MEDICAL/DENTAL RECORDS.

**IMA PROGRAM REQUIREMENTS:**

\*TRAVEL CLAIM MUST BE SUBMITTED WITHIN FIVE DAYS OF COMPLEATION OF DUTY.

\*I HAVE READ AND UNDERSTAND III MEF STATEMENT OF UNDERSTANDING? YES / NO

COMMENTS:

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