

# LINE OF DUTY INFORMATION

**COMPLETE ALL ITEMS – ATTACH COPY OF ORDERS**

**FOR ILLNESS/INJURY OCCURRING ONLY AT FORT HUACHUCA**

NAME: \_\_\_\_\_

RANK: \_\_\_\_\_

SSN or DoD ID Number: \_\_\_\_\_

SM's PHONE NUMBER: \_\_\_\_\_ UNIT PHONE NUMBER: \_\_\_\_\_

LOCAL UNIT: \_\_\_\_\_

NATIONAL Guard or Reserve Unit & Address:

\_\_\_\_\_

PERSONAL EMAIL: \_\_\_\_\_

Graduation Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

How illness/injury happened: \_\_\_\_\_

\_\_\_\_\_

When injury happened (date & time if possible):

\_\_\_\_\_

Geographic Location where illness/injury happened:

\_\_\_\_\_

Date and Location of initial treatment:

\_\_\_\_\_