Warrior Transition Battalion Outreach Application

Thank you for your interest in our program. All information provided will be held in the strictest of confidence. It will only be shared with those interests that are relevant to the activity. The outreach is specifically for those who have combat related injuries, or his/her Primary Care Manager has certified that the Outreach Event at large is a therapeutic event for the individual Soldier. Please complete this form and return with your appropriate signatures.

Activity: _____

Location: _____

Date(s) & Time(s): _____

Name (Last, First, MI): _____

Company: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone: _____

Alternate Phone: _____

E-Mail Address: _____

Squad Leader Name: _____

Squad Leader Phone Number: _____

Emergency Contact: _____

Relationship: _____

Emergency Phone Number: _____

Emergency E-Mail: _____

Signature of Participant: _____ Date: _____

Please indicate your military status. (If deployed with Reserves or National Guard, please select one of those options):

Branch of Military: _____ Rank: _____ ☐ Active ☐ Reserve ☐ National Guard

Profile: _____ MEB Phase: _____

Limitations: _____ Did you receive a Purple Heart?: ☐ Yes ☐ No

_____

_____

Have you ever participated in an event similar to this?: ☐ Yes ☐ No

Please indicate your current skill level: ☐ Beginner (instruction needed) ☐ Intermediate (needs skill brush up) ☐ Advanced (no instruction needed)

NOTE: To consider your application, your Nurse Case Manager (NCM) must sign this form along with your Command's approval.

Please return your completed 2 page application to:

Soldier & Family Assistance Center (SFAC) • 1481 Titus Blvd. Building 7492 • (719) 526-5807

Medical Release Statement

Are you in the following category for Wounded, Ill and Injured? ☐ Yes ☐ No

While on active duty, on or after September 11, 2001, incurred an illness or injury as a direct result of armed conflict; while engaged in hazardous service; in the performance of their duty under conditions simulating war; through an instrumentality of war; or in an operation area designated by the Secretary of Defense as a combat operation or combat zone.

The Soldier has been MEDICALLY Cleared to participate in activity. This Activity has therapeutic value toward the Soldier's Comprehensive Transition Plan (CTP) Scrimmage Goals. Please sign and date to indicate this statement to be true.

I, the Nurse Case Manger _____ *ensure Soldier has no conflicting appointments and*
(name of NCM)

hereby release _____ for the activities listed on the first page of this form.
(ST name)

This event is considered a therapeutic event for this Soldier: ☐ Yes ☐ No

Signature: _____ Date: _____

NCM, please indicate required signatures below, based on activity listed on the first page of this form:

Signature required: ☐ Yes ☐ No

Physical Therapist: _____

Signature: _____ Date: _____

Signature required: ☐ Yes ☐ No

Occupational Therapist: _____

Signature: _____ Date: _____

Signature required: ☐ Yes ☐ No

Social Worker: _____

Specify if any weapons restrictions/specific concerns for Soldiers who are AMBER, RED or BLACK: _____

_____

Signature: _____ Date: _____

Signature required: ☐ Yes ☐ No

Primary Care Provider: _____

Signature: _____ Date: _____

Please list any Precautions: _____

_____

Unit Command

PSG: _____ Date _____ ☐ Approved ☐ Disapproved

1SG: _____ Date _____ ☐ Approved ☐ Disapproved

CDR: _____ Date _____ ☐ Approved ☐ Disapproved

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