**State Active Duty Line of Duty**

**SERVICE MEMBER’S STATEMENT**

1. I have reviewed my current Record of Emergency Data. The information contained thereon is to be effective while I am on State Active Duty (SAD) and is to be used to administer benefits and protections that apply while I am in the active service with the State of New York.

2. I have provided a copy of or have completed a current Initial Medical Review/Annual Medical Certificate form DA 7349.

3. To the best of my knowledge, I have no prior medical condition that may fundamentally interfere with, restrict or be aggravated by the performance of my normal duty requirements.

4. The 🞏 injury 🞏 illness 🞏 disease occurred on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

5. This SAD LOD investigation file results from 🞏 a new medical condition 🞏 an aggravation of a pre-existing condition.

6. The details of the incident are as follows.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. I was on Orders for State Active Duty at the time of the incident. 🞏 YES 🞏 NO

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FULLY UNDERSTAND THE CONTENTS OF THE INFORMATION PROVIDED AND SWEAR THE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I HAVE PROVIDED THIS INFORMATION FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT

Service Member signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN Last 4:\_\_\_\_\_\_\_\_

Name (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last, First Mi Date