DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service Commissioned Corps

INCENTIVE PAY (IP) AGREEMENT

(Privacy Act Notice is on the Second Page)

IDENTIFICATION			**DCCPR USE ONLY**
NAME *(Last, First, Middle Initial)*	GRADE/RANK	PHS SERIAL NUMBER	Date Received in DCCPR
ORGANIZATION	DUTY PHONE NUMBER	SSN	

LENGTH OF AGREEMENT REQUESTED *(Check appropriate box)*

I AGREE TO REMAIN ON ACTIVE DUTY IN THE COMMISSIONED CORPS OF THE PUBLIC HEALTH SERVICE (Corps) WITH AN INCENTIVE PAY (IP) OBLIGATION FOR: ☐ 12 MONTHS

CONDITIONS OF AGREEMENT

In consideration of payment of the IP for which I qualify under 37 U.S.C. 335; Commissioned Corps Directive (CCD) 151.05; I hereby agree to the following:

A. To remain on active duty in the Corps for the agreement period specified above, commencing on the following date: _____.

B. That I will be paid IP in the amount specified for my category of _____ and specialty of _____ for each year of obligation.

C. That I hold a current, valid and unrestricted license as directed for my category under CCI251.01 "Professional Licensure and Certification" or certification as required by CCI231.01, "General Appointment Standards." I agree to remain certified in the specialty referenced in section B, above, during the period I receive IP.

D. That I will receive the IP in 12 monthly installments.

E. That if I fail to complete the period of service for which IP is paid:

(1) Under the provisions contained in Sections 6-7 of CCD 151.05, the officer will be required to refund a pro rata portion of the payment received which represents the unserved portion of that annual payment of a terminated agreement in accordance with 37 U.S.C. 373.

(2) Any amount I am obligated to refund because of the termination of this agreement will be a debt due to the United States which I hereby agree to pay in full as directed by the appropriate collections officials in accordance with CCI 645.02.

F. If I am not eligible to receive base pay because of a period of Absence Without Leave (AWOL), then I am not eligible for IP for the duration of the AWOL, and I am required to repay the prorated portion.

CERTIFICATION

I certify that I have read and understand CCD 151.05, and I have read and agree to abide by the terms of this IP agreement as stated above and that the above information is true and correct. Further, I understand that making a false statement or claim against the U.S. Government is punishable by a fine, or imprisonment, or both. 18 U.S.C. § 287; 18 U.S.C. § 1001.

PRINTED NAME	DATE
SIGNATURE	DATE

SUPERVISOR CERTIFICATION

PRINTED NAME	TITLE	DATE
SIGNATURE		DATE

AGENCY / OPERATING DIVISION / PROGRAM RECOMMENDATION

The above named officer ***is / is not*** recommended for IP payment.

PRINTED NAME	TITLE	DATE
SIGNATURE		DATE

Privacy Act Statement for
Public Health Service Commissioned Corps
"Incentive Pay (IP) Agreement
(Form PHS-6189)

Authority: This statement is provided pursuant to the Privacy Act of 1974 (5 U.S.C. 552a). Our authority to collect this information is 42 U.S.C. 202 et seq. and Executive Order 9397, "Numbering System for Federal Accounts Relating to Individual Persons."

Principal Purpose: This information is used by the Department of Health and Human Services to record a Public Health Service (PHS) Commissioned Corps officer's eligibility to receive IP. If you are selected for award of IP, the information collected will be used for issuance of personnel orders to authorize payment. These records, or information therefrom, may also be provided to other Federal Agencies to which Corps officers are assigned. The information also may be used for study purposes and/or collection of statistical data for reports to other Federal Agencies and the Congress. It may also be used for other lawful purposes including collection of a debt owed the Federal Government, law enforcement, and litigation.

Routine Uses: Information may be provided to the Internal Revenue Service to resolve matters relating to an individual's tax withholding; to the Federal Retirement Thrift Investment Board to establish eligibility for contributions to the Thrift Savings Plan for Uniformed Service personnel; and to the Department of Justice or State and local governments when a question of conflicting interest is raised concerning a member's eligibility for and payment of bonuses.

Information Regarding Disclosure of Your Social Security Number (SSN): Under Executive Order 9397, Agencies are required to use the SSN as a means of identifying individuals in Agency personnel information systems. Solicitation of your SSN is authorized by this order so that Agencies, by being able to identify you, can ensure that the data furnished is accurately recorded for each employee in the personnel system. It will be used for this purpose only.

Records System: The information provided on this form will become part of record system 09-40-0001, PHS Commissioned Corps General Personnel Records, HHS/PSC/HRS; 09-40-0002, PHS Commissioned Corps Medical Records, HHS/PSC/HRS; 09-40-0003, PHS Commissioned Corps Board Proceedings, HHS/PSC/HRS; 09-40-0004, PHS Commissioned Corps Grievance, Investigatory and Disciplinary Files, 09-90-1402, HHS Payroll Records, HHS; and 09-40-0011, Proceedings of the Board for Correction of PHS Commissioned Corps Records, HHS/PSC/HRS. A copy of this system notice can be obtained from the office to which you submit these forms.

Disclosure: Voluntary; however, failure to provide complete and accurate information by the time instructed by the PHS Commissioned Corps could result in delays and/or errors in determining eligibility and, therefore, may result in late payment or nonpayment, or be cause for collection of pay if you receive an award based on erroneous information. All statements are subject to verification.