

**FISCAL YEAR 2004
PHARMACY OFFICER SPECIAL PAY (POSP)
AGREEMENT
(01 October 2003)**

NAME: _____ **RANK:** _____ **SSN:** _____

AUTHORITY: *Title 37, U.S.C. 302i, Special Pay: Pharmacy Officers*

Member Instructions: Place your INITIALS in each numbered bracket and fill in appropriate information.

1. I hereby request Pharmacy Officer Special Pay (POSP) under the provisions of the reference indicated above. I hereby certify that:

a. [] I am a qualified pharmacy officer in the Biomedical Sciences Corps of the Air Force and I am on active duty for a period of not less than one year.

b. [] I am licensed as a Pharmacist in the State or jurisdiction of _____.

My license number is _____ and my license expiration date is _____.

c. [] I will keep my license current during the POSP agreement period.

CONDITIONS OF AGREEMENT:

2. [] I understand that I will receive annual POSP payments (subject to availability of funds) of _____, subject to applicable State and Federal taxes, payable to me in two equal annual installments.

Annual amount is payable as soon as possible after approval of this agreement and on the second year of the agreement effective date.

3. [] I understand that the effective date of my entitlement to POSP is _____.

4. [] I understand that I will incur a two year active duty obligation (ADO) beginning on the effective date of my entitlement as indicated in 3 above. This service is concurrent with all other existing ADOs.

5. [] I understand that the rate of my POSP remains fixed at the rate indicated in 2 above until the expiration of this agreement.

6. [] I have sufficient retainability to complete my ADO under this agreement.

7. [] I understand that I do not qualify for POSP if I am not eligible to remain on active duty long enough to complete my ADO under this agreement.

(a) If I have an established separation or retirement date, I will immediately apply to withdraw that date. I understand this agreement will not be approved and payment will not be made until and unless withdrawal of my separation/retirement date is approved and updated in MilPDS.

(b) If I am a regular officer and will reach age 62 before I complete my ADO under this agreement, I will immediately apply for an age waiver. I understand the Air Force will not approve this agreement and payment will not be made until and unless my age waiver is approved. If I fail to disclose my need for an age waiver before approval of this agreement, the Air Force will terminate my entitlement to POSP and I must repay all POSP payments received.

(c) If I am a reserve officer and will reach age 60 before I complete my ADO under this agreement, I will immediately request a waiver to allow me to continue to serve as a reserve officer beyond age 60 and up to age 67. I understand the Air Force will not approve this agreement and payment will not be made until and unless my age waiver is approved. If I fail to disclose my need for an age waiver before approval of this agreement, the Air Force will terminate my entitlement to POSP and I must repay all POSP payments received.

8. I understand that the appropriate Air Force officials must approve this agreement before payment will be authorized.

9. I understand that the POSP program constitutes a voluntary retention program and that, unless a waiver approved by the Secretary of the Air Force or designee is obtained, I will not be released from active duty before fulfilling the term of continuous active duty agreed to in paragraphs 3 and 4 above, even if that obligation will extend me beyond 20 years of active federal service.

10. I understand that my entitlement to POSP will terminate immediately, and my POSP ADO will be adjusted appropriately, in the event that I am promoted to the grade of brigadier general.

11. I understand that this agreement will be terminated upon my separation from active duty, including separation after declination for selective continuation, or upon my death. This agreement may be terminated by the Surgeon General for failure to meet the eligibility requirements or when clear evidence exists that I should be denied further practice in the POSP specialty or further active duty. It may also be terminated when in the best interest of the military.

12. I understand that requests for resignation, release from active duty or voluntary retirement to be effective during the period of this agreement will be disapproved except where considered to be in the best interest of the Air Force.

13. I understand that in the event of termination under paragraphs 10, 11, or 12 above, unearned POSP pay will be recouped by the government on a pro rata basis based on length of POSP active duty obligation actually served, unless the failure to complete the period of active duty specified in the agreement is due to:

(a) Death or disability that is not the result of misconduct or willful neglect and not incurred during a period of unauthorized absence.

(b) Separation from the military service by operation of law or regulation of DoD or the Air Force, when a waiver for recoupment has been approved by the Service Secretary.

14. I understand that a discharge in bankruptcy under Title 11, USC, that is entered less than five years after the termination of this agreement does not discharge me from a debt arising from this agreement. This paragraph applies to any case commenced under Title 11, USC after 29 November 1989.

15. [] In accordance with the privacy act, I understand that disclosure of my social security number is voluntary; however, failure to provide the number may result in non-verification of my agreement and payment of POSP may be affected. I also understand that information compiled from the agreement may be used for special pay program and budget analysis.

16. [] I understand that, by signing below, I agree to the retention requirements in accordance with the rules outlined in this agreement.

17. [] I understand this agreement is binding as of the date of my signature.

MEMBER'S SIGNATURE: _____ **DATE:** _____

PRINTED NAME: _____ **SSN:** _____

RANK: _____ **EMAIL ADDRESS:** _____

1st Indorsement:

TO: HQ AFPC/DPAMF1

I have verified the information contained in this agreement. I certify that _____ is a qualified, licensed pharmacy officer in the Biomedical Sciences Corps of the Air Force and is on active duty for a period of not less than one year. I further certify that this member is in compliance with the conduct, competence, and standards expected by the Air Force.

Signature, Authorized Indorsing Authority

Date

**Typed or Stamped Signature Block,
Authorized Indorsing Authority**