Plan of Action: *(Outlines actions that the subordinate will do after the counseling session to reach the agreed upon goal(s). The actions must be specific enough to modify or maintain the subordinate's behavior and include a specified time line for implementation and assessment (Part IV below).)*

FTNGD APPLICATION CHECKLIST:

1. Complete all required entries on DA Form 1058-R July 93, by completing blocks 2-24, certify all information by signing and dating blocks 22 and 24.
   a. BN S-1 or representative will complete blocks 25 - 36d.
   b. Obtain your unit commands signature in block 35e, DA Form 1058-R.

2. From you unit of assignment:
   a. Certified height/weight or DA 5500R.
   b. DA Form 705 (APFT scorecard)
   c. Copy of Physical Health Assessment (PHA) (Must be accomplished before orders are cut)
   d. Coordination of HIV and Pregnancy test as appropriate (Can be accomplished after selection)
   e. Print MEDPROS IMR record. This can be obtained by accessing your AKO account / My Medical / My Medical readiness / View Detailed Information / IMR record.

3. Submit with your application for position advertised.

4. Failure to follow the above instruction will slow down the application process.

Session Closing: *(The leader summarizes the key points of the session and checks if the subordinate understands the plan of action. The Subordinate agrees/disagrees and provides remarks if appropriate.)*

Individual counseled: ☐ I agree ☐ disagree with the information above.

Individual counseled remarks:

Signature of Individual Counseled: ______________________ Date: ____________

Leader Responsibilities: *(Leader's responsibilities in implementing the plan of action).*

1. Forward FTNGD application through approval authorities to the HRO-ADOS Manager
2. Assist soldier in the management of accrued leave by maintaining DA 481.
3.Ensure the soldier obtains Active Duty ID Card and applies for TRICARE Prime Remote for Self and family.
4. Ensure FTNGD orders are published prior to start date of tour.
5. Ensure adequate physical fitness time is provided (3 - 5 hrs per week)

Signature of Counselor: ______________________ Date: ____________

PART IV – ASSESSMENT OF THE PLAN OF ACTION

Assessment: *(Did the plan of action achieve the desired results? This section is completed by both the leader and the individual counseled and provides useful information for follow-up counseling.*

Counselor: ____________ Individual Counseled: ____________ Date of Assessment: ____________

Note: Both the counselor and the individual counseled should retain a record of the counseling.