DEVELOPMENTAL COUNSELING FORM

For use of this form, see ATP 6-22.1; the proponent agency is TRADOC.

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: 5 USC 301, Departmental Regulations; 10 USC 3013, Secretary of the Army.

PRINCIPAL PURPOSE: To assist leaders in conducting and recording counseling data pertaining to subordinates.

ROUTINE USES: The DoD Blanket Routine Uses set forth at the beginning of the Army's compilation of systems or records notices also apply to this system.

DISCLOSURE: Disclosure is voluntary.

PART I - ADMINISTRATIVE DATA

Name *(Last, First, MI)*	Rank/Grade	Date of Counseling

Organization	Name and Title of Counselor

PART II - BACKGROUND INFORMATION

Purpose of Counseling: *(Leader states the reason for the counseling, e.g. Performance/Professional or Event-Oriented counseling, and includes the leader's facts and observations prior to the counseling.)*

This is an event-oriented counseling.
ON ____________________________ (Date of Self ID) YOU ADMITTED TO THE USE OF THE DRUG____ (Name of Drug).

PART III - SUMMARY OF COUNSELING

Complete this section during or immediately subsequent to counseling.

Key Points of Discussion:

On _____________(YYMMDD), I advised ____(Soldier's full name and rank) of his/her rights under the limited Use Policy IAW AR 600-85. Based on self-identification, I suspect him/her of being abusing drugs. Substance abuse is incompatible with the maintenance of high standards of performance, military discipline, and readiness, and poses a substantial threat to the health and welfare of this unit. This counseling is imposed as an administrative measure and is not to be construed as punishment. You are to seek evaluation, treatment, and rehabilitation at a State certified substance abuse treatment center of your choice and at your own expense. Your treatment under AR 600-85 will not include either methadone maintenance or mandatory disulfiram (Antabuse) treatment. I will work closely with the counselor (employed at no expense to the Army) and assist you in your attempts to return to full, productive duty as soon as possible; however, continued abuse may result in your discharge from the West Virginia Army National Guard (WV ARNG). Participation and completion of rehabilitation does not guarantee retention in the WVARNG if retention is recommended.

You must provide documentation to me within 30 days of this counseling session as evidence you have completed the evaluation/counseling required by AR 600-85. Be advised that your failure to sign a release (DA Form 8004), seek counseling, and complete Army approved (State certified) treatment may result in your discharge IAW AR 135-178.

Note 1: The evaluation will determine the need for treatment.

Note 2: Commanders must be kept informed regarding a soldier's treatment progress. Therefore, written updates from rehabilitation personnel must be provided to the commander monthly.

Note 3: Court Referral Programs are NOT an approved Army program for treatment.

Note 4: Self- help programs such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) cannot be used alone as a treatment program but can be used in conjunction with prescribed treatment as directed by state certified counselors.

Substance abuse is serious. It makes you unfit for duty in this command. The impact on your personal and family life is equally serious.

OTHER INSTRUCTIONS

This form will be destroyed upon: reassignment *(other than rehabilitative transfers)*, separation at ETS, or upon retirement. For separation requirements and notification of loss of benefits/consequences see local directives and AR 635-200.

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)*

I WILL/WILL NOT SEEK EVALUATION AT A STATE CERTIFIED REHABILITATION PROGRAM. (Have soldier circle response and initial the circle)
REGARDLESS OF MY INTENTION TO SEEK TREATMENT, I WILL CONTACT THE PREVENTION COORDINATOR TO DISCUSS TREATMENT REQUIREMENTS, OPTIONS, LOCATIONS, AND SERVICES AVAILABLE FROM THE PREVENTION, TREATMENT, AND OUTREACH OFFICE.
SM INITIALS________
(Have soldier initial)

Mrs Jenny Colagrosso 304-561-6816 email jenny.r.colagrosso.ctr@mail.mil
Mr. Eric Tissenbaum 304-561-5716 email eric.a.tissenbaum.ctr@mail.mil

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.)*

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.