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FAMILY CARE PLAN ADDITIONAL INFORMATION SHEET*(Attachment to Completed AF Form 357)*

In accordance with AFI 36-2908, paragraph 2.8.2.6, Family Care Plans, the following additional information is required to assist my caregiver(s) and dependent(s) with the transition of care and to deal with my absence:

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 U.S.C. 8013 and E.O. 9397, Secretary of the Air Force, powers and duties; delegation by.

PRINCIPAL PURPOSE: To contact persons designated by the member as accepting family care responsibility, to verify their willingness to act for the member in this capacity, to advise the caregivers when they are expected to discharge these responsibilities and to insure member's compliance with the instruction.

ROUTINE USE: None.

DISCLOSURE IS VOLUNTARY: Use of the SSN is required to establish positive identification. Other information is required to ensure members have met their family care responsibilities. Failure to provide the information may result in discharge from the Active Air Force, Air National Guard, or Air Force Reserve.

MEMBER INFORMATION

NAME (Last Name, First, MI)	DATE	SIGNATURE	PAGE 1 OF
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DEPENDENT INFORMATION

NAME (Last Name, First, MI)	DOB	SEX	SCHOOL GRADE
SCHOOL'S NAME	SCHOOL'S ADDRESS (Include Zip Code)	SCHOOL'S PHONE NUMBER (Include Area Code)	

DIRECTIONS TO SCHOOL

AFTER CARE FACILITY/ROUTINE CARE PROVIDER

PROVIDER'S NAME	PROVIDER'S ADDRESS (Include Zip Code)	PROVIDER'S PHONE NUMBER (Include Area Code)
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DIRECTIONS TO FACILITY/CARE PROVIDER

SPECIAL NEEDS OR UNIQUE SITUATIONS

PLEASE LIST ANY SPECIAL MEDICAL NEEDS, LANGUAGE LIMITATIONS, OR OTHER UNIQUE SITUATIONS (Attention disorder, speech impediments, medication, phobias, etc.)