Section/Heading	Subheading	Modal?	Question	Field Type	Answer Choices (If	Required/Not Required	Instructional Text	
Applicant Type	*In what way are you authorized to complete this application on behalf of the Public Safety Officer's Employing Agency?*		Applicant Type	Radio	Employee of the Agency/National Stakeholder/Other (please describe)	Required		
			Describe "other" here:	Text Box	NA	Only required if "other" was chosen in the previous question.		
Enter the Public Safety Officer's information								
			Prefix	Dropdown	Mr., Mrs., Ms., Miss, Dr., Other(please describe)	Not Required		
			Describe "other" here	Text Box		Required (if "other" is chosen)		
			Public Safety Officer First Name	Text Box	NA	Required		
			Public Safety Officer Middle Name	Text Box	NA	Not Required		
			Public Safety Officer Last Name	Text Box	NA	Required		
			Public Safety Officer Suffix	Text Box	NA	Not Required		
			Public Safety Officer Job Title	Text Box	NA	Required		
			Public Safety Officer Social Security Number (Enter in this format: 555-55-5555)	Text Box	NA	Required		
			Public Safety Officer Date of Birth	Text Box/Date Picker	NA	Required		
			Public Safety Officer Date of Injury	Text Box/Date Picker	NA	Required		
			Public Safety Officer Date of Medical Retirement	Text Box/Date Picker	NA	Not Required		
			Public Safety Officer Phone Number	Text Box	NA	Required		
			Public Safety Officer Alternate Phone Number	Text Box	NA	Not Required		
			Public Safety Officer Email Address	Text Box	NA	Required		
Enter information about the Public Safety Officer and Employing Agency								
			Public Safety Officer Type	Radio	Law Enforcement Officer, Firefighter, Rescue Squad or Ambulance Crew Member, Emergency Management or Civil Defense Member, Other (please describe)	Required		
			Describe "other" here	Text Box	NA	Only required if "other" was chosen in the previous question.		

			Jurisdiction Type	Radio	1 - Local Unit of Government (City, County, Township), 2 - State Government, 3 - Tribal Government, 4 - Federal Government, 5 - Volunteer Fire Department, 6 - Nonprofit entity serving the public (Fire Services, Rescue Activities, Emergency Medical Services), 7 - Other (please describe)	Required		
			Describe "other" here:	Text Box	NA	Only required if "other" was chosen in the previous question.		
			Was the Officer serving in a volunteer capacity at the time of injury?	Radio	Yes/No	Required		
			Was the Officer serving as a contractor at the time of injury?	Radio	Yes/No	Required		
Enter the Employing Agency's								
	Employing Agency Contact iIformation		Name of Employing Agency, Organization or Unit	Text Box	NA	Required		
			Employing Agency Address Line 1	Text Box	NA	Required		
			Employing Agency Address Line 2	Text Box	NA	Not Required		
			Employing Agency City	Text Box	NA	Required		
			Employing Agency State	Dropdown	Alabama (AL) Alaska (AK) Arizona (AZ)	Required		
			Describe "other" here	Text Box	NA	Only required if "other" chosen in the previous question.		
			Employing Agency Zip/Postal Code	Text Box	NA	Required		
			Employing Agency Country	Text Box	NA	Not Required		
			Employing Agency Phone Number	Text Box	NA	Required		
			Employing Agency Alternate Phone Number	Text Box	NA	Not Required		
	Agency Head Contact Information							
			Agency Head Prefix	Dropdown	Mr., Mrs., Ms., Miss, Dr.,	Not Required		
			Agency Head Prefix Other	Text Box	NA	Only required if "other" chosen in the previous question.		
			Agency Head First Name	Text Box	NA	Required		
			Agency Head Last Name	Text Box	NA	Required		
			Agency Head Suffix	Text Box	NA	Not Required		
			Agency Head Job Title	Text Box	NA	Required		

			Agency Head Email Address	Text Box	NA	Required		
			The address of the Agency Head is the same as the Agency Point of Contact.	Check Box	NA	Not Required		
			Agency Head Address Line 1	Text Box	NA	Required		
			Agency Head Address Line 2	Text Box	NA	Not Required		
			Agency Head City	Text Box	NA	Required		
			Agency Head State	Dropdown	Alabama (AL)	Required		
			Agency Head Zip/Postal Code	Text Box	NA	Required		
			Agency Head Country	Text Box	NA	Not Required		
			Agency Head Phone Number	Text Box	NA	Required		
			Agency Head Alternate Phone Number	Text Box	NA	Not Required		
	Employing Agency Point of Contact Information							
			Agency Point of Contact Prefix	Dropdown	Mr., Mrs., Ms., Miss, Dr., Other(please describe)	Not Required		
			Agency Point of Contact Other	Text Box	NA	Only required if "other" chosen in the previous question.		
			Agency Point of Contact First Name	Text Box	NA	Required		
			Agency Point of Contact Last Name	Text Box	NA	Required		
			Agency Point of Contact Suffix	Text Box	NA	Not Required		
			Agency Point of Contact Job Title	Text Box	NA	Required		
			Agency Point of Contact Email Address	Text Box	NA	Required		
			The address of the Agency Point of Contact is the same as the Employing Agency.	Check Box	NA	Not Required		
			Agency Point of Contact Address Line 1	Text Box	NA	Required		
			Agency Point of Contact Address Line 2	Text Box	NA	Not Required		
			Agency Point of Contact City	Text Box	NA	Not Required		
			Agency Point of Contact State	Dropdown	Alabama (AL) Alaska (AK) Arizona (AZ) Arkansas (AR)	Required		
			Agency Point of Contact Zip/Postal Code	Text Box	NA	Required		
			Agency Point of Contact Country	Text Box	NA	Not Required		
			Agency Point of Contact Phone Number	Text Box	NA	Required		
			Agency Point of Contact Alternate Phone Number	Text Box	NA	Not Required		
Officer Injury Profile								

			Cause of Injury: (Check all that apply)	Checkbox	Bullets Explosives Sharp Instruments/ Blunt Objects Physical Blows Motor Vehicle/ Boat/ Airplane/ Helicopter Accident Fire/ Smoke Inhalation Chemicals Electricity Climatic Conditions Infectious Disease Radiation Viral Infection Heart Attack Stroke Vascular Rupture Occupational Disease Stress or Strain Other (please describe)	Required		
			Describe "other" here:	Text Box	NA	Only required if "other" chosen as an answer for the previous question.		
			Was this injury related to the events of September 11, 2001?	Radio	Yes/No	Required		
			At the time of injury, was the Officer	Radio	On-duty, Off-duty, Other (please describe)	Required		
			Describe "other" here	Text Box	NA	Only required if "other" is chosen as the answer to the previous question.		
Statement of Circumstances								
			Describe the circumstances of the Public Safety Officer's injury. Please provide details about what happened, as well as when, where, and how the incident occurred, and whether or not the Public Safety Officer was on duty.	Text Box	NA	Required		
			Select this option if you would prefer to upload a Statement of Circumstances as a document instead of entering a new record below. If selected, you will be prompted to upload your document in the Required Documents section.	Checkbox - "I will upload a Statement of Circumstances"	NA	Not Required		
Potential Limitations on Payments			Was there any indication that the Officer was performing duties in a grossly negligent manner at the time of the injury?	Radio	Yes/No	Required		
			If yes, please explain.	Text Box	NA	Required if yes is chosen as an answer to the previous question.		

			Was there any indication that the Officer's injury was caused by an intention to bring about the injury or death?	Radio	Yes/No	Required		
			If yes, please explain.	Text Box	NA	Required if yes is chosen as an answer to the previous question.		
			Was there any indication that the Officer's injury was caused by intentional misconduct?	Radio	Yes/No	Required		
			If yes, please explain.	Text Box	NA	Required if yes is chosen as an answer to the previous question.		
			Was there any indication that the Officer was voluntarily intoxicated at the time of injury?	Radio	Yes/No	Required		
			If yes, please explain.	Text Box	NA	Required if yes is chosen as an answer to the previous question.		
Other Benefits								
			Has a claim for benefits been filed under any of the following (Check all that apply)	Checkbox	Medical Retirement/Disability Workers' Compensation Social Security Federal Employees Compensation Act D.C. Retirement and Disability Act of September 1, 1916 September 11th Victim Compensation Fund Other (please describe) None of the Above (please describe)	Required		
			Describe "other" or "none of the above" here:	Text Box	NA	Only required if "other" or "none of the above" was chosen in the previous question.		
			Has a final determination been issued for any of the following: (Check all that apply)	Checkbox	Medical Retirement/Disability Workers' Compensation Social Security Federal Employees Compensation Act D.C. Retirement and Disability Act of September 1, 1916 September 11th Victim Compensation Fund Other (please describe)	Required		
			Describe "other" or "none of the above" here:	Text Box	NA	Only required if "other" or "none of the above" was chosen in the previous question.		
APPLICATION PREVIEW	**Please Review and Confirm**						The following is a summary of the information you have entered. Please review and make any necessary changes to this page before submitting your application.	
							Based on your responses, a customized checklist has been generated. The following required documents must be uploaded for the application to be considered complete. If you have any questions, please contact the PSOB Customer Resource Center at 1-888-744-6513 or AskPSOB@usdoj.gov.	
			Association	Static Text Box	NA	Auto filled		
			Document Type	Static Text Box	NA	Auto filled		

			Date Uploaded	Static Text Box	NA	Auto filled		
			Instructions	Static Text Box	NA	Auto filled	All doc instructions are located in the "Required D	
			Review Status	Static Text Box	NA	Auto filled		
			Add document clarifying notes if necessary.	Text Box	NA	Not Required		
			Missing Document Justification	Text Box	NA	Required only if a required document is not uploaded		
		Click Here to Add Other Documentation. (Modal)						
Missing Documents							Your application is missing one or more required documents needed to successfully submit your application. Please go to the previous screen to review the list of required documents, to upload all required documents or to provide an explanation of why a document is missing.	
CERTIFICATION OF APPLICATION							The information provided will be used by the Department of Justice to determine eligibility of an Applicant/Claimant for PSOB Program benefits. To verify eligibility for benefits, the information provided is subject to investigation and may be disclosed to federal, state, tribal,	
			Certification of Application	Checkbox	NA	Required		
FINAL REVIEW FORM	**Please Review and Confirm**						This final review form serves as the version of the application you are about to submit. If you wish to make edits, return to the editable preview screen to do so.	
Part B Application Successfully Submitted							A PSOB Disability Benefits Application consists of two parts, Part A and Part B. Part A is completed by the Officer or Authorized Representative, Part B is completed by the Employing Agency. Parts A and B, and all required supporting documents must be provided before the application can be considered complete. A Customer Resource Specialist will review the application. If all required documents are provided, the application will be assigned a claim number and will move to the next stage of review. If the contact information you initially provided changes, please log into the PSOB portal to update your contact details.	