



Border Patrol Foundation
Assistance Request Form

Date of Incident _____ Line of Duty Yes/No Today's Date _____

Name of Agent or Employee _____ Title _____

Duty Station _____ Sector _____

Number of Dependents _____ Ages _____

Address: _____

Beneficiary Name _____ Relationship to injured _____

In hospital: Yes/No ICU: Yes/No Estimated hospital stay: _____

Estimated time off work: _____

Describe Incident or injuries:

Please articulate financial hardship to help us better determine level of support:

Information Provided by

**must be signed by Peer Support or Direct Line Supervisor*

Name: _____ Title: _____

Office Phone: _____ Mobile Phone _____

Email: _____

Sector or Station address: _____

I hereby state that all the information provided is true and correct to the best of my knowledge;

Signature: _____

Assistance Check Delivery

Make benefit check to: _____

Address to mail check: _____

Person delivering check (if not mailed directly to agent's family): Name: _____

Title: _____

Station: _____ Sector: _____

Please email request to Shannon.staples@borderpatrolfoundation.org.