UNITED STATES MARINE CORPS
MARINE AIR GROUND TASK FORCE TRAINING COMMAND
MARINE CORPS AIR GROUND COMBAT CENTER
BOX 788100
TWENTYNINE PALMS, CALIFORNIA 92278-8100

1533
G-3/5
NOV 26 2025

LETTER OF INSTRUCTION 36-25

From: Commanding General
To: Distribution List

Subj: DESERT HOT SPRINGS HIGH SCHOOL MARINE CORPS JUNIOR RESERVE OFFICERS TRAINING CORPS VISIT

Ref: (a) MCO 1533.6E
(b) CCO 3500.4M

Encl: (1) Desert Hot Springs High School JROTC Roster
(2) Desert Hot Springs High School JROTC Itinerary/Schedule
(3) Hold Harmless Agreement
(4) Civilian Medical Treatment Form

1. Situation. The Desert Hot Springs High School (DHSHS) Marine Corps Junior Reserve Officers Training Corps (MCJROTC) will visit the Marine Corps Air Ground Task Force (MAGTF) Training Command (MAGTFTC), Marine Corps Air Ground Combat Center (MCAGCC) on 11 December 2025, in order to provide their cadets an orientation of the United States Marine Corps per chapter 5, paragraph 9 of reference (a).

2. Mission. Coordinate and support the DHSHS MCJROTC visit aboard MAGTFTC MCAGCC on 11 December 2025.

3. Execution

a. Commander's Intent and Concept of Operations

(1) Commander's Intent. Provide the cadets with the opportunity to practice their marksmanship at the Marksmanship Training Unit, Indoor Simulated Marksmanship Trainer (ISMT). This event serves as an opportunity to build upon community relations by welcoming a group of young cadets, who are already inclined to consider a career in military service, and allow them the opportunity to learn and practice basic marksmanship fundamentals in a safe environment.

(2) Concept of Operations. The estimated attendance will be 53 cadets (age range 15-17 years old), and 2 adult staff members, see enclosure (1). A finalized roster will be submitted no later than seven days prior to the visit. Enclosure (2) is the complete itinerary for the visiting group.

b. Subordinate Element Missions

(1) Assistant Chief of Staff (AC/S), G-3/5 MAGTF Training

(a) Plan and coordinate the training.

(b) Schedule the required elements of the itinerary in accordance with enclosure (2).

(c) Provide cadet personnel rosters to Installation Support and Mission Assurance.

(d) Provide driver information to the Provost Marshal's Office.

(e) Collect the Hold Harmless Agreements from the MCJROTC unit; see enclosure (3).

(f) Reserve the MTU ISMT and ensure proper instructor-staff support is available to support a shoot of simulated small-arms weapon systems.

(2) AC/S, G-4 Installation Support. Coordinate with Littleton Dining Facility to provide the cadets the requested meal during the date and time required per the enclosure. Arrange for the appropriate tables to be set aside for the group.

(3) AC/S, Marine Corps Community Services. Notify the main base exchange and provide letter of authorization for limited use of MCCS facilities for 53 cadets on the afternoon of 11 December 2025.

(4) Mission Assurance. Verify DHSHS MCJROTC students against authorized access roster, adult leaders and bus driver, and provide vehicle access for one bus on 11 December 2025.

c. Coordinating Instructions

(1) Safety

(a) In the event of an emergency situation or accident the DHSHS MCJROTC Escort Officer, Mr Scott Campbell, G-3 Deputy Operations Officer, will notify the MAGTFTC Command Duty Officer in accordance with reference (b).

(b) The MCJROTC cadets may be treated at Bush Naval Hospital, Twentynine Palms (NHTP). Any medical services incurred will be billed to their non-Tricare insurance via enclosure (4).

(c) The MCJROTC unit must conduct Risk Management for all activities in accordance with reference (b).

(d) The training must be accomplished in strict compliance with established safety guidance. Cadets must have constant instructor supervision per reference (b).

(2) Transportation. The MCJROTC unit will use one bus to transport the cadets and staff throughout the Combat Center.

(3) Hold Harmless Agreements

(a) Non-Department of Defense civilians must sign the MAGTFTC MCAGCC Hold Harmless Agreement prior to any training aboard the Combat Center; see enclosure (3).

(b) Each cadet's parents or legal guardians must sign the MAGTFTC MCAGCC Hold Harmless Agreement prior to any training aboard the Combat Center, enclosure (3).

4. Administration and Logistics. Directives issued by this Headquarters are published and distributed electronically. Electronic versions of Combat Center letter of instruction (LOI) can be found at https://www.29palms.marines.mil/Staff-Offices/Resource-Management-Directorate/Adjutant/#combat-center-loi-library.

5. Command and Signal

a. Command

(1) The MAGTFTC MCAGCC Action Officer's for this event are Major Brant Esprit at (760)830-1827 or brant.esprit@usmc.mil and Mr. Scott Campbell (760)830-1882 or scott.t.campbell@usmc.mil.

(2) The senior DHSHS staff member is Master Sergeant Terrance Simmons, U.S. Marine Corps (Ret.), at Work (760) 288-7102, and (951) 691-9686 Cell, or tsimmons@psusd.us

(3) This LOI is applicable to active duty and civilian personnel participating in or supporting this event.

b. Signal. This LOI is effective the date signed.

M. H. CLINGAN

DISTRIBUTION: A

Desert Hot Springs High School

ISMT 29 Palms

Adult Personnel

MSgt Terrance Simmons (Ret)

MCJROTC Cadets (53)

Last Name	First Name	Student ID #	Gender
Belmonte	Josephine	1315089885	Female
Ramirez	Daniel	1315079936	Male
Christopher	Spivey	1315063287	Male
Villa	Mario	1315077724	Male
Lovelace	Joseph	1315074844	Male
Gonzalez	Josue	1315074989	Male
Salas	Alexia	1315074932	Female
Rivera-Tobar	Tiffany	1315081715	Female
Pimentel	Khloe	1315104336	Female
Valdivia-Anaya	Manuel	1315076477	Male
Flores	Jerry	1315075319	Male
Benitez	Emanuel	1315079738	Male
Hernandez	Mauricio	1315064409	Male
Gutierrez	Noah	1315086584	Male
Robinson	De'Nysha	1315080658	Female
Dawson	Kahlaya	1315076356	Female
Laguna	Dana	1315076754	Female
Mejia	America	1315100381	Female
Morales	Ashley	1315074345	Female
Flores	Reina	1315081823	Female
Sanchez	Ulices	1315078294	Male
Vazquez	Juliana	1315070329	Female
Hilario	Marvin	1315075346	Male
Cervantes	Roberto	1315075382	Male
Puentes	Donna	1315080774	Female

Velderraint	Joseph	1315073648	Male
Morin	Harmony	1315071997	Female
Velasquez	Sophia	1315073531	Female
Garcia	Alexa	1315077435	Female
Monterroso	Emerson	1315100898	Male
Hummel	Ryan	1315077513	Male
Delgadillo	Yoleiny	1315104151	Female
Duran	Margarita	1315091591	Female
De La Cruz	Miley	1315076356	Female
Salgado	Miley	1315074459	Female
Gieling	Lillian	1315093478	Female
Martinez	Christopher	1315087493	Male
Jurado	Jeraldine	1315070058	Female
Montanez	Amelia	1315080435	Female
Oble	Carlos	1315102410	Male
Danielsen	Cameron	1315077502	Male
James	Deyo	1315088516	Male
Villaba-Orozco	Emmanuel	1315071372	Male
Diaz	Adrian	1315061812	Male
Flores	Jacob	1315076719	Male
Sarza	Guillermo	1315076437	Male
Landry	Aiden	1315083945	Male
Smith	Avareigh	1315074386	Female
Perez	Mazatzin	1315074375	Male
Arias	Carol	1315065753	Female
Galvan De La Rosa	Jesus	1315095628	Male
Matthews	Marcus	1315072697	Male
Chase	Guerri	1315081462	Male

DESERT HOT SPRINGS HIGH SCHOOL MCJROTC VISIT

Visit Schedule – (MCAGCC)

Thursday – 11 December 2025

Time	Event	Location	Who	Support
0700	Depart DHSHS	Desert Hot Springs, CA	MCJROTC Cadets	Chartered Bus
0745	Arrive	Main Gate, MCAGCC	MCJROTC Cadets	PMO
0800 - 1100	Arrive	MTU ISMT	MCJROTC Cadets	HQBN MTU
1100	Depart MTU ISMT	MTU ISMT	MCJROTC Cadets	Chartered Bus
1130 - 1230	Lunch	Littleton Dining Facility	MCJROTC Cadets	AC/S G-4 IS
1230	Depart	Littleton Dining Facility	MCJROTC Cadets	Chartered Bus
1300 - 1430	MCX Visit	Main Exchange	MCJROTC Cadets	AC/S MCCS
1430	Depart	Main Exchange	MCJROTC Cadets	Chartered Bus
1530	Arrive DHSHS	Desert Hot Springs, CA	MCJROTC Cadets	Chartered Bus

HOLD HARMLESS AGREEMENT

Visiting the training areas is a valuable physical, social and educational opportunity. The visit carries with it risks from extreme heat, lack of water and poisonous and carnivorous life forms, isolation, slipping, falling, falling building parts, cuts and abrasions from sharp edges and objects, subsequent infections, fire, electrical shock, hazardous and/or toxic waste and substances, explosives, military ordnance and projectiles, and explosive conditions. I understand these risks create the possibility of permanent, disfiguring, disabling injury, or death.

In consideration of participation in the visit to the Marine Corps Air Ground Task Force Training Command, I agree to release the United State, the U.S. Marine Corps, Marine Corps Air Ground Combat Center 29 Palms, California, and any other partners, agents, employees, service members and agencies from any liability arising from the visit.

I consent to relieve the United States, the U.S. Marine Corps, Marine Corps Air Ground Combat Center 29 Palms, California and any of their partners, agents and agencies from any duty of care they owe to me, and I agree to my chances of injury or death from the risks inherent in this visit. I agree that neither the United States, the U.S. Marine Corps, Marine Corps Air Ground Combat Center 29 Palms, California, nor any of their partners, agents, employees, service members and agencies will protect me against any of the risks inherent in this visit. I am aware of the risks inherent in this visit and I am voluntarily encountering those risks.

I will never prosecute or assist in prosecuting any civil action against the United States, the U.S. Marine Corps, Marine Corps Air Ground Combat Center 29 Palms, California, or any of their partners, agents, employees, service members and agencies for any liability arising from any claim arising from this visit.

I know consulting with an attorney before reaching this agreement is prudent. I have had a full and fair opportunity to consult an attorney about this agreement, and I waive the further advice of counsel.

I have considered purchasing insurance for this activity. I agree that neither the United States, the U.S. Marine Corps, Marine Corps Air Ground Combat Center 29 Palms, California, nor any of their partners, agents, employees, service members and agencies will insure me.

This agreement is binding on all persons and entities claiming by, through, for or on account of their relation to me, including but not limited to my heirs, successors and assigns.

I sign this agreement voluntarily and of my own free will. No one has forced or coerced me in any way to sign this agreement.

_____	_____	_____
Participant Printed Name	Participant Signature	Date
_____	_____	_____
Government Witness Printed Name	Government Witness Signature	Date

THIRD PARTY COLLECTION PROGRAM/MEDICAL SERVICES ACCOUNT/ OTHER HEALTH INSURANCE

https://www.esd.whs.mil/Portals/54/Documents/DD/forms/dd/dd2569.pdf

(Read Privacy Act Statement before completing this form.)

OMB No. 0720-0055
OMB approval expires December 31, 2026

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 1079b, Procedures for charging fees for care provided to civilians; retention and use of fees collected; 10 U.S.C. 1095, Health care services incurred on behalf of covered beneficiaries: Collection from third-party payers; 42 U.S.C. Chapter 32, Third Party Liability For Hospital and Medical Care; and E.O. 9397 (SSN), as amended.
PURPOSE: DD Form 2569 collects individual's information to assist the Department of Defense ("DoD") in its recovery from third parties for medical care provided to an individual in a Military Treatment Facility.
ROUTINE USES: In addition to those disclosures generally permitted under 5 U.S.C. § 552a(b) of the Privacy Act of 1974, as amended, these records may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. § 552a(b)(3) as follows: to commercial insurance carriers and third parties involved in support of DoD's collection activities for health care provided; to the Departments of Treasury, Veterans Affairs, and Homeland Security for reimbursement of DoD provided medical services; to other persons or organizations who may be liable for payment of DoD provided health care and medical services; to data clearinghouses and insurance carriers related to converting medical and pharmacy claims to an industry-wide format related to payment of claims. For additional details as to routine uses and exceptions to the DoD Blanket Routine Uses, see the below hyperlinked SORN.
APPLICABLE SORN: EDHA 12, Third Party Collection System (July 15, 2016; 81 FR 46069)
https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570677/edha-12/
DISCLOSURE: Voluntary. If you choose not to provide the requested information, no penalties will be imposed; however, failure to provide complete and accurate information may result in disqualification for health care services.

PATIENT INFORMATION

1. PATIENT NAME *(Last, First, Middle Initial)*	**2. SSN OR DOD ID NUMBER**	**3. DATE OF BIRTH** *(YYYY/MM/DD)*

4. MAILING ADDRESS *(Include ZIP Code)*	**5. HOME TELEPHONE NO.** ( )
	6. SPONSOR/GUARANTOR SSN

INSURANCE INFORMATION

7. ARE YOU ELIGIBLE FOR VETERANS AFFAIRS BENEFITS?

☐ a. **YES.** *(If you have an insurance card (e.g., Veterans Health Identification Card (VHIC), Veterans Choice Card), that can be copied or scanned by the MTF representative, please provide it and proceed to Item 8; otherwise, please complete items 7.a.(1) through (5) below.)*

(1) Member ID	(2) Plan ID	(3) Expiration Date *(YYYY/MM/DD)*

(4) VA Facility Name *(e.g., primary care/specialty clinic)* that assists in coordinating your care

(5) VA Facility Address and Telephone Number ( )

☐ b. **NO.** *(Proceed to Item 8.)*

8. DO YOU HAVE OTHER HEALTH INSURANCE? *(This includes employer health insurance benefits, other commercial health insurance coverage, and Medicare Supplement.)* **PLEASE ATTACH COPY OF INSURANCE CARD**.

☐ a. **YES.** *(Complete Item 9 and the remaining sections below.)*
☐ b. **NO**, I am a DoD beneficiary and rely solely on TRICARE, Medicare, or Medicaid. *(Proceed to Item 13.)*
☐ c. **NO**, but I am not a DoD beneficiary. *(Proceed to Item 12.)*

9. PRIMARY MEDICAL INSURANCE INFORMATION. If you have an insurance card that can be copied or scanned by the MTF representative, please provide it and proceed to Item 11; otherwise, please complete the blocks below.

a. NAME OF POLICY HOLDER *(Last, First, Middle Initial)*	b. DATE OF BIRTH *(YYYY/MM/DD)*	c. RELATIONSHIP TO POLICY HOLDER

d. POLICY HOLDER'S EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER	e. INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

f. MEMBER ID	g. POLICY ID	h. GROUP POLICY ID	i. GROUP PLAN NAME

j. ENROLLMENT/PLAN CODE	k. INSURANCE TYPE	l. POLICY EFFECTIVE DATE *(YYYY/MM/DD)*	m. POLICY END DATE *(YYYY/MM/DD)*

n.(1) Pharmacy (Rx) Insurance Company Name, Address and Telephone Number

(2) Rx Policy ID	(3) Rx Bin Number	(4) Rx PCN Number

10. SECONDARY MEDICAL INSURANCE INFORMATION. If you have an insurance card that can be copied or scanned by the MTF representative, please provide it and proceed to Item 11; otherwise, please complete the blocks below.

a. NAME OF POLICY HOLDER *(Last, First, Middle Initial)*	b. DATE OF BIRTH *(YYYY/MM/DD)*	c. RELATIONSHIP TO POLICY HOLDER
d. POLICY HOLDER'S EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER		
e. INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER		

f. MEMBER ID	g. POLICY ID	h. GROUP POLICY ID	i. GROUP PLAN NAME
j. ENROLLMENT/PLAN CODE	k. INSURANCE TYPE	l. POLICY EFFECTIVE DATE *(YYYY/MM/DD)*	m. POLICY END DATE *(YYYY/MM/DD)*
n.(1) Pharmacy (Rx) Insurance Company Name, Address and Telephone Number			
(2) Rx Policy ID	(3) Rx Bin Number	(4) Rx PCN Number	

11. ARE THERE OTHER FAMILY MEMBERS COVERED UNDER THIS POLICY HOLDER?

☐ a. **YES** *(Complete 11c.-f. and proceed to Item 13.)* ☐ b. **NO** *(Proceed to Item 13.)*

c. NAME *(Last, First, Middle Initial)*	d. SSN	e. DATE OF BIRTH *(YYYY/MM/DD)*	f. RELATIONSHIP TO POLICY HOLDER	c. NAME *(Last, First, Middle Initial)*	d. SSN	e. DATE OF BIRTH *(YYYY/MM/DD)*	f. RELATIONSHIP TO POLICY HOLDER

12. MEDICARE OR MEDICAID INFORMATION

a. MEDICARE ID NUMBER	b. MEDICARE MANAGED CARE PLAN NAME
c. MEDICARE PART D NUMBER AND PLAN NAME	d. MEDICAID NUMBER/MANAGED CARE PLAN NAME/ISSUING

13. CERTIFICATION, RELEASE, AND ASSIGNMENT

a. I certify that the information on this form is true and accurate to the best of my knowledge. Falsification of information is covered by Title 18, United States Code, Section 1001, which provides for a maximum fine of $250,000 or imprisonment for five years, or both.

b. I acknowledge that the authority to bill third party payers has been conveyed to the medical facility within the Department of Defense by Title 10, United States Code, Sections 1095 and 1079b, and that no personal entitlement to reimbursement or payment has been granted to me by virtue of this act.

c. NON-UNIFORMED SERVICES PATIENTS: I authorize and request that the proceeds of any and all benefits be paid directly to the MTF for healthcare services provided me and/or my minor dependents. ACKNOWLEDGEMENT: I hereby agree to pay for any service not covered in whole or in part by my third-party insurer.

d. NON-DoD MEDICARE, MEDICAID AND VETERANS AFFAIRS PATIENTS: I authorize and request that the proceeds of any and all benefits be paid directly to the MTF for healthcare services provided to me and/or my family member. I acknowledge I am responsible for full payment of any services not covered by Medicare, Medicaid and Veterans Affairs, including but not limited to patient copayments and deductibles.

e. UNIFORMED SERVICES BENEFICIARIES: I hereby acknowledge that the proceeds of any and all benefits shall be paid directly to the facility of the Uniformed Service for services provided to me and/or my family member.

f. ALL PATIENTS: I authorize portions of my medical records necessary to support claims for reimbursement for the cost of care rendered to be released to my insurance carriers.

14a. PATIENT OR ADULT FAMILY MEMBER SIGNATURE	b. DATE *(YYYY/MM/DD)*
15a. IF PATIENT REFUSES TO SIGN THIS FORM: MTF REPRESENTATIVE SIGNATURE	b. DATE *(YYYY/MM/DD)*

16. ANNUAL PATIENT INSURANCE VERIFICATION

a. If any information on this form has changed, a new form must be completed and signed. Otherwise, after initial signature, verify with your initials and date at least annually.

b. I certify that the information on this form has been verified on the date(s) specified below, and that all information is true and accurate to the best of my knowledge.

17a. SIGNATURE *(Patient or Adult Family Member)*	b. DATE *(YYYY/MM/DD)*

18. VERIFICATION a. (1) Date *(YYYY/MM/DD)*	(2) Initials	b.(1) Date *(YYYY/MM/DD)*	(2) Initials	c.(1) Date *(YYYY/MM/DD)*	(2) Initials