OMB Approved No. 2900-0404
Respondent Burden: 45 minutes
Expiration Date:10/31/2020

Department of Veterans Affairs

VETERAN'S APPLICATION FOR INCREASED COMPENSATION BASED ON UNEMPLOYABILITY

(DO NOT WRITE IN THIS SPACE)
(VA DATE STAMP)

Received Centralized Mail Processing, Janesville, WI
09/13/2021

NOTE: This is a claim for compensation benefits based on unemployability. When you complete this form you are claiming total disability because of a service-connected disability(ies) which has/have prevented you from securing or following any substantially gainful occupation. Answer all questions fully and accurately. See mail/fax information on page 3 of this form.

Social Security Benefits: Individuals who have a disability and meet medical criteria may qualify for Social Security of Supplemental Security Income disability benefits. If you would like more information about Social Security benefits, contact your nearest Social Security Administration (SSA) office. You can locate the address of the nearest SSA office in your telephone book blue pages under "United States Government, Social Security Administration" or call 1-800-772-1213 (Hearing Impaired TDD line 1-800-325-0778.). You may also contact SSA by Internet at **http://www.ssa.gov/**.

SECTION I - VETERAN IDENTIFICATION INFORMATION

NOTE: You can ***either*** complete the form online or by hand. If completed by hand print the information requested in ink, neatly, and legibly to expedite processing the form.

1. NAME OF VETERAN *(FIRST, MIDDLE INITIAL, LAST)*

Gordan L Stevens

2. VETERAN'S SOCIAL SECURITY NUMBER

TRA – 93 – 0604

3. VA FILE NUMBER

6Y20XX00

4. DATE OF BIRTH *(MM,DD,YYYY)*

Month 07 – Day 30 – Year 1962

5. MAILING ADDRESS OF VETERAN *(No. and street or rural route, city or P.O., State, ZIP Code and Country)*

No. & Street: 31 Hopkins Plaza

Apt./Unit Number:

City: Baltimore

State/Province: MD

Country: US

ZIP Code/Postal Code: 21201 –

6. EMAIL ADDRESS *(If applicable)*

7. TELEPHONE NUMBER *(Include Area Code)*

(555)555-1212

SECTION II - DISABILITY AND MEDICAL TREATMENT

8. WHAT SERVICE-CONNECTED DISABILITY PREVENTS YOU FROM SECURING OR FOLLOWING ANY SUBSTANTIALLY GAINFUL OCCUPATION?

Cervical Strain and Lumbosacral Strain

9. HAVE YOU BEEN UNDER A DOCTOR'S CARE AND/OR HOSPITALIZED WITHIN THE PAST 12 MONTHS?

☐ YES ☒ NO

10. DATE(S) OF TREATMENT BY DOCTOR(S)

FROM	TO

11. NAME AND ADDRESS OF DOCTOR(S)

12. NAME AND ADDRESS OF HOSPITAL

13. DATE(S) OF HOSPITALIZATION

FROM	TO

SECTION III - EMPLOYMENT STATEMENT

14. DATE YOUR DISABILITY AFFECTED FULL-TIME EMPLOYMENT
Month – Day – Year

15. DATE YOU LAST WORKED FULL-TIME
Month – Day – Year

16. DATE YOU BECAME TOO DISABLED TO WORK
Month – Day – Year

17A. WHAT IS THE MOST YOU EVER EARNED IN ONE YEAR?

$

17B. WHAT YEAR?
Year

17C. OCCUPATION DURING THAT YEAR

VETERAN'S SOCIAL SECURITY NO. T R A – 9 3 – 0 6 0 4

SECTION III - EMPLOYMENT STATEMENT *(Continued)*

18. LIST ALL YOUR EMPLOYMENT INCLUDING SELF-EMPLOYMENT FOR THE LAST FIVE YEARS YOU WORKED (Include any military duty including inactive duty for training)

A. NAME AND ADDRESS OF EMPLOYER (OR UNIT)	B. TYPE OF WORK	C. HOURS PER WEEK	D. DATES OF EMPLOYMENT FROM	D. DATES OF EMPLOYMENT TO	E. TIME LOST FROM ILLNESS	F. HIGHEST GROSS EARNINGS PER MONTH
Big Tires R Us, 121 Jerry RD, Townsend, MD 21201	Sales	40	6/2012	5/2018	3 months	$4500

18G. IF YOU ARE CURRENTLY SERVING IN THE RESERVE OR NATIONAL GUARD, DOES YOUR SERVICE CONNECTED DISABILITY PREVENT YOU FROM PERFORMING YOUR MILITARY DUTIES?

☐ YES ☒ NO

18H. INDICATE YOUR TOTAL EARNED INCOME FOR THE PAST 12 MONTHS	18I. IF PRESENTLY EMPLOYED, INDICATE YOUR CURRENT MONTHLY EARNED INCOME
$ 20,000	$ 0

19. DID YOU LEAVE YOUR LAST JOB/SELF-EMPLOYMENT BECAUSE OF YOUR DISABILITY?	20. DO YOU RECEIVE/EXPECT TO RECEIVE DISABILITY RETIREMENT BENEFITS?	21. DO YOU RECEIVE/EXPECT TO RECEIVE WORKERS COMPENSATION BENEFITS?
☒ YES ☐ NO *(If "Yes," give the facts in Item 26, "Remarks")*	☐ YES ☒ NO	☐ YES ☒ NO

22. HAVE YOU TRIED TO OBTAIN EMPLOYMENT SINCE YOU BECAME TOO DISABLED TO WORK?

☐ YES ☒ NO *(If "Yes," complete Items 22A, 22B, and 22C)*

A. NAME AND ADDRESS OF EMPLOYER	B. TYPE OF WORK	C. DATE APPLIED

SECTION IV - SCHOOLING AND OTHER TRAINING

23. EDUCATION *(Check highest year completed)*

GRADE SCHOOL ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 HIGH SCHOOL ☐ 1 ☐ 2 ☐ 3 ☒ 4 COLLEGE ☒ 1 ☐ 2 ☐ 3 ☐ 4

24A. DID YOU HAVE ANY OTHER EDUCATION AND TRAINING BEFORE YOU WERE TOO DISABLED TO WORK?

☐ YES ☒ NO *(If "Yes," complete Items 24B, and 24C)*

24B. TYPE OF EDUCATION OR TRAINING	24C. DATES OF TRAINING BEGINNING	24C. DATES OF TRAINING COMPLETION

25A. HAVE YOU HAD ANY EDUCATION AND TRAINING SINCE YOU BECAME TOO DISABLED TO WORK?

☐ YES ☐ NO *(If "Yes," complete Items 25B, and 25C)*

25B. TYPE OF EDUCATION OR TRAINING	25C. DATES OF TRAINING BEGINNING	25C. DATES OF TRAINING COMPLETION

VETERAN'S SOCIAL SECURITY NO. T R A – 9 3 – 0 6 0 4

26. REMARKS *(If any)*

My neck and low back pain have become so severe I was unable to maintain my employment as it required me to be on my feet most of the time. My conditions continue to deteriorate and I have been unable to find another job.

SECTION IV - AUTHORIZATION, CERTIFICATION, AND SIGNATURE

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize the person or entity, including but not limited to any organization, service provider, employer, or Government agency, to give the Department of Veterans Affairs any information about me except protected health information, and I waive any privilege which makes the information confidential.

CERTIFICATION OF STATEMENTS: I CERTIFY THAT as a result of my service-connected disabilities, I am unable to secure or follow *any* substantially gainful occupation and that the statements in this application are true and complete to the best of my knowledge and belief. I understand that these statements will be considered in determining my eligibility for VA benefits based on unemployability because of service-connected disability.

I UNDERSTAND THAT IF I AM GRANTED SERVICE-CONNECTED TOTAL DISABILITY BENEFITS BASED ON MY UNEMPLOYABILITY, I MUST IMMEDIATELY INFORM VA IF I RETURN TO WORK. I ALSO UNDERSTAND THAT TOTAL DISABILITY BENEFITS PAID TO ME AFTER I BEGIN WORK MAY BE CONSIDERED AN OVERPAYMENT REQUIRING REPAYMENT TO VA.

27. SIGNATURE OF CLAIMANT *(Do Not Print) (Sign in ink)*	28. DATE SIGNED
Gordan Leroy Stevens	09/11/2021

WITNESS TO SIGNATURE OF CLAIMANT IF MADE "X" MARK. NOTE: Signature made by mark must be witnessed by two persons to whom the person making the statement is personally know and the signature and address of such witnesses must be shown below.

29A. SIGNATURE OF WITNESS *(Sign in ink)*	29B. ADDRESS OF WITNESS
30A. SIGNATURE OF WITNESS *(Sign in ink)*	30B. ADDRESS OF WITNESS

SECTION V - WHERE TO SEND CORRESPONDENCE

MAIL TO:	FAX TO:
Department of Veterans Affairs **Evidence Intake Center** **PO Box 4444** **Janesville, WI 53547-4444**	**844-531-7818 (Toll Free) *OR*** **Local: 248-524-4260**

PENALTY: The law provides severe penalties which include fine or imprisonment or both for the willful submission of any statement or evidence of a material fact, knowing it to be false or for the fraudulent acceptance of any payment to which you are not entitled.

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. Giving us your SSN account information is mandatory. Applicants are required to provide their SSN under Title 38, U.S.C. 5101(c)(1). VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits provided under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to determine your eligibility for compensation. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 45 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

OMB Control No. 2900-0321
Respondent Burden: 5 minutes
Expiration Date: 02/28/2022

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

Received Centralized Mail Processing,
Janesville, WI
Date Received 09/13/2021

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

IMPORTANT: Please read the Privacy Act and Respondent Burden Information on Page 3 before completing the form.

NOTE: If you prefer to have an individual assist you with your claim instead of a veterans service organization, please complete VA Form 21-22a, *Appointment of Individual as Claimant's Representative.* When completed you can mail ***or*** fax this form to the appropriate intake center address shown on Page 4. VA forms are available at www.va.gov/vaforms.

SECTION I: VETERAN'S INFORMATION

NOTE: You can *either* complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing of the form.

1. VETERAN'S NAME *(First, Middle Initial, Last)*

Gordan L Stevens

2. VETERAN'S SOCIAL SECURITY NUMBER *(SSN)*

TRA – 93 – 0604

3. VA FILE NUMBER *(If applicable)*

6Y20XX00

4. VETERAN'S DATE OF BIRTH

Month 07 – Day 30 – Year 1962

5. VETERAN'S SERVICE NUMBER *(If applicable)*

6. INSURANCE NUMBER(S) *(If applicable) (Include letter prefix)*

7. VETERAN'S MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street: 31 Hopkins Plaza

Apt./Unit Number:

City: Baltimore

State/Province: MD

Country: US

ZIP Code/Postal Code: 21201 –

8. VETERAN'S TELEPHONE NUMBER *(Include Area Code)*

9. VETERAN'S EMAIL ADDRESS *(Optional)*

SECTION II: CLAIMANT'S INFORMATION (If other than veteran)

10. CLAIMANT'S NAME *(First, Middle Initial, Last)*

11. CLAIMANT'S MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street:

Apt./Unit Number:

City:

State/Province:

Country:

ZIP Code/Postal Code: –

12. CLAIMANT'S TELEPHONE NUMBER *(Include Area Code)*

13. CLAIMANT'S EMAIL ADDRESS *(Optional)*

14. RELATIONSHIP TO VETERAN

SECTION III: SERVICE ORGANIZATION INFORMATION

15. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS *(See list on Page 3 before selecting organization)*

Disabled American Veterans

16A. NAME OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 15 *(This is an appointment of the entire organization and does not indicate the designation of only this specific individual to act on behalf of the organization)*

James Harper

16B. JOB TITLE OF PERSON NAMED IN ITEM 16A

NSO

17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15

JHarper.DAV@email.com

18. DATE OF THIS APPOINTMENT *(MM/DD/YYYY)*

09/11/2021

VETERAN'S SOCIAL SECURITY NUMBER T R A – 9 3 – 0 6 0 4

SECTION IV: AUTHORIZATION INFORMATION

19. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C. - By checking the box below I authorize VA to disclose to the service organization named on this appointment form any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

☒ I **authorize** the VA facility having custody of my VA claimant records to disclose to the service organization named in Item 15 all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Redisclosure of these records by my service organization representative, other than to VA or the Court of Appeals for Veterans Claims, is not authorized without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the service organization named in Item 15, either by explicit revocation or the appointment of another representative.

20. LIMITATION OF CONSENT- I authorize disclosure of records related to treatment for all conditions listed in Item 19 except:

☐ DRUG ABUSE ☐ INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)

☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

21. AUTHORIZATION TO CHANGE CLAIMANT'S ADDRESS - By checking the box below, I authorize the organization named in Item 15 to act on my behalf to change my address in my VA records.

☒ I **authorize** any official representative of the organization named in Item 15 to act on my behalf to change my address in my VA records. This authorization does not extend to any other organization without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I file a written revocation with VA; or (2) I appoint another representative, or (3) I have been determined unable to manage my financial affairs and the individual or organization named in Item 16A is not my appointed fiduciary.

I, the claimant named in Items 1 ***or*** 10, hereby **appoint** the service organization named in Item 15 as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 19 and 20), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.6. *Additionally, in some cases a veteran's income is developed because a match with the Internal Revenue Service necessitated income verification. In such cases, the assignment of the service organization as the veteran's representative is valid for only five years from the date the claimant signs this form for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

SECTION V: SIGNATURES

NOTE: THIS POWER OF ATTORNEY DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC

22A. SIGNATURE OF VETERAN OR CLAIMANT *(Do Not Print)*	22B. DATE SIGNED *(MM/DD/YYYY)*
Gordan Leroy Stevens	09/11/2021
23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A *(Do Not Print)*	**23B. DATE SIGNED** *(MM/DD/YYYY)*
James Harper	09/11/2021

NOTE: As long as this appointment is in effect, the organization named herein will be recognized as the sole representative for preparation, presentation and prosecution of your claim before the Department of Veterans Affairs in connection with your claim or any portion thereof.

VA USE ONLY	COPY OF VA FORM 21-22 SENT TO: ☐ VR&E FILE ☐ EDU FILE ☐ LG FILE ☐ INSURANCE FILE	DATE SENT	ACKNOWLEDGED *(Date)*	REVOKED *(Reason and date)*

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement of a material fact, knowing it to be false or for the fraudulent acceptance of any payment to which you are not entitled.

RECOGNIZED SERVICE ORGANIZATIONS

Membership in an organization is not a prerequisite to appointment of the organization as claimant's representative.

The following is a listing of national, regional, or local organizations recognized by the Secretary of Veterans Affairs in the preparation, presentation, and prosecution of claims under laws administered by the Department of Veterans Affairs.

African American PTSD Association
American Legion
American Red Cross
AMVETS
American Ex-Prisoners of War, Inc.
American GI Forum, National Veterans Outreach Program
Armed Forces Services Corporation
Army and Navy Union, USA
Associates of Vietnam Veterans of America
Blinded Veterans Association
Catholic War Veterans of the U.S.A.
Disabled American Veterans
Fleet Reserve Association
Gold Star Wives of America, Inc.
Italian American War Veterans of the United States, Inc.
Jewish War Veterans of the United States
Legion of Valor of the United States of America, Inc.
Marine Corps League
Military Officers Association of America (MOAA)
Military Order of the Purple Heart
National Amputation Foundation, Inc.
National Association of County Veterans Service Officers, Inc,
National Association for Black Veterans, Inc.
National Veterans Legal Services Program
National Veterans Organization of America
Navy Mutual Aid Association
Paralyzed Veterans of America, Inc.
Polish Legion of American Veterans, U.S.A.
Swords to Plowshares, Veterans Rights Organization, Inc.
The Retired Enlisted Association
The Veterans Assistance Foundation, Inc.
The Veterans of the Vietnam War, Inc. & The Veterans Coalition
United Spanish War Veterans of the United States
United Spinal Association, Inc.
Veterans of Foreign Wars of the United States
Veterans of World War I of the U.S.A., Inc.
Vietnam Era Veterans Association
Vietnam Veterans of America
West Virginia Department of Veterans Assistance
Wounded Warrior Project

Although agency titles vary, the following States and possessions maintain veterans service agencies which are recognized to present claims:

Alabama	Hawaii	Minnesota	North Dakota	Tennessee
American Samoa	Idaho	Mississippi	Northern Mariana Islands	Texas
Arizona	Illinois	Missouri	Ohio	Utah
Arkansas	Iowa	Montana	Oklahoma	Vermont
California	Kansas	Nebraska	Oregon	Virginia
Colorado	Kentucky	Nevada	Pennsylvania	Virgin Islands
Connecticut	Louisiana	New Hampshire	Puerto Rico	Washington
Delaware	Maine	New Jersey	Rhode Island	West Virginia
Florida	Maryland	New Mexico	South Carolina	Wisconsin
Georgia	Massachusetts	New York	South Dakota	Wyoming
Guam	Michigan	North Carolina		

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. However, the requested information is considered relevant and necessary to recognize a service organization as your representative and/or identify disclosable records. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to recognize the service organization you name to act on your behalf in the preparation, presentation, and prosecution of claims for VA benefits (38 U.S.C. 5902). We will also use the information to identify any VA records that we may disclose to the service organization (38 U.S.C. 5701(b)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

FOR ALL **COMPENSATION** CLAIMS MAIL OR FAX THIS FORM TO THE FOLLOWING ADDRESS:

Mail your form to:
Department of Veterans Affairs
Claims Intake Center
P.O. Box 4444
Janesville, WI 53547- 4444
Or fax your form to:
Toll Free: (844) 531- 7818
Local: 248-524-4260

FOR **VETERANS PENSION** AND **SURVIVOR BENEFIT** CLAIMS MAIL OR FAX THIS FORM TO THE APPROPRIATE ADDRESS SHOWN BELOW:

Mail your form to:
Department of Veterans Affairs
Claims Intake Center
Attn: Milwaukee Pension Center
P.O. Box 5192
Janesville, WI 53547-5192
Or fax your form to:
Toll Free: (844) 655-1604

This Pension Center Serves The Following:

Alabama	Arkansas	Illinois	Indiana
Kentucky	Louisiana	Michigan	Mississippi
Missouri	Ohio	Tennessee	Wisconsin

Mail your form to:
Department of Veterans Affairs
Claims Intake Center
Attn: Philadelphia Pension Center
P.O. Box 5206
Janesville, WI 53547-5206
Or fax your form to:
Toll Free: (844) 655-1604

This Pension Center Serves The Following:

Connecticut	Delaware	Florida	Georgia
Maine	Maryland	Massachusetts	New Hampshire
New Jersey	New York	North Carolina	Pennsylvania
Rhode Island	South Carolina	Vermont	Virginia
West Virginia	District of Columbia	Puerto Rico	Canada
Countries outside of North, Central or South America			

Mail your form to:
Department of Veterans Affairs
Claims Intake Center
Attn: St. Paul Pension Center
P.O. Box 5365
Janesville, WI 53547-5365
Or fax your form to:
Toll Free: (844) 655-1604

This Pension Center Serves The Following:

Alaska	Arizona	California	Colorado
Hawaii	Idaho	Iowa	Kansas
Minnesota	Montana	Nebraska	Nevada
New Mexico	North Dakota	Oklahoma	Oregon
South Dakota	Texas	Utah	Washington
Wyoming	Mexico	Central America	South America
Caribbean			

DEPARTMENT OF VETERANS AFFAIRS

09/16/2021

GORDAN LEROY STEVENS
31 HOPKINS PLAZA
BALTIMORE, MD 21201 (US)

In reply, refer to:
372/WS
File Number: TRA-93-0604
GORDAN STEVENS

IMPORTANT -- reply needed within 30 days

Dear Mr. STEVENS:

We are working on your claim.

This letter tells you what we will do with your claim and what you can do to help us. Please read the enclosure to this letter entitled, *What the Evidence Must Show to Support your Claim*. The enclosure explains how we obtain evidence related to your claim and the legal requirements for supporting your claim.

What Do We Still Need From You?

We may need additional evidence from you.

- If you have any treatment records related to your claimed condition(s), send them to VA now. This includes reports or statements from doctors, hospitals, laboratories, medical facilities, mental health facilities, as well as reports of x-rays, physical therapy, surgery, etc. These reports should include the dates of treatment, findings, and diagnoses.
- VA has provided Disability Benefits Questionnaires that may be helpful for you to take to your doctor to complete. They can be found at the attached link http://benefits.va.gov/COMPENSATION/dbq_disabilityexams.asp
- If you are unable to obtain any doctor, hospital, or medical report and want us to try to obtain it on your behalf, please complete and return the enclosed VA Form 21-4142, *Authorization to Disclose Information*, and VA Form 21-4142a, *General Release for Medical Provider Information*, so that we can request treatment records from your private medical sources.
- If you have received treatment at a Department of Veterans Affairs (VA) facility or treatment authorized by VA, please tell us the dates and places of treatment. We will then obtain the necessary records if you give us enough information to locate them.

- You may also send us your own statement or statements from people who have witnessed how your claimed disabilities are related to service and/or how such disabilities affect you. All statements submitted on your behalf should conclude with the following certification: "I hereby certify that the information I have given is true to the best of my knowledge and belief."

- **We have enclosed a *38 U.S.C. §5103 Notice Response*. We encourage you to return this document, as it may expedite a decision on your claim.**

VA Is Responsible for Taking the Following Actions

- Retrieving relevant records from another Federal agency, or from a Federal facility, such as a VA medical center or military treatment facility, that you adequately identify and authorize VA to obtain
- Providing a medical examination for you, or get a medical opinion, if we determine it is necessary to decide your claim
- Making every reasonable effort to obtain relevant records not held by a Federal facility that you adequately identify and authorize VA to obtain. These may include records from State or local governments and privately held evidence and information you tell us about, such as private doctor or hospital records, or records from current or former employers

How You Can Help

If you are submitting evidence now or have nothing further to provide, please complete and return the enclosed *38 U.S.C. 5103 Notice Response* within 30 days from the date of this letter.

If you have any information or evidence that you have not previously told us about or given to us, please tell us or give us that evidence now. If the evidence is not in your possession, you must give us enough information about the evidence so that we can request it from the person or agency that has it. If the holder of the evidence declines to give it to us, asks for a fee to provide it, or VA otherwise cannot get the evidence, we will notify you. It is your responsibility to make sure we receive all requested records that are not in the possession of a Federal department or agency.

You can submit any additional information to us in the following ways:

- Using eBenefits at http://www.ebenefits.va.gov;
- Using mail, please send (or fax) all responses to the appropriate address listed on the attached *Where to Send Your Written Correspondence* chart; or
- Using the telephone, call 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the number is 711.

How Soon Should You Send What We Need?

We strongly encourage you to send any information or evidence as soon as you can. **If we do not hear from you, we may make a decision on your claim after 30 days**. However, you have up to one year from the date of this letter to submit the information and evidence necessary to support your claim. If we decide your claim before one year from the date of this letter, you will still have the remainder of the one-year period to submit additional information or evidence necessary to support your claim.

What is eBenefits?

eBenefits provides electronic resources in a self-service environment to Servicemembers, Veterans, and their families. Use of these resources often helps us serve you faster! Through the eBenefits website you can:

- Submit claims for benefits and/or upload documents directly to the VA
- Request to add or change your dependents
- Update your contact and direct deposit information and view payment history
- Request a Veterans Service Officer to represent you
- Track the status of your claim or appeal
- Obtain verification of military service, civil service preference, or VA benefits
- And much more!

Enrolling in eBenefits is easy. Just visit www.eBenefits.va.gov for more information. If you submit a claim in the future, consider filing through eBenefits. Filing electronically, especially if you participate in our fully developed claim program, may result in a faster decision than if you submit your claim through the mail.

We sent a copy of this letter to MILITARY ORDER OF THE PURPLE HEART, who you have appointed as your representative(s). If you have questions or need assistance, you can also contact your representative.

We look forward to resolving your claim in a fair and timely manner.

Thank you for your service,

Regional Office Director

Enclosure(s): Where to Send Written Correspondence Chart
VA Form 21-4142a
What Evidence Must Show
VA Form 21-4142
38 U.S.C. 5103 Notice
38 U.S.C. 5103 Notice Response

cc:

Where to Send Your Written Correspondence

In order to properly determine where to send your written correspondence, please first identify your benefit type (Compensation, Veterans Pension, or Survivor Benefits); then, locate the corresponding address based on your location of residence.

For correspondence relating to all **Compensation** claims:

Location of Residence	Address
All United States and Foreign Locations *__Note__: For foreign Veterans Pension and Survivor Benefits please refer to the below addresses.	Department Of Veterans Affairs Evidence Intake Center **P.O. Box 4444** Janesville, WI, 53547-4444 Or fax your information to: Toll Free: 844-531-7818 Local: 248-524-4260

For correspondence relating to all **Veterans Pension** and **Survivor Benefit** claims

Location of Residence			Address
Alabama Arkansas Illinois Indiana	Kentucky Louisiana Michigan Mississippi	Missouri Ohio Tennessee Wisconsin	Department Of Veterans Affairs Claims Intake Center Attention: Milwaukee Pension Center **P.O. Box 5192** Janesville, WI 53547-5192 Or fax your information to: Toll Free: (844) 655-1604
Alaska Arizona California Colorado Hawaii Idaho Iowa Kansas Minnesota	Montana Nebraska Nevada New Mexico North Dakota Oklahoma Oregon South Dakota	Texas Utah Washington Wyoming Mexico Central America South America Caribbean	Department Of Veterans Affairs Claims Intake Center Attention: St. Paul Pension Center **P.O. Box 5365** Janesville, WI 53547-5365 Or fax your information to: Toll Free: (844) 655-1604
Connecticut Delaware Florida Georgia Maine Maryland Massachusetts Countries outside of North, Central or South America	New Hampshire New Jersey New York North Carolina Pennsylvania Rhode Island	South Carolina Vermont Virginia West Virginia District of Columbia Puerto Rico Canada	Department Of Veterans Affairs Claims Intake Center Attention: Philadelphia Pension Center **P.O. Box 5206** Janesville, WI 53547-5206 Or fax your information to: Toll Free: (844) 655-1604

OMB Control No. 2900-0001
Respondent Burden: 5 minutes
Expiration Date: 8/31/2017

Department of Veterans Affairs

GENERAL RELEASE FOR MEDICAL PROVIDER INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

NOTE - PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION BELOW BEFORE COMPLETING THIS FORM.

INSTRUCTIONS - COMPLETE AND ATTACH THIS FORM WITH A SIGNED VA FORM 21-4142, *AUTHORIZATION TO DISCLOSE INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)*. IF YOU HAVE MORE THAN THREE PROVIDERS, FILL OUT ADDITIONAL COPIES OF THIS FORM, AVAILABLE AT **WWW.VA.GOV/VAFORMS.**

SECTION I - PATIENT IDENTIFICATION FOR RECORDS VA IS REQUESTING

1. LAST NAME - FIRST NAME - MIDDLE NAME OF VETERAN *(Type or print)*	2. VETERAN'S SOCIAL SECURITY NUMBER	3. VA FILE NUMBER

SECTION II - MEDICAL PROVIDER INFORMATION

4A. PROVIDER OR FACILITY NAME	4B. DATE(S) OF TREATMENT: *(Include the time period (month/day/year) for the treatment by the provider listed in Item 4A)*
	From: To: From: To:

4C. PROVIDER/FACILITY STREET ADDRESS (Number and street, P.O. or rural route)		
4D. CITY	4E. STATE AND ZIP CODE	4F. PROVIDER OR FACILITY TELEPHONE NUMBER (Include Area Code)

5A. PROVIDER OR FACILITY NAME	5B. DATE(S) OF TREATMENT: *(Include the time period (month/day/year) for the treatment by the provider listed in Item 5A)*
	From: To: From: To:

5C. PROVIDER/FACILITY STREET ADDRESS (Number and street, P.O. or rural route)		
5D. CITY	5E. STATE AND ZIP CODE	5F. PROVIDER OR FACILITY TELEPHONE NUMBER (Include Area Code)

6A. PROVIDER OR FACILITY NAME	6B. DATE(S) OF TREATMENT: *(Include the time period (month/day/year) for the treatment by the provider listed in Item 6A)*
	From: To: From: To:

6C. PROVIDER/FACILITY STREET ADDRESS (Number and street, P.O. or rural route)		
6D. CITY	6E. STATE AND ZIP CODE	6F. PROVIDER OR FACILITY TELEPHONE NUMBER (Include Area Code)

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28 Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, and published in the Federal Register. Your obligation to respond is voluntary. However, if the information including your Social Security Number (SSN) is not furnished completely or accurately, the health care provider to which this authorization is addressed may not be able to identify and locate your records, and provide a copy to VA. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975 and still in effect.

RESPONDENT BURDEN: We need this information to obtain your treatment records. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 minutes to review the instructions, find the information and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you may call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

WHAT THE EVIDENCE MUST SHOW TO SUPPORT YOUR CLAIM

If you are claiming...	See the evidence table titled...
You have a disability that was caused or aggravated by your service	Disability Service Connection
Your service connected disability caused or aggravated an additional disability	Secondary Service Connection
Your service connected disability has worsened	Increased Disability Compensation
Your service connected disability caused you to be hospitalized or to undergo surgery or other treatment	Temporary Total Disability Rating
Your service connected disability(ies) prevents you from getting or keeping substantial employment	Individual Unemployability
You have a disability caused or aggravated by VA medical treatment, vocational rehabilitation, or compensated work therapy	Compensation Under 38 U.S.C. 1151
Your service connected disability(ies) causes you to be in need of aid and attendance or to be confined to your residence	Special Monthly Compensation

If you are claiming benefits...	See the evidence table titled...
For adapting and/or purchasing a residence	Special Adapted Housing or Special Home Adaptation
For adapting and/or purchasing a vehicle	Auto Allowance
Because your spouse is severely disabled	Special Monthly Compensation
Because your child is severely disabled	Helpless Child

EVIDENCE TABLES

Disability Service Connection

To support a claim for **service connection**, the evidence must show:

- You had an injury in service, or a disease that began in or was made permanently worse during service, or there was an event in service that caused an injury or disease; **AND**
- You have a current physical or mental disability. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that are visible or observable; **AND**
- A relationship exists between your current disability and an injury, disease, symptoms, or event in service. This may be shown by medical records or medical opinions or, in certain cases, by lay evidence. However, under certain circumstances, VA may presume that certain current disabilities were caused by service, even if there is no specific evidence proving this in your particular claim. The cause of a disability is presumed for the following veterans who have certain diseases:
  - Former prisoners of war;
  - Veterans who have certain chronic or tropical diseases that become evident within a specific period of time after discharge from service;
  - Veterans who were exposed to ionizing radiation, mustard gas, or Lewisite while in service;
  - Veterans who were exposed to certain herbicides, such as by serving in Vietnam; or
  - Veterans who served in the Southwest Asia theater of operations during the Gulf War.

To support a claim **for service connection based upon a period of active duty for training**, the evidence must show:

- You were disabled during active duty for training due to disease or injury incurred or aggravated in the line of duty; **AND**
- You have a current physical or mental disability. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that are visible or observable; **AND**
- There is a relationship between your current disability and the disease or injury incurred or aggravated during active duty for training. This may be shown by medical records or medical opinions or, in certain cases, by lay evidence.

To support a claim for **service connection based upon a period of *inactive* duty training**, the evidence must show:

- You were disabled during inactive duty training due to an injury incurred or aggravated in the line of duty or an acute myocardial infarction, cardiac arrest, or cerebrovascular accident during inactive duty training; **AND**
- You have a current physical or mental disability. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that are visible or observable; **AND**
- There is a relationship between your current disability and your inactive duty training. This may be shown by medical records or medical opinions or, in certain cases, by lay evidence.

EVIDENCE TABLES (Continued)

Disability Service Connection (Continued)

In order to reopen a claim previously denied by VA, we need new and material evidence. New and material evidence must raise a reasonable possibility of substantiating your claim. The evidence cannot simply be repetitive or cumulative of the evidence we had when we previously decided your claim. VA will make reasonable efforts to help you obtain currently existing evidence. However, we cannot provide a medical examination or obtain a medical opinion until your claim is successfully reopened.

- To qualify as new, the evidence must currently exist and be submitted to VA for the first time
- In order to be considered material, the additional existing evidence must pertain to the reason your claim was previously denied

Secondary Service Connection

To support a claim for compensation based upon an additional disability that was caused or aggravated by a service-connected disability, the evidence must show:

- **You currently have a physical or mental disability shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that are visible or observable, in addition to your service-connected disability; AND**
- Your service-connected disability either caused or aggravated your additional disability. This may be shown by medical records or medical opinions or, in certain cases, by lay evidence. However, VA may presume service-connection for cardiovascular disease developing in a claimant with certain service-connected amputation(s) of one or both lower extremities.

Increased Disability Compensation

If VA previously granted service connection for your disability and you are seeking an increased evaluation of your service connected disability, we need medical or lay evidence to show a worsening or increase in severity and the effect that worsening or increase has on your ability to work.

Temporary Total Disability Rating

In order to support a claim for a temporary total disability rating due to hospitalization, the evidence must show:

- You were treated for more than 21 days for a service-connected disability at a VA or other approved hospital; **OR**
- You underwent hospital observation at VA expense for a service-connected disability for more than 21 days.

In order to support a claim for a temporary total disability rating due to surgical or other treatment performed by a VA or other approved hospital or outpatient facility, the evidence must show:

- The surgery or treatment was for a service-connected disability; **AND**
- The surgery required convalescence of at least one month; **OR**
- The surgery resulted in severe postoperative residuals, such as incompletely healed surgical wounds, stumps of recent amputations, therapeutic immobilizations, house confinement, or the required use of a wheelchair or crutches; **OR**
- One major joint or more was immobilized by a cast without surgery.

Individual Unemployability

In order to support a claim for a total disability rating based on individual unemployability, the evidence must show:

- That your service-connected disability or disabilities are sufficient, without regard to other factors, to prevent you from performing the mental and/or physical tasks required to get or keep substantially gainful employment; **AND**
- Generally, you meet certain disability percentage requirements as specified in 38 Code of Federal Regulations 4.16 (i.e. one disability ratable at 60 percent or more, **OR** more than one disability with one disability ratable at 40 percent or more and a combined rating of 70 percent or more).

In order to support a claim for an **extra-schedular evaluation based on exceptional circumstances**, the evidence must show:

- That your service-connected disability or disabilities present such an exceptional or unusual disability picture, due to such factors as marked interference with employment or frequent periods of hospitalization, that application of the regular schedular standards is impractical.

Compensation Under 38 U.S.C. §1151

In order to support a claim for compensation under 38 U.S.C. §1151, the evidence must show that, as a result of VA hospitalization, medical or surgical treatment, examination, or training, you have:

- An additional disability or disabilities; **OR**
- An aggravation of an existing injury or disease; **AND**
- The disability was the direct result of VA fault such as carelessness, negligence, lack of proper skill, or error in judgment, or not a reasonably expected result or complication of the VA care or treatment; **OR**
- The direct result of participation in a VA Vocational Rehabilitation and Employment or compensated work therapy program.

Special Monthly Compensation

In order to support a claim for **increased benefits based on the need for aid and attendance**, the evidence must show that, due to your service-connected disability or disabilities:

- You require the aid of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing yourself, attending to the wants of nature, adjusting prosthetic devices, or protecting yourself from the hazards of your daily environment (38 Code of Federal Regulation 3.352(a)); **OR**
- You are bedridden, in that your disability or disabilities requires that you remain in bed apart from any prescribed course of convalescence or treatment (38 Code of Federal Regulation 3.352(a)).

In order to support a claim for **increased benefits based on an additional disability or being housebound**, the evidence must show:

- You have a single service-connected disability evaluated as 100 percent disabling **AND** an additional service-connected disability, or disabilities, evaluated as 60 percent or more disabling; **OR**
- You have a single service-connected disability evaluated as 100 percent disabling AND, due solely to your service-connected disability or disabilities, you are permanently and substantially confined to your immediate premises.

In order to support a claim **for increased benefits based on your spouse's need for aid and attendance**, per the provisions of 38 C.F.R. § 3.351(c), the evidence must show:

- Your spouse is blind or so nearly blind as to have corrected visual acuity of 5/200 or less, in both eyes, or concentric contraction of the visual field to 5 degrees or less; **OR**
- Your spouse is a patient in a nursing home because of mental or physical incapacity; **OR**
- Your spouse requires the aid of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting him or her from the hazards of his or her daily environment (See 38 C.F.R. § 3.352(a) for complete explanation).

IMPORTANT: For additional benefits to be payable for a spouse, the veteran must be entitled to compensation and evaluated as 30 percent or more disabling.

Specially Adapted Housing or Special Home Adaptation

To support your claim for **specially adapted housing (SAH)**, the evidence must show you are a:

- Veteran entitled to compensation under 38 U.S.C. Chapter 11 for a permanent and totally disabling qualifying condition; OR
- Service member on active duty who has a permanent and totally disabling qualifying condition incurred or aggravated in the line of duty.

To support that you have a **qualifying condition for SAH** the evidence must show:

- Amyotrophic lateral sclerosis (ALS); **OR**
- Loss (amputation) or loss of use of
  - both lower extremities; **OR**
  - one lower extremity and one upper extremity affecting balance or propulsion; **OR**
  - one lower extremity plus residuals of organic disease or injury affecting balance or propulsion creating a need for regular, constant use of a wheelchair, braces, crutches or canes as a normal mode of getting around (although getting around by other methods may be occasionally possible); **OR**
- Loss or loss of use of both upper extremities precluding use of the arms at or above the elbow; **OR**
- Blindness in both eyes, with light perception only and the loss or loss of use of one lower extremity; **OR**
- A severe burn injury, meaning full thickness or subdermal burns that have resulted in contractures with limitation of motion of
  - two or more extremities; **OR**
  - at least one extremity and the trunk.

To support your claim for **SAH** the evidence may alternatively show you are a:

- Veteran who served and became permanently disabled from a qualifying condition on or after September 11, 2001; OR
- Service member on active duty who was permanently disabled in the line of duty from a qualifying condition on or after the same date.

To support that you have a **qualifying condition under the alternative service criteria** the evidence must show:

- Loss (amputation) or loss of use of
  - one or more lower extremities, severely affecting the functions of balance or propulsion and creating a need for regular, constant use of a wheelchair, braces, crutches or canes as a normal mode of getting around (although getting around by other methods may be occasionally possible).

To support your claim for a **special home adaptation (SHA) grant** the evidence must show you are a:

- Veteran entitled to compensation under 38 U.S.C. Chapter 11 for a qualifying condition; OR
- Service member on active duty who has a qualifying condition incurred or aggravated in the line of duty.

To support that you have a **qualifying condition for SHA** the evidence must show:

- Blindness with central visual acuity of 20/200 or worse in each eye using a standard correcting lens; **OR**
- Blindness such that the visual field in each eye subtends an angle no greater than 20 degrees; **OR**
- Permanent and total disability from loss, or loss of use, of both hands; **OR**
- Permanent and total disability from a severe burn injury meaning
  - deep partial thickness burns that have resulted in contractures with limitation of motion of two or more extremities or of at least one extremity and the trunk; **OR**
  - full thickness or subdermal burns that have resulted in contracture(s) with limitation of motion of one or more extremities or the trunk; **OR**
  - residuals of inhalation injury (including, but not limited to, pulmonary fibrosis, asthma, and chronic obstructive pulmonary disease).

Auto Allowance

To support a claim for **automobile allowance or adaptive equipment**, the evidence must show that you have a service-connected disability resulting in:

(1) the loss, or permanent loss of use, of at least a foot or a hand; **OR**
(2) permanent impairment of vision of both eyes, resulting in:
  (a) vision of 20/200 or less in the better eye with corrective glasses; **OR**
  (b) vision of 20/200 or better, if there is a severe defect in your peripheral vision; **OR**
(3) deep partial thickness or full thickness burns resulting in scar formation that cause contractures and limit motion of one or more extremities of the trunk and preclude effective operation of an automobile; **OR**
(4) amyotrophic lateral sclerosis (ALS).

NOTE - You may be entitled to ***only*** adaptive equipment if you have ankylosis ("freezing") of at least one knee or one hip due to service-connected disability. Medical evidence, including a VA examination, will show these things. VA will provide an examination if it determines that one is necessary.

Helpless Child

To support a claim for **benefits based on a veteran's child being helpless**, the evidence must show that the child, before his or her 18th birthday, became permanently incapable of self-support due to a mental or physical disability.

IMPORTANT: For additional benefits to be payable for a child, the veteran must be entitled to compensation and evaluated as 30 percent or more disabling.

HOW VA DETERMINES THE EFFECTIVE DATE

If we grant your claim, the beginning date of your entitlement or increased entitlement to benefits will generally be based on the following factors:

- When we received your claim, **OR**
- When the evidence shows a level of disability that supports a certain rating under the rating schedule

If VA received your claim prior to or within one year of your separation from the military, entitlement will be from the day following the date of your separation.

HOW VA DETERMINES THE DISABILITY RATING

When we find disabilities to be service-connected, we assign a disability rating. That rating can be changed if there are changes in your condition. Depending on the disability involved, we will assign a rating from 0 percent to as much as 100 percent. VA uses a schedule for

evaluating disabilities that is published as title 38, Code of Federal Regulations, Part 4. In rare cases, we can assign a disability level other than the levels found in the schedule for a specific condition if your impairment is not adequately covered by the schedule.

We consider evidence of the following in determining disability rating:

- Nature and symptoms of the condition;
- Severity and duration of the symptoms; AND
- Impact of the condition and symptoms on employment.

Examples of evidence that you should tell us about or give to us that may affect how we assign a disability evaluation include the following:

- Information about on-going treatment records, including VA or other Federal treatment records, you have not previously told us about;
- Social Security determinations;
- Statements from employers as to job performance, lost time, or other information regarding how your condition(s) affect your ability to work; **OR**
- Statements discussing your disability symptoms from people who have witnessed how the symptoms affect you.

OMB Control No. 2900-0001
Respondent Burden: 5 minutes
Expiration Date: 6/30/2017

Department of Veterans Affairs

AUTHORIZATION TO DISCLOSE INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

NOTE - PLEASE READ THE ENTIRE FORM *(both pages) BEFORE SIGNING IN ITEM 11 BELOW.*

SECTION I - RECORDS TO BE RELEASED TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange) of: ***All* my medical records; including information related to my ability to perform tasks of daily living. This includes specific permission to release:**

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) *including,* but not limited to:
   a. Psychological, psychiatric, or other mental impairment(s) excluding "psychotherapy notes" as defined in 45 C.F.R. §164.501,
   b. Drug abuse, alcoholism, or other substance abuse,
   c. Sickle cell anemia,
   d. Records which may indicate the presence of a communicable or non-communicable disease; and tests for or records of HIV/AIDS,
   e. Gene-related impairments (including genetic test results).
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
3. Information created within 12 months *after* the date this authorization is signed in Item 11, as well as past information.

YOU SHOULD NOT COMPLETE THIS FORM UNLESS YOU WANT THE VA TO OBTAIN PRIVATE TREATMENT RECORDS ON YOUR BEHALF. IF YOU HAVE ALREADY PROVIDED THESE RECORDS OR INTEND TO OBTAIN THEM YOURSELF, THERE IS NO NEED TO FILL OUT THIS FORM. DOING SO WILL LENGTHEN YOUR CLAIM PROCESSING TIME.

IMPORTANT - In accordance with 38 C.F.R. §3.159(c), **"VA will not pay any fees charged by a custodian to provide records requested."**

SECTION II - VETERAN IDENTIFICATION

1. LAST NAME - FIRST NAME - MIDDLE NAME *(Type or print)*	2. DATE OF BIRTH (MM,DD,YYYY)	3. SOCIAL SECURITY NUMBER/VA FILE NUMBER

SECTION III - PATIENT IDENTIFICATION FOR RECORDS VA IS REQUESTING

4. LAST NAME - FIRST NAME - MIDDLE NAME *(Type or print)*	5. DATE OF BIRTH (MM,DD,YYYY)	6. SOCIAL SECURITY NUMBER
7. STREET ADDRESS	**8. CITY, STATE, ZIP CODE**	**9. TELEPHONE NUMBER *(Include Area Code)***

SECTION IV - INFORMATION REGARDING SOURCE OF RECORD(S)

SOURCE OF RECORD(S):

- **ALL** medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities,
- Social workers/rehabilitation counselors,
- Consulting examiners used by VA,
- Employers, insurance companies, workers' compensation programs, and
- Others who may know about my condition (family, neighbors, friends, public officials).

SECTION V - AUTHORIZATION AND CONSENT TO RELEASE INFORMATION TO VA AND SIGNATURE

10. IF MY CONSENT TO THIS INFORMATION IS LIMITED, THE LIMITATION IS WRITTEN HERE *(If this space is left blank, there is no limitation to records):*

TO WHOM: The Department of Veterans Affairs (VA).
PURPOSE: Determining my eligibility for benefits, and whether I can manage such benefits.
EXPIRES: This authorization is good for 12 months from the date shown in Item 12.

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above in Section I.
- I understand that there are some circumstances in which this information may be re-disclosed to other parties (See page 2 for details).
- I may write to VA and my source(s) to revoke this authorization at any time (See page 2 for details).
- VA will give me a copy of this form, if I ask; I may also ask the source(s) to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed. See Patient Acknowledgement on Page 2.**

11. SIGNATURE OF PERSON AUTHORIZING DISCLOSURE **(Required)**	12. DATE SIGNED (MM,DD,YYYY) **(Required)**
13. PRINTED NAME OF PERSON SIGNING (First, Middle Initial, Last)	**14. TELEPHONE NUMBER *(Include Area Code)***

15. RELATIONSHIP TO VETERAN/CLAIMANT (If other than self, please provide full name, title, organization, city, State, and ZIP code. All court appointments must include docket number, county, and State)

NOTE: This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical and other information under P.L. 104-191 ("HIPAA"); 45 C.F.R. parts 160 and 164; 42 U.S.C. §290dd-2; 42 C.F.R. part 2, and State Law.

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28 Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. However, if the information including your Social Security Number (SSN) is not furnished completely or accurately, the source to which this authorization is addressed may not be able to identify and locate your records, and provide a copy to VA. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975 and still in effect.

If you do not revoke this authorization, it will automatically expire in 12 months from the date you sign and date the form. Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information could prevent an accurate or timely decision on your claim, and could result in denial or loss of benefits. Although the information we obtain with this form is almost never used for any purpose other than those stated above, the information may be disclosed by VA without your consent if authorized by Federal laws such as the Privacy Act.

Under the Government Paperwork Elimination Act (GPEA) (Public Law 105-277), the Office of Management and Budget (OMB) ensures that agencies, when practicable, provide for the option of electronic maintenance, submission of disclosure of information and for the use and acceptance of electronic signatures. GPEA states that electronic records submitted or maintained in accordance with the procedures developed by OMB, or electronic signature or other forms of electronic authentication used in accordance with such procedures, "shall not be denied legal effect, validity, or enforceability merely because such records are in electronic form" (Public Law 105-277, section 1707).

RESPONDENT BURDEN: We need this information and your written authorization to obtain your treatment records to help us get the information required to process your claim. Title 38, United States Code, allows us to ask for this information. You can provide this authorization by signing VA Form 21-4142. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all possible sources. We will make copies of it for each source. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations. We estimate that you will need an average of 5 minutes to review the instructions, find the information and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you may call 1-800-827-1000 to get information on where to send comments or suggestions about this form. If you use the Telecommunications Device for the Deaf (TDD), the Federal relay number is 711.

PATIENT ACKNOWLEDGMENT: I HEREBY AUTHORIZE the sources listed in Section IV, to release any information that may have been obtained in connection with a physical, psychological or psychiatric examination or treatment, with the understanding that VA will use this information in determining my eligibility to veterans benefits I have claimed. I understand that the source being asked to provide the Veterans Benefits Administration with records under this authorization may not require me to execute this authorization before it provides me with treatment, payment for health care, enrollment in a health plan, or eligibility for benefits provided by it. I understand that once my source sends this information to VA under this authorization, the information will no longer be protected by the HIPAA Privacy Rule, but will be protected by the Federal Privacy Act, 5 USC 552a, and VA may disclose this information as authorized by law. I also understand that I may revoke this authorization in writing, at any time except to the extent a source of information has already relied on it to take an action. To revoke, I must send a written statement to the VA Regional Office handling my claim or the Board of Veterans' Appeals (if my claim is related to an appeal) and also send a copy directly to any of my sources that I no longer wish to disclose information about me. I understand that VA may use information disclosed prior to revocation to decide my claim.

NOTE: For additional information regarding VA Form 21-4142, refer to the following website: www.benefits.va.gov/compensation/consent_privateproviders.asp.

38 U.S.C. §5103 Notice

VA is Responsible for Getting the Following Evidence:

- Relevant records that you adequately identify and authorize VA to obtain from any Federal agency. These may include records from the military, VA medical centers (including private facilities where VA authorized treatment), or the Social Security Administration.
- VA will provide a medical examination for you, or get a medical opinion, if we determine it is necessary to decide your compensation claim.

On Your Behalf, VA Will Make Reasonable Efforts to Get the Following Evidence:
Relevant records not held by a Federal agency that you adequately identify and authorize VA to obtain. These may include records from State or local governments, private doctors and hospitals, or current or former employers.

How Can You Help: If you have any information or evidence that you have not previously told us about or given to us, please tell us or give us that evidence now. If the evidence is not in your possession, you must give us enough information about the evidence so that we can request it from the person or agency that has it. If the holder of the evidence declines to give it to us, asks for a fee to provide it, or VA otherwise cannot get the evidence, we will notify you. It is your responsibility to make sure we receive all requested records that are not in the possession of a Federal department or agency.

How VA Determines the Disability Rating: When we find disabilities to be service connected, we assign a disability rating. That rating can be changed if there are changes in your condition. Depending on the disability involved, we will assign a rating from 0 percent to as much as 100 percent. VA uses a schedule for evaluating disabilities that is published as title 38, Code of Federal Regulations, Part 4. In rare cases, we can assign a disability level other than the levels found in the schedule for a specific condition if your impairment is not adequately covered by the schedule.

We consider evidence of the following in determining the disability rating:

- Nature and symptoms of the condition;
- Severity and duration of the symptoms; and
- Impact of the condition and symptoms on employment.

Examples of evidence that you should tell us about or give to us that may affect how we assign a disability evaluation include the following:

- Information about on-going treatment records, including VA or other Federal treatment records, you have not previously told us about;
- Recent Social Security determinations;
- Statements from employers as to job performance, lost time, or other information regarding how your condition(s) affect your ability to work; or
- Statements discussing your disability symptoms from people who have witnessed how they affect you.

How VA Determines the Effective Date: If we grant your claim, the beginning date of your entitlement or increased entitlement to benefits will generally be based on the following factors:

- When we received your claim; or
- When the evidence shows a level of disability that supports a certain rating under the rating schedule or other applicable standards.

If VA received your claim within one year of your separation from the military, entitlement will be from the day following the date of your separation.

Examples of evidence that are relevant to determining the effective date of any benefits we award include the following:

- Information about continuous treatment or when treatment began;
- Service treatment records in your possession that you may not have sent us; or
- Reports of treatment for your condition while attending training in the Guard or Reserve.

38 U.S.C. § 5103 NOTICE RESPONSE

We provided a notice to you about the evidence and information VA needs to support your claim for benefits. At this time, you may choose to indicate whether you intend to submit additional information or evidence that would help support your claim,

Your signed response will let us know whether to decide your claim without waiting 30 days, or whether we should give you the full 30 days from the date of the letter sent with this notice response before deciding your claim.

Your signature on this response will not affect:

- Whether or not you are entitled to VA Benefits;
- The amount of benefits to which you may be entitled;
- The assistance VA will provide you in obtaining evidence to support your claim; or
- The date any benefits will begin if your claim is granted.

RESPONSE

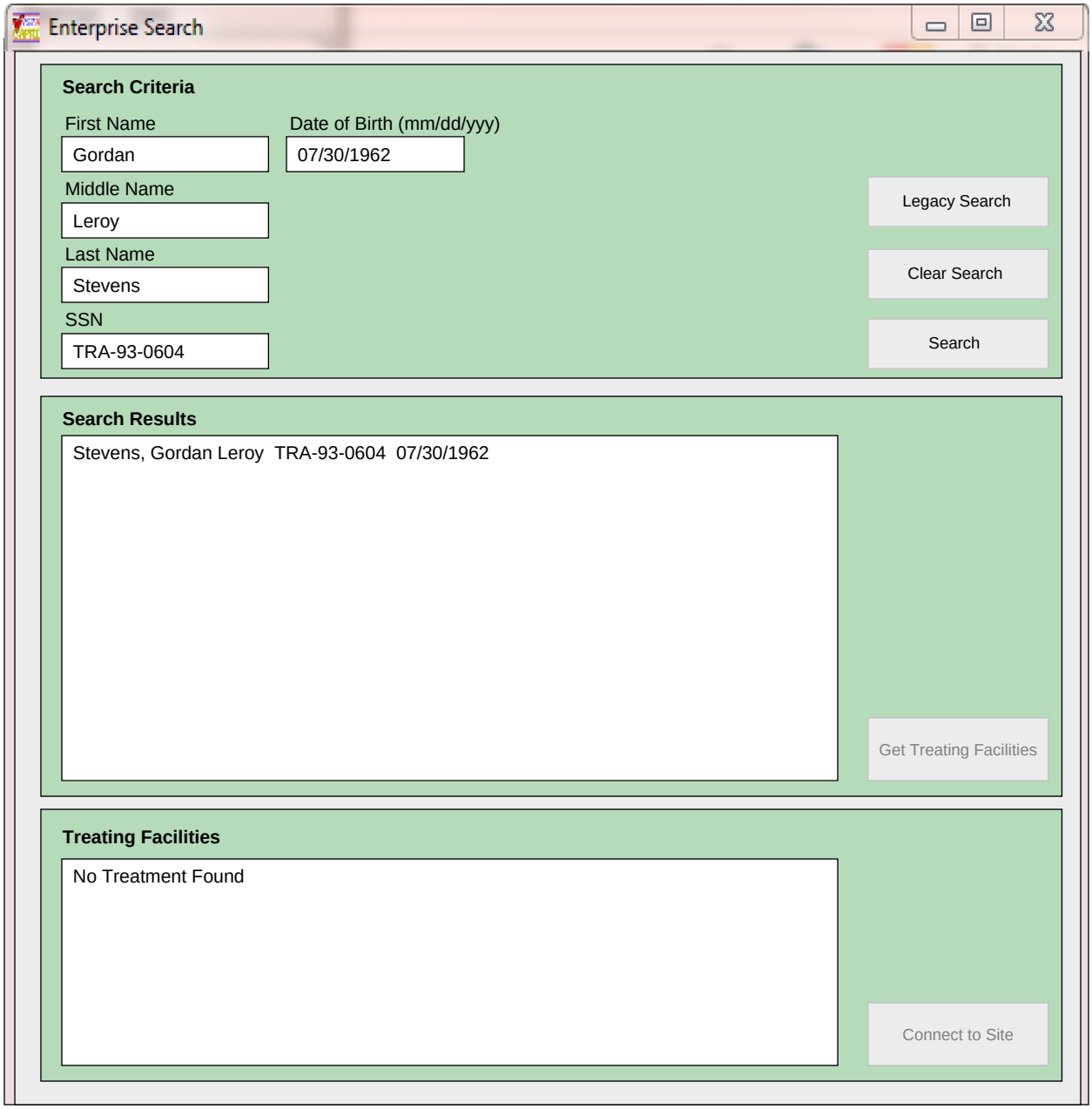
I elect *one* of the following: (Whichever box you check, you have one year from the date of the notice to give VA any other information or evidence you think will support your claim.)

_____ I have enclosed all the remaining information or evidence that will support my claims, or I have no other information or evidence to give VA to support my claim. Please decide my claim as soon as possible.

_____ I will send more information or evidence to VA to support my claim. VA will wait the full 30 days from the date of the letter sent with this notice response before deciding my claim.

_____ _____

Claimant/Representative Signature Date


Enterprise Search
Search Criteria
First Name
Gordan
Date of Birth (mm/dd/yyy)
07/30/1962
Middle Name
Leroy
Last Name
Stevens
SSN
TRA-93-0604
Legacy Search
Clear Search
Search
Search Results
Stevens, Gordan Leroy TRA-93-0604 07/30/1962
Get Treating Facilities
Treating Facilities
No Treatment Found
Connect to Site

DEPARTMENT OF VETERANS AFFAIRS
Veterans Benefits Administration
Regional Office

Gordan Stevens

VA File Number
TRA-93-0604

Rating Decision
October 19, 1999

INTRODUCTION

The records reflect that you are a Veteran of Peacetime. You served in the Navy from October 01, 1982, to September 30, 1990. You filed an original disability claim that was received on February 11, 1999. Based on a review of the evidence listed below, we have made the following decision(s) on your claim.

DECISION

1. Service connection for cervical strain (claimed as neck strain) is granted with an evaluation of 10 percent effective February 11, 1999.
2. Service connection for lumbosacral strain (claimed as back strain) is granted with an evaluation of 10 percent effective February 11, 1999.
3. Service connection for psoriasis is denied.

EVIDENCE

- DD Form 214, Certificate of Release or Discharge from Active Duty received February 26, 1999, for the period October 01, 1982, to September 30, 1990.
- Service treatment records received March 03, 1999, for the period February 29, 1960, to September 30, 1990.

- VA Form 21-526EZ, Application for Disability Compensation and Related Compensation Benefits, received February 11, 1999.
- VA Form 21-4138, Statement in Support of Claim from the Veteran, received February 11, 1999.
- Disability Benefits Questionnaire conducted at Baltimore VAMC on April 02, 1999.

REASONS FOR DECISION

1. Service connection for cervical strain (claimed as neck strain).

Service connection for cervical strain (claimed as neck strain) has been established as directly related to military service.

An evaluation of 10 percent is assigned from February 11, 1999.

We have assigned a 10 percent evaluation for your cervical strain (claimed as neck strain) based on:

• Combined range of motion of the cervical spine greater than 170 degrees but not greater than 335 degrees

• Forward flexion of the cervical spine greater than 30 degrees but not greater than 40 degrees

Additional symptom(s) include:

• Painful motion upon examination

The provisions of 38 CFR §4.40 and §4.45 concerning functional loss due to pain, fatigue, weakness, or lack of endurance, incoordination, and flare-ups, as cited in DeLuca v. Brown and Mitchell v. Shinseki, have been considered and are not warranted.

A higher evaluation of 20 percent is not warranted for cervical strain unless the evidence shows:

• Combined range of motion of the cervical spine not greater than 170 degrees; or,

• Forward flexion of the cervical spine greater than 15 degrees but not greater than 30 degrees; or,

• Muscle spasm or guarding severe enough to result in an abnormal gait or abnormal spinal contour such as scoliosis, reversed lordosis, or abnormal kyphosis.

2. Service connection for lumbosacral strain (claimed as back strain)

Service connection for lumbosacral strain (claimed as back strain) has been established as directly related to military service.

The effective date of this grant is February 11, 1999. Service connection has been established from the day VA received your claim. When a claim of service connection is received more than one year after discharge from active duty, the effective date is the date VA received the claim.

An evaluation of 10 percent is assigned from February 11, 1999.

We have assigned a 10 percent evaluation for your lumbosacral strain (claimed as back strain) based on:

• Combined range of motion of the thoracolumbar spine greater than 120 degrees but not greater than 235 degrees

• Forward flexion of the thoracolumbar spine greater than 60 degrees but not greater than 85 degrees

Additional symptom(s) include:

• Painful motion upon examination

The provisions of 38 CFR §4.40 and §4.45 concerning functional loss due to pain, fatigue, weakness, or lack of endurance, incoordination, and flare-ups, as cited in DeLuca v. Brown and Mitchell v. Shinseki, have been considered and applied under 38 CFR §4.59.

A higher evaluation of 20 percent is not warranted for lumbosacral strain unless the evidence shows:

• Combined range of motion of the thoracolumbar spine not greater than 120 degrees; or,

• Forward flexion of the thoracolumbar spine greater than 30 degrees but not greater than 60 degrees; or,

• Muscle spasm or guarding severe enough to result in an abnormal gait or abnormal spinal contour such as scoliosis, reversed lordosis, or abnormal kyphosis.

3. Service connection for psoriasis.

Active military service includes active duty or any period of active duty for training during which the individual concerned was disabled or died from a disease or injury incurred or aggravated in line of duty. "Active duty" means full-time duty in the Armed Forces, other than active duty for training. "Active duty for training" means full-time duty in the Armed Forces performed by Reserves for training purposes. Disabilities caused by a disease process cannot be service connected if they are discovered during a period of inactive duty for training. Service connection may be warranted for an injury incurred or aggravated while performing inactive duty for training. Service connection may also be warranted for an acute myocardial infarction, a cardiac arrest, or a cerebrovascular accident which occurred during inactive duty for training.

Service connection may be granted for a disability which began in military service or was caused by some event or experience in service.

Service connection for psoriasis is denied since this condition neither occurred in nor was caused by service.

Although the evidence shows diagnosis of and treatment for psoriasis, there is no evidence of diagnosis during a period of active duty.

REFERENCES

Title 38 of the Code of Federal Regulations, Pensions, Bonuses and Veterans' Relief contains the regulations of the Department of Veterans Affairs which govern entitlement to all veteran benefits. For additional information regarding applicable laws and regulations, please consult your local library, or visit us at our web site, www.va.gov.

Rating Decision	***Department of Veterans Affairs***		Page 1 of 1
	Veterans Benefits Administration		10/19/1999

NAME OF VETERAN	VA FILE NUMBER	SOCIAL SECURITY NR	POA	COPY TO
Gordan Stevens	TRA-93-0604	TRA-93-0604		

ACTIVE DUTY			
EOD	**RAD**	**BRANCH**	**CHARACTER OF DISCHARGE**
10/01/1982	09/30/1990	Navy	Honorable

LEGACY CODES			
ADD'L SVC CODE	**COMBAT CODE**	**SPECIAL PROV CODE**	**FUTURE EXAM DATE**
	2		None

JURISDICATION: Original Disability Claim Received 02/11/1999

ASSOCIATED CLAIM(s): 110; Original Disability Claim; 02/11/1999

SUBJECT TO COMPENSATION (1.SC)

5237	LUMBOSACRAL STRAIN (CLAIMED AS BACK STRAIN) Service Connected, Gulf War, Incurred Static Disability 10% from 02/11/1999
5237	CERVICAL STRAIN (CLAIMED AS NECK STRAIN) Service Connected, Gulf War, Incurred Static Disability 10% from 02/11/1999

COMBINED EVALUATION FOR COMPENSATION:

20% from 02/11/1999

NOT SERVICE CONNECTED/NOT SUBJECT TO COMPENSATION (8.NSC Gulf War)

7816	PSORIASIS Not Service Connected, Gulf War, Not Incurred/Caused by Service

eSign: certified by VBADENJOHNSD, RVSR
Training Consultant

Reviewer

CAUTION: NOT TO BE USED FOR IDENTIFICATION PURPOSES | THIS IS AN IMPORTANT RECORD SAFEGUARD IT | ANY ALTERATIONS IN SHADED AREAS RENDER FORM VOID

CERTIFICATE OF RELEASE OR DISCHARGE FROM ACTIVE DUTY

1. NAME *(Last, First, Middle)*	2. DEPARTMENT, COMPONENT AND BRANCH	3. SOCIAL SECURITY NO.
Stevens, Gordan Leroy	Navy	TRA 93 0604

4.a. GRADE, RATE OR RANK	4.b. PAY GRADE	5. DATE OF BIRTH *(YYYYMMDD)*	6. RESERVE OBLIG. TERM. DATE (Year / Month / Day)
Lieutenant	O-3	19620730	

7.a. PLACE OF ENTRY INTO ACTIVE DUTY	7.b. HOME OF RECORD AT TIME OF ENTRY *(City and State, or complete address if known)*
	31 Hopkins Plaza, Baltimore, MD 21201 (US)

8.a. LAST DUTY ASSIGNMENT AND MAJOR COMMAND	8.b. STATION WHERE SEPARATED
EOD Mobile Unit One	Naval Base Point Loma, CA

9. COMMAND TO WHICH TRANSFERRED	10. SGLI COVERAGE
N/A	X NONE AMOUNT: $

11. PRIMARY SPECIALTY *(List number, title and years and months in specialty. List additional speciality numbers and titles involving periods of one or more years.)*

EOD - Explosive Ordnance Disposal (7 years)

12. RECORD OF SERVICE	YEAR(S)	MONTH(S)	DAY(S)
a. Date Entered AD This Period	82	10	01
b. Separation Date This Period	90	09	30
c. Net Active Service This Period	08	01	01
d. Total Prior Active Service	00	00	00
e. Total Prior Inactive Service	00	00	00
f. Foreign Service	00	00	00
g. Sea Service	00	00	00
h. Effective Date of Pay Grade	89	07	22

13. DECORATIONS, MEDALS, BADGES, CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED *(All periods of service)*

Joint Service Commendation Medal

14. MILITARY EDUCATION *(Course title, number of weeks, and months and years completed)*

Explosive Ordnance Disposal (52 weeks)

15.a. MEMBER CONTRIBUTED TO POST VIETNAM ERA VETERAN'S EDUCATION ASSISTANCE PROGRAM	YES	NO	15.b. HIGH SCHOOL GRADUATE OR EQUIVALENT	YES	NO	16. DAYS ACCRUED LEAVE PAID
	X			X		

17. MEMBER WAS PROVIDED COMPLETE DENTAL EXAMINATION AND ALL APPROPRIATE DENTAL SERVICES AND TREATMENT WITHIN 90 DAYS PRIOR TO SEPARATION — YES / NO

18. REMARKS

Received Centralized Mail Processing, Janesville, WI 09/13/2021

I HEREBY CERITFY THAT THIS IS A TRUE AND EXACT COPY OF THE ORIGINAL DOCUMENT.
Certified by Quincy Jamerson this 11 day of September, 2021.

19.a. MAILING ADDRESS AFTER SEPERATION *(Include Zip Code)*	19.b. NEAREST RELATIVE *(Name and Address - include Zip Code)*
31 Hopkins Plaza Baltimore, MD 21201 (US)	Judy J. Stevens 25102 Springwater, Wenatchee, WA 98801 (US)

20. MEMBER REQUESTS COPY 6 BE SENT TO _____ DIR. OF VET AFFAIRS — YES / NO

22. OFFICIAL AUTHORIZED TO SIGN *(Type name, grade, title and signature)* Capt. Samuel D. Hawkins ADMINO

Samuel D. Hawkins

21. SIGNATURE OF MEMBER BEING SEPARATED

Gordan Leroy Stevens

DD FORM 214, NOV 88 S/N 0102-LF-006-5500 *Previous editions are obsolete.* **MEMBER - 1**

SPECIAL ADDITIONAL INFORMATION *(For use by authorized agencies only)*

23. TYPE OF SEPARATION	24. CHARACTER OF SERVICE *(Include upgrades)*	
Discharge	Honorable	
25. SEPARATION AUTHORITY	**26. SEPARATION CODE**	**27. REENTRY CODE**
MILPERSMAN 3620150	MBK	RE-1

28. NARRATIVE REASON FOR SEPARATION

RESIGNATION

29. DATES OF TIME LOST DURING THIS PERIOD	30. MEMBER REQUESTS COPY 4
TL: None	_____ Initials

DD FORM 214, NOV 88 S/N 0102-LF-006-5500 *Previous editions are obsolete.* **MEMBER - 4**

NO. OF ATTACHED SHEETS:

MEDICAL RECORD	REPORT OF MEDICAL HISTORY	DATE OF EXAM
		09/21/1990

NOTE: This information is for official and medically-confidential use only and will not be released to unauthorized persons

1. NAME OF PATIENT (Last, first, middle)	2. IDENTIFICATION NUMBER	3. GRADE
Gordan Leroy Stevens	TRA-93-0604	O-3

4a. HOME STREET ADDRESS (Street or RFD; City or Town; State; and ZIP Code)	5. EXAMINING FACILITY
31 Hopkins Plaza	Baltimore MEPS, Maryland

4b. CITY	4c. STATE	4d. ZIP CODE
Baltimore	MD	21201

6. PURPOSE OF EXAMINATION

Discharge

7. STATEMENT OF PATIENT'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Use additional pages if necessary)

a. PRESENT HEALTH	b. CURRENT MEDICATION	REGULAR OR INTERM.
Good	Motrin for head/neck pain	Interm. as needed
c. ALLERGIES (Include insect bites/stings and common foods)		
	d. HEIGHT	e. WEIGHT
	5' 11"	160

8. PATIENT'S OCCUPATION	9. ARE YOU (Check one)
Explosive Ordnance Disposal	☒ RIGHT HANDED ☐ LEFT HANDED

10. PAST/CURRENT MEDICAL HISTORY

CHECK EACH ITEM	YES	NO	DON'T KNOW	CHECK EACH ITEM	YES	NO	DON'T KNOW	CHECK EACH ITEM	YES	NO	DON'T KNOW
Household contact with anyone with tuberculosis		X		Shortness of breath		X		Bone, joint or other deformity	X		
				Pain or pressure in chest		X		Loss of finger or toe		X	
Tuberculosis or positive TB test		X		Chronic cough		X		Painful or "trick" shoulder or elbow	X		
Blood in sputum or when coughing		X		Palpitation or pounding heart		X					
				Heart trouble		X		Recurrent back pain or any back injury	X		
Excessive bleeding after injury or dental work		X		High or low blood pressure		X					
				Cramps in your legs		X		"Trick" or locked knee		X	
Suicide attempt or plans		X		Frequent indigestion		X		Foot trouble		X	
Sleepwalking		X		Stomach, liver or intestinal trouble		X		Nerve Injury		X	
Wear corrective lenses		X		Gall bladder trouble or gallstones		X		Paralysis (including infantile)		X	
Eye surgery to correct vision		X						Epilepsy or seizure		X	
Lack vision in either eye		X		Jaundice or hepatitis		X		Car, train, sea or air sickness		X	
Wear a hearing aid		X		Broken bones		X		Frequent trouble sleeping		X	
Stutter or stammer		X		Adverse reaction to medication		X		Depression or excessive worry		X	
Wear a brace or back support				Skin diseases		X		Loss of memory or amnesia		X	
Scarlet fever				Tumor, growth, cyst, cancer		X		Nervous trouble of any sort		X	
Rheumatic fever				Hernia		X		Periods of unconsciousness		X	
Swollen or painful joints	X			Hemorrhoids or rectal disease		X		Parent/sibling with diabetes, cancer, stroke or heart disease		X	
Frequent or severe headaches	X			Frequent or painful urination		X					
Dizziness or fainting spells				Bed wetting since age 12		X		X-ray or other radiation therapy		X	
Eye trouble		X		Kidney stone or blood in urine		X		Chemotherapy		X	
Hearing loss		X		Sugar or albumin in urine		X		Asbestos or toxic chemical exposure		X	
Recurrent ear infections		X		Sexually transmitted diseases		X					
Chronic or frequent colds		X		Recent gain or loss of weight		X		Plate, pin or rod in any bone		X	
Severe tooth or gum trouble		X		Eating disorder (anorexia bulimia, etc.)		X		Easy fatigability		X	
Sinusitis		X						Been told to cut down or criticized for alcohol use		X	
Hay fever or allergic rhinitis		X		Arthritis, Rheumatism, or Bursitis	X						
Head injury	X							Used illegal substances		X	
Asthma		X		Thyroid trouble or goiter		X		Used tobacco		X	

11. FEMALES ONLY

CHECK EACH ITEM	YES	NO	DON'T KNOW	DATE OF LAST MENSTRUAL PERIOD	DATE OF LAST PAP SMEAR	DATE OF LAST MAMMO-GRAM
Treated for a female disorder						
Change in menstrual pattern						

CHECK EACH ITEM. IF "YES" EXPLAIN IN BLANK SPACE TO RIGHT. LIST EXPLANATION BY ITEM NUMBER.

ITEM	YES	NO	
12. Have you been refused employment or been unable to hold a job or stay in school because of:			
a. Sensitivity to chemicals, dust, sunlight, etc.		X	
b.Inability to perform certain motions.	X		Neck hurts when bend or turn head
c. Inability to assume certain positions.		X	
d.Other medical reasons (If yes, give reasons.)		X	
13. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details.)		X	
14. Have you ever been denied life insurance? (If yes, state reason and give details.)		X	
15. Have you had, or have you been advised to have, any operation. (If yes, describe and give age at which occurred.)		X	
16. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)		X	
17. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)	X		Neck and shoulder injury
18. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection.)		X	
19. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)		X	
20. Have you ever received, is there pending, or have you ever applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.)		X	
21. Have you ever been arrested or convicted of a crime, other than minor traffic violations. (If yes, provide details.)		X	
22. Have you ever been diagnosed with a learning disability? (If yes, give type, where, and how diagnosed.)		X	Baltimore Regional Office Date Received 01/25/1991

23. LIST ALL IMMUNIZATIONS RECEIVED

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

24a. TYPED OR PRINTED NAME OF EXAMINEE	24b. SIGNATURE	24c. DATE
Gordan Leroy Stevens	*Gordan Leroy Stevens*	09/21/1990

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY".

25. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (Physician shall comment on all positive answers in Items 7 through 11. Physician may develop by interview any additional medical history deemed important, and record any significant findings here.)

Cervical strain s/p truck accident X-rays mild degenerative changes C1-2; 2-3

L shoulder pain, X-rays negative

R knee pain, X-rays negative

26a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	26b. SIGNATURE	26c. DATE
Dr. Adelle Tyler	Adelle Tyler	09/21/1990

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE	SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
X-ray of right knee	28	M	TRA-93-0604		
	FILM NO. 04081989-0000-Veteran				PREGNANT ☐ YES ☒ NO
	REQUESTED BY *(Print)* Frank N Stein, MD, DO				TELEPHONE/PAGE NO. 555-555-9875
	SIGNATURE OF REQUESTOR Frank N Stein				DATE REQUESTED 09/10/1990

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

Patient has had complaints of right knee pain, especially following physical exercise/5-mile humps. Need to r/o arthritis.

Patient also has complaints of neck pain, after his HumVee hit a 5-ton truck while he was a passenger.

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSACTION *(Month, day, year)*
09/10/1990	09/10/1990	09/10/1990

RADIOLOGIC REPORT

Three views of the right knee were taken. No other abnormalities noted.

Three views of the cervical spine were taken showing degenerative changes of C-4, C-5, and C-6.

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle, Medical Facility)*

Gordan Leroy Stevens

Louisville MTF

LOCATION OF MEDICAL RECORDS

Fort Campbell Medical Clinic

LOCATION OF RADIOLOGIC FACILITY

Fort Campbell Medical Clinic

SIGNATURE

Dr. Xavier Ray

RADIOLOGIC CONSULTATION REQUEST/REPORT

STANDARD FORM 519-B (Rev. 8-83)
Prescribed by GSA/MIR FIRMR
(41 CFR) 201-45.505

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

PRIVACY ACT STATEMENT: This information is subject to the Privacy Act of 1974 (5 U.S.C. Section 552a). This information may be provided to appropriate Government agencies when relevant to civil, criminal or regulatory investigations or prosecutions. The Social Security Number, authorized by Public Law 93-579 Section 7 (b) and Executive Order 9397, is used as a unique identifier to distinguish between employees with the same names and birth dates and to ensure that each individual's record in the system is complete and accurate and the information is properly attributed.

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
03/14/1990	Servicemember seen following vehicle's collision with a 5-ton truck. Complaints about severe cervical
	pain, headaches, left shoulder dysfunction and discomfort, blurry vision, and numbness to left hand.
	Exam: Cervical motion limited by pain - 20 degrees flexion; 20 degrees R/L lateral; 5 deg extension;
	25 degrees R/L rotation
	Tenderness C1-2; C2-3 no defect felt
	X-rays negative (spine/bilateral shoulders)
	Eyes - pupils fully dilated - normal
	Left shoulder full range of motion but with hesitancy and pain near insertion of bicep at rotator cuff
	Dx. Cervical strain
	Left shoulder pain
	Motrin for pain and discomfort - return 2 weeks
	Ice & rest

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPARTMENT/SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SOCIAL SECURITY/ID NUMBER	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID NUMBER or Social Security Number; Gender; Date of Birth; Rank/Grade.)*

REGISTER NUMBER	WARD NUMBER

Stevens, Gordan Leroy
TRA-93-0604
Male
07/30/1962
Lieutenant
/* grade */

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 11/2010)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

PREVIOUS EDITION IS NOT USABLE

AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
05/03/1990	Patient is complaining of pain in L shoulder
	Taking pain medication (Motrin)
06/22/1990	Patient states pain in R knee w/ swelling
	Taking Motrin for pain
	Continue exercises
	Also complains of pain in the neck
	Taking Motrin for pain
07/17/1990	Patient seen in clinic for complaints of shoulder pain following an accident that he was involved in when
	transporting MPs in Iraq. Physical review noted warmth to the Left shoulder. There was slight crackling
	sound in the left shoulder, none in the right shoulder. No subluxation noted. Range of motion was noted
	to be 0 to 180 degrees in the right and 0 to 90 degrees in the left with pain. X-ray requested.
	Radiologist report was negative.
08/11/1990	Patient seen in emergency room, complaining of neck pain following a motor vehicle accident. Physical
	examination noted fasciculations along the upper back, as well as warmth. Range of motion was limited to
	0 to 30 degrees forward flexion, with normal range of motion for the backward extension and bilateral
	flexion and rotation. Order input for physical therapy.
	Radiologist report revealed degenerative disc disease of the cervical spine.
	Diagnosis was degenerative changes of the cervical spine.

MEDICAL RECORD	**REPORT OF MEDICAL EXAMINATION**	DATE OF EXAM 09/28/1982

1. LAST NAME - FIRST NAME - MIDDLE NAME	2. IDENTIFICATION NUMBER	3. GRADE AND COMPONENT OR POSITION
Stevens, Gordan Leroy	TRA-93-0604	Civilian

4. HOME ADDRESS (*Number, street or RFD, city or town, state and ZIP Code*)	5. EMERGENCY CONTACT (*Name and address of contact*)
31 Hopkins Plaza Baltimore, MD 21201 (US)	Judy J. Stevens 25102 Springwater Wenatchee, WA 98801 (US)

6. DATE OF BIRTH	7. AGE	8. SEX	9. RELATIONSHIP OF CONTACT
07/30/1962	20	☐ FEMALE ☒ MALE	Sister

10. PLACE OF BIRTH	11. RACE					
Bothell, WA	☐ WHITE	☐ BLACK	☐ AMERICAN INDIAN/ ALASKA NATIVE	☒ HISPANIC WHITE	☐ HISPANIC BLACK	☐ ASIAN/PACIFIC ISLANDER

12a. AGENCY	12b. ORGANIZATION UNIT	13. TOTAL YEARS GOVERNMENT SERVICE	
		a. MILITARY	b. CIVILIAN
Navy	Navy	0	

14. NAME OF EXAMINING FACILITY OR EXAMINER, AND ADDRESS	15. RATING OR SPECIALTY OF EXAMINER
Baltimore MEPS, Maryland	MD - General Practitioner
	16. PURPOSE OF EXAMINATION: Entrance

17. CLINICAL EVALUATION

NOR-MAL	(*Check each item in appropriate column, enter "NE" if not evaluated*)	ABNOR-MAL	NOR-MAL	(*Check each item in appropriate column, enter "NE" if not evaluated*)	ABNOR-MAL
X	A. HEAD, FACE, NECK AND SCALP		X	O. PROSTATE (Over 40 or clinically indicated)	
X	B. EARS - GENERAL (INTERNAL CANALS) *(Auditory acuity under items 39 and 40)*		X	P. TESTICULAR	
			X	Q. ANUS AND RECTUM *(Hemorrhoids, Fistulae) (Hemocult Results)*	
X	C. DRUMS (*Perforation*)		X	R. ENDOCRINE SYSTEM	
X	D. NOSE		X	S. G-U SYSTEM	
X	E. SINUSES		X	T. UPPER EXTREMITIES *(Except feet) (Strength, range of motion)*	
X	F. MOUTH AND THROAT		X	U. FEET	
X	G. EYES - GENERAL (*Visual acuity and refraction under items 28, 29, and 36*)		X	V. LOWER EXTREMITIES *(Except feet) (Strength, range of motion)*	
X	H. OPHTHALMOSCOPIC		X	W. SPINE, OTHER MUSCULOSKELETAL	
X	I. PUPILS *(Equality and reaction)*		X	X. IDENTIFYING BODY MARKS, SCARS,TATTOOS	
X	J. OCULAR MOTILITY *(Associated parallel movements nystagmus)*		X	Y. SKIN, LYMPHATICS	
X	K. LUNGS AND CHEST		X	Z. NEUROLOGIC *(Equilibrium tests under item 41)*	
X	L. HEART *(Thrust, size, rhythm, sounds)*		X	AA. PSYCHIATRIC *(Specify any personality deviation)*	
X	M. VASCULAR SYSTEM *(Varicosities, etc.)*			BB. BREASTS	
X	N. ABDOMEN AND VISCERA *(Include hemia)*			CC. PELVIC *(Females only)*	

NOTES: *(Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 42 and use additional sheets if necessary)*

18. DENTAL *(Place appropriate symbols, show in examples, above or below number of upper and lower teeth.)*

0 / X
1 2 3 — 1 2 3 — 1 2 3 — X X X — (X)
32 31 30 — 32 31 30 — 32 31 30 — 32 31 30 — 32 31 30
0 / X — X X X — (X)

Restorable Teeth; Non-restorable Teeth; Missing Teeth; Replaced by Dentures; Fixed Partial Dentures

RIGHT																	LEFT
	X															X	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
	X															X	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

Two small cavities/fillings.

19. TEST RESULTS (Copies of results are preferred as attachments)

A. URINALYSIS: (1) SPECIFIC GRAVITY		B. CHEST X-RAY OR PPD *(Place, date, film number and result)*
(2) URINE ALBUMIN	(4) MICROSCOPIC	
(3) URINE SUGAR		

C. SYPHILIS SEROLOGY *(Specify test used and results)*	D. EKG	E. BLOOD TYPE AND HR FACTOR	F. OTHER TESTS
		O pos/- Rh	

NAME	IDENTIFICATION	NO. OF SHEETS ATTACHED
Gordan Leroy Stevens	TRA-93-0604	

MEASUREMENTS AND OTHER FINDINGS

20. HEIGHT	21. WEIGHT	22. COLOR HAIR	23. COLOR EYES	24. BUILD	25. TEMPERATURE
5' 11"	160	Brown	Green	☒ SLENDER ☐ MEDIUM ☐ HEAVY ☐ OBESE	

26. BLOOD PRESSURE *(Arm at heart level)*						27. PULSE *(Arm at heart level)*				
A. SITTING	SYS. 128 DIAS. 55	B. RECUM-BENT	SYS. 129 DIAS. 57	C. STANDING (5 MINS.)	SYS. 130 DIAS. 70	A. SITTING	B. RECUMBENT	C. STANDING (3mins.)	D. AFTER EXERCISE	E. 2 MINS. AFTER
						59	57	59	75	66

28. DISTANT VISION			29.REFRACTION			30. NEAR VISION	
RIGHT 20/	20	CORR. TO 20/	BY	S.	CX	CORR. TO	BY
LEFT 20/	20	CORR. TO 20/	BY	S.	CX	CORR. TO	BY

31. HETEROPHORIA *(Specify distance)*

ESO	EXO	R.H.	L.H.	PRISM DIV.	PRISM CONV. CT	PC	PD

32. ACCOMMODATION		33. COLOR VISION *(Test used and result)*	34. DEPTH PERCEPTION (Test used and score)	UNCORRECTED
RIGHT	LEFT			CORRECTED
35. FIELD OF VISION		36. NIGHT VISION *(Test used and result)*	37. RED LENS TEST	38. INTRAOCULAR TENSION
RIGHT	LEFT			RIGHT LEFT

39. HEARING			40. AUDIOMETER								41. PSYCHOLOGICAL AND PSYCHOMOTOR *(Tests used and score)*
RIGHT W/V	/15SV	/15		250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
LEFT W/V	/15SV	/15	RIGHT	5	5	10	10	15	10	10	0	
			LEFT	0	0	5	10	5	10	15	0	

42. NOTES *(Continued)* AND SIGNIFICANT OR INTERVAL HISTORY

Baltimore Regional Office
Date Received 01/25/1991

(Use additional sheets if necessary)

43. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers)*

44. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED *(Specify)*

45A. PHYSICAL PROFILE

P	U	L	H	E	S
1	1	1	1	1	1

46. EXAMINEE *(Check)*
A ☒ IS QUALIFIED FOR
B ☐ IS NOT QUALIFIED FOR _____

45B. PHYSICAL CATEGORY

47. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E
1	1	1	1

48. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
Dr. John Watson, MD	Dr. John Watson, MD
49. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
50. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)*	SIGNATURE
Herbert Wonka, DMD	Herbert Wonka, DMD
51 TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE
Henry Blake, MD, LtCol	Henry Blake

STANDARD FORM 88 (REV. 10-94)