OMB Control No. 2900-0747
Respondent Burden: 25 minutes
Expiration Date: 09/30/2022

Department of Veterans Affairs

APPLICATION FOR DISABILITY COMPENSATION AND RELATED COMPENSATION BENEFITS

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

Received Centralized Mail Processing,
Janesville, WI
Date Received 01/12/2021

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 12 before completing the form.

1. SELECT THE TYPE OF CLAIM PROGRAM/PROCESS *(Check the appropriate box) (See instruction pages 1-3 for definitions of the Fully Developed Claim (FDC) Program (Optional Expedited Process) or the Standard Claim Process. See instruction page 5 for the definition of a Benefits Delivery at Discharge (BDD) Program Claim)*

- [X] FULLY DEVELOPED CLAIM (FDC) PROGRAM
- [ ] STANDARD CLAIM PROCESS
- [ ] IDES (Select this option ***only*** if you have been referred to the IDES Program by your Military Service Department)
- [ ] BDD Program Claim (Select this option ***only*** if you meet the criteria for the BDD Program specified on Instruction Page 5)

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.

SECTION I: IDENTIFICATION AND CLAIM INFORMATION
(if claim is not an original, only Section I, IV, and a signature are required)

2. VETERAN/SERVICE MEMBER NAME *(First, Middle Initial, Last)*

Gary A Ludlum

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

TRA – 46 – 3793

4. HAVE YOU EVER FILED A CLAIM WITH VA?

- [X] YES
- [ ] NO

(If "Yes," provide your file number in Item 5)

5. VA FILE NUMBER

TRA463793

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

Month 05 – Day 25 – Year 1955

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

6Y2XX0

8. GENDER

- [X] MALE
- [ ] FEMALE

9. BDD CLAIMS ***ONLY:*** **PROVIDE THE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE DUTY** ***(MM,DD,YYYY)***

Month ___ – Day ___ – Year ____

10. TELEPHONE NUMBER(S) *(Include Area Code)*

Daytime: (555)555-1212
Evening:
Cell phone:

11. CURRENT 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 –

12. EMAIL ADDRESS *(Optional)*

- [ ] 13. IF YOU ARE CURRENTLY A VA EMPLOYEE, CHECK THE BOX *(Includes Work Study/Internship)? (If you are not a VA employee skip to Section II, if applicable)*

SECTION II: CHANGE OF ADDRESS

NOTE: If you are temporarily or permanently changing your address, complete Items 14A through 14C.

14A. TYPE OF ADDRESS CHANGE *(Complete if applicable) (Check only one box)*

- [ ] TEMPORARY
- [ ] PERMANENT

14B. NEW 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: –

14C. EFFECTIVE DATE(S) OF NEW ADDRESS *(If your change of address is **temporary**, complete both the beginning and ending date of your temporary address) (If your change of address is **permanent**, please enter your effective date in the beginning date only)*

BEGINNING DATE: Month ___ – Day ___ – Year ____

ENDING DATE: Month ___ – Day ___ – Year ____

VETERANS SOCIAL SECURITY NO. T R A – 4 6 – 3 7 9 3

SECTION III: HOMELESS INFORMATION

IMPORTANT: The following questions (Items 15A through 15F) should ***only*** be completed if you are currently homeless or at risk of becoming homeless. If this item does not apply to you, skip to Section IV.

15A. ARE YOU CURRENTLY HOMELESS?

☐ YES *(If "Yes," complete Item 15B regarding your living situation)*

☒ NO

15B. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION:

☐ LIVING IN A HOMELESS SHELTER

☐ NOT CURRENTLY IN A SHELTERED ENVIRONMENT (e.g., living in a car or tent)

☐ STAYING WITH ANOTHER PERSON

☐ FLEEING CURRENT RESIDENCE

☐ OTHER (Specify): _____

15C. ARE YOU CURRENTLY AT RISK OF BECOMING HOMELESS?

☐ YES *(If "Yes," complete Item 15D regarding your living situation)*

☒ NO

15D. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION:

☐ HOUSING WILL BE LOST IN 30 DAYS

☐ LEAVING PUBLICLY FUNDED SYSTEM OF CARE (e.g., homeless shelter)

☐ OTHER (Specify): _____

15E. POINT OF CONTACT *(Name of person VA can contact in order to get in touch with you)*

15F. POINT OF CONTACT TELEPHONE NUMBER *(Include Area Code)*

SECTION IV: CLAIM INFORMATION

16. LIST THE CURRENT DISABILITY(IES) OR SYMPTOMS THAT YOU CLAIM ARE RELATED TO YOUR MILITARY SERVICE AND/OR SERVICE-CONNECTED DISABILITY *(If applicable, identify whether a disability is due to a service-connected disability; confinement as a prisoner of war; exposure to Agent Orange, asbestos, mustard gas, ionizing radiation, or Gulf War environmental hazards; or a disability for which compensation is payable under 38 U.S.C. 1151)*

NOTE: List your claimed conditions below. **See the following three examples for guidance on how to complete Section IV**.

EXAMPLES OF DISABILITY(IES)	EXAMPLES OF EXPOSURE TYPE	EXAMPLES OF HOW THE DISABILITY(IES) RELATE TO SERVICE	EXAMPLES OF DATES
Example 1. HEARING LOSS	NOISE	HEAVY EQUIPMENT OPERATOR IN SERVICE	JULY 1968
Example 2. DIABETES	AGENT ORANGE	SERVICE IN VIETNAM WAR	DECEMBER 1972
Example 3. LEFT KNEE, SECONDARY TO RIGHT KNEE		INJURED LEFT KNEE WHEN BRACE ON RIGHT KNEE FAILED	6/11/2008

	CURRENT DISABILITY(IES)	IF DUE TO EXPOSURE, EVENT, OR INJURY, PLEASE SPECIFY (e.g., Agent Orange, radiation)	EXPLAIN HOW THE DISABILITY(IES) RELATES TO THE IN-SERVICE EVENT/EXPOSURE/INJURY	APPROXIMATE DATE DISABILITY(IES) BEGAN OR WORSENED
1.	left wrist arthritis with pain and stiffness			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

VETERANS SOCIAL SECURITY NO. T R A – 4 6 – 3 7 9 3

17. LIST VA MEDICAL CENTER(S) (VAMC) AND DEPARTMENT OF DEFENSE (DOD) MILITARY TREATMENT FACILITIES (MTF) WHERE YOU RECEIVED TREATMENT AFTER DISCHARGE FOR YOUR CLAIMED DISABILITY(IES) LISTED IN ITEM 16 AND PROVIDE APPROXIMATE BEGINNING DATE (Month and Year) OF TREATMENT:
NOTE: If treatment began from 2005 to present, you do not need to provide dates in Item 17B.

A. ENTER THE DISABILITY TREATED AND NAME/LOCATION OF THE TREATMENT FACILITY	B. DATE OF TREATMENT (MM/YYYY)	C. CHECK THE BOX IF YOU DO NOT HAVE DATE(S) OF TREATMENT
		☐ Don't have date
		☐ Don't have date
		☐ Don't have date
		☐ Don't have date

NOTE: IF YOU WISH TO CLAIM ANY OF THE FOLLOWING, COMPLETE AND ATTACH THE REQUIRED FORM(S) AS STATED BELOW (VA forms are available at www.va.gov/vaforms).

For:	***Required Form(s):***
Supplemental Claims	VA Form 20-0995, *Decision Review Request: Supplemental Claim*
Dependents	VA Form 21-686c and, if claiming a child aged 18-23 years and in school, VA Form 21-674
Individual Unemployability	VA Form 21-8940 and 21-4192
Post-Traumatic Stress Disorder	VA Form 21-0781 and 21-0781a
Specially Adapted Housing or Special Home Adaptation	VA Form 26-4555
Auto Allowance	VA Form 21-4502
Veteran/Spouse Aid and Attendance benefits	VA Form 21-2680 or, if based on nursing home attendance, VA Form 21-0779

SECTION V: SERVICE INFORMATION

18A. DID YOU SERVE UNDER ANOTHER NAME?
☐ YES *(If "Yes," complete Item 18B)* ☒ NO *(If "No," skip to Item 19A)*

18B. LIST THE OTHER NAME(S) YOU SERVED UNDER:

19A. BRANCH OF SERVICE *(Check all that apply)*
☐ ARMY ☒ NAVY ☐ MARINE CORPS ☐ AIR FORCE ☐ COAST GUARD

19B. COMPONENT *(Check all that apply)*
☒ ACTIVE ☐ RESERVES ☐ NATIONAL GUARD

20A. MOST RECENT ACTIVE SERVICE DATES *(MM,DD,YYYY)*
ENTRY DATE: Month 0 6 – Day 1 0 – Year 1 9 7 3
EXIT DATE: Month 0 6 – Day 0 9 – Year 1 9 7 6

20B. PLACE OF LAST OR ANTICIPATED SEPARATION
Norfolk Naval Shipyard Virginia

20C. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001?
☐ YES ☒ NO

20D. ADDITIONAL PERIODS OF SERVICE *(Indicate enlistment and discharge dates, if applicable)*

Enlistment Date(s)	Discharge Date(s)

21A. ARE YOU CURRENTLY SERVING OR HAVE YOU EVER SERVED IN THE RESERVES OR NATIONAL GUARD?
☐ YES *(If "Yes," complete Items 21B thru 21F)*
☒ NO *(If "No," skip to Item 22A)*

21B. COMPONENT
☐ NATIONAL GUARD
☐ RESERVES

21C. OBLIGATION TERM OF SERVICE
From: Month ___ – Day ___ – Year ____
To: Month ___ – Day ___ – Year ____

21D. CURRENT OR LAST ASSIGNED NAME AND ADDRESS OF UNIT:

21E. CURRENT OR ASSIGNED PHONE NUMBER OF UNIT *(Include Area Code)*
( )

21F. ARE YOU CURRENTLY RECEIVING INACTIVE DUTY TRAINING PAY?
☐ YES ☐ NO

22A. ARE YOU CURRENTLY ACTIVATED ON FEDERAL ORDERS WITHIN THE NATIONAL GUARD OR RESERVES?
☐ YES *(If "Yes," complete Items 22B & 22C)*
☒ NO

22B. DATE OF ACTIVATION: *(MM,DD,YYYY)*
Month ___ – Day ___ – Year ____

22C. ANTICIPATED SEPARATION DATE: *(MM,DD,YYYY)*
Month ___ – Day ___ – Year ____

23A. HAVE YOU EVER BEEN A PRISONER OF WAR?
☐ YES *(If "Yes," complete Item 23B)*
☒ NO

23B. DATES OF CONFINEMENT *(MM,DD,YYYY)*

From:	To:
Month ___ – Day ___ – Year ____	Month ___ – Day ___ – Year ____
Month ___ – Day ___ – Year ____	Month ___ – Day ___ – Year ____

VETERANS SOCIAL SECURITY NO. T R A – 4 6 – 3 7 9 3

SECTION VI: SERVICE PAY (Retired Pay, Separation Pay, and Disability Severance Pay)

24A. ARE YOU RECEIVING MILITARY RETIRED PAY?

☐ YES *(If "Yes," complete Items 24C and 24D)*

☒ NO

24B. WILL YOU RECEIVE MILITARY RETIRED PAY IN THE FUTURE?

☐ YES *(If "Yes," explain below (e.g. future Reserve/National Guard retirement, pending MEB/PEB and also complete Items 24C and 24D)*

☐ NO

24C. BRANCH OF SERVICE	24D. MONTHLY AMOUNT	25. RETIRED STATUS
	$	☐ RETIRED ☐ PERMANENT DISABILITY RETIRED LIST ☐ TEMPORARY DISABILITY RETIRED LIST

IMPORTANT INFORMATION ON MILITARY RETIRED PAY (Includes all Uniformed Services Retired Pay):
Submission of this application constitutes a waiver of military retired pay in an amount equal to VA compensation awarded, if you are entitled to both benefits. Your retired pay may be reduced by the amount of VA compensation awarded. Receipt of the full amount of military retired pay and VA compensation at the same time ***may*** result in an overpayment, which ***may*** be subject to collection. If you qualify for concurrent receipt of VA compensation and military retired pay, the waiver of retired pay will not apply. If you do not want to waive any retired pay to receive VA compensation, you should check the box in **Item 26**.
Note that if you check the box in Item 26, you will not receive VA compensation, if granted. If you are currently in receipt of VA compensation and you check the box in Item 26, your VA compensation will be terminated, if you are also eligible for military retired pay.

IMPORTANT: VA COMPENSATION PAY IS NON-TAXABLE. THEREFORE, VA COMPENSATION PAY MAY BE THE GREATER BENEFIT.

☐ **26. Do NOT pay me VA compensation. I do NOT want to receive VA compensation in lieu of retired pay.**

IMPORTANT INFORMATION ON SEPARATION/SEVERANCE PAY:
VA compensation, if granted, may be withheld to recoup any disability severance or separation pay such as involuntary separation pay, voluntary separation pay, or special separation benefit, you receive from your branch of service. In addition, if you receive a Voluntary Separation Incentive (VSI), your VSI payments may be reduced if you are awarded VA compensation. Receipt of VA compensation and VSI at the same time may result in an overpayment of VSI, which ***may*** be subject to collection.

27A. HAVE YOU EVER RECEIVED SEPARATION PAY, DISABILITY SEVERANCE PAY, OR ANY OTHER LUMP SUM PAYMENT FROM YOUR BRANCH OF SERVICE?

☐ YES *(If "Yes," complete Items 27B through 27D)*

☒ NO

27B. DATE PAYMENT RECEIVED *(MM,DD,YYYY)*	27C. BRANCH OF SERVICE	27D. AMOUNT RECEIVED *(Provide pre-tax amount)*
Month ☐☐ – Day ☐☐ – Year ☐☐☐☐		$

IMPORTANT INFORMATION ON INACTIVE DUTY TRAINING PAY:
You may elect to keep the active or inactive duty training pay you received from the military service department. However, to be legally entitled to keep your training pay, you must waive VA benefits for the number of days equal to the number of days for which you received training pay. In most instances, it will be to your advantage to waive your VA benefits and keep your training pay.

If you waive VA benefits to receive training pay by checking the box in **Item 28**, VA will retroactively adjust your VA award to withhold benefits equal to the total number of training days waived and at the monthly rate in effect for the fiscal year period for which you received training pay. This action may result in an overpayment of compensation, which ***may*** be subject to collection.

IMPORTANT: VA COMPENSATION PAY IS NON-TAXABLE. THEREFORE VA COMPENSATION PAY MAY BE THE GREATER BENEFIT.

☐ **28. Do NOT pay me VA compensation. I do NOT want to receive VA compensation in lieu of training pay.**

SECTION VII: DIRECT DEPOSIT INFORMATION

The Department of Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. Please attach a voided personal check or deposit slip or provide the information requested below in **Items 30, 31 and 32** to enroll in direct deposit. If you do not have a bank account, you must receive your payment through Direct Express Debit MasterCard. To request a Direct Express Debit MasterCard you must apply at www.usdirectexpress.com or by telephone at 1-800-333-1795. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

☐ 29. I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT *(If you check this box skip to Section VIII)*

30. ACCOUNT NUMBER *(Check only **one** box below and provide the account number)*

Account No.: **999555111222** ☒ CHECKING ☐ SAVINGS

31. NAME OF FINANCIAL INSTITUTION *(Provide the name of the bank where you want your direct deposit)*	32. ROUTING OR TRANSIT NUMBER *(The first nine numbers located at the bottom left of your check)*
USAA FSB	**314074269**

VETERANS SOCIAL SECURITY NO. T R A – 4 6 – 3 7 9 3

SECTION VIII: CLAIM CERTIFICATION AND SIGNATURE

VETERAN/SERVICEMEMBER CERTIFICATION AND SIGNATURE

I certify and authorize the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any 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, and I waive any privilege which makes the information confidential.

I certify I have received the notice attached to this application titled, ***Notice to Veteran/Service Member of Evidence Necessary to Substantiate a Claim for Veterans Disability Compensation and Related Compensation Benefits.***

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility such as a VA medical center; **OR,** I have no information or evidence to give VA to support my claim; **OR**, I have checked the box in Item 1, on page 8, indicating I want my claim processed under the standard claim process because I plan to submit additional evidence in support of my claim.

33A. VETERAN/SERVICE MEMBER SIGNATURE (**REQUIRED**) *(Sign in ink)*	33B. DATE SIGNED *(MM,DD,YYYY)*
Gary Albert Ludlum	01/12/2021

SECTION IX: WITNESSES TO SIGNATURE

34A. SIGNATURE OF WITNESS *(Sign in ink)* (**Note**: *Only sign if veteran signed in Item 33A using an "X")*	34B. PRINTED NAME AND ADDRESS OF WITNESS
35A. SIGNATURE OF WITNESS *(Sign in ink)* (**Note**: *Only sign if veteran signed in Item 33A using an "X"*	35B. PRINTED NAME AND ADDRESS OF WITNESS

SECTION X: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE
(NOTE: REQUIRED ONLY IF ITEM 33A IS BLANK)

I certify that by signing on behalf of the claimant, that I am a court-appointed representative; **OR**, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; **OR**, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; **OR**, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; **AND**, that the claimant is under the age of 18; **OR**, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; **OR**, is physically unable to sign this form.

I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

36A. ALTERNATE SIGNER SIGNATURE (**REQUIRED**) *(Sign in ink)*	36B. DATE SIGNED

SECTION XI: POWER OF ATTORNEY (POA) SIGNATURE
(NOTE: POA'S CANNOT SIGN FOR AN ORIGINAL CLAIM ONLY)

I certify that the claimant has authorized the undersigned representative to file this supplemental claim on behalf of the claimant and that the claimant is aware and accepts the information provided in this document. I certify that the claimant has authorized the undersigned representative to state that the claimant certifies the truth and completion of the information contained in this document to the best of claimant's knowledge.

NOTE: A POA's signature ***will not*** be accepted unless at the time of submission of this claim a valid VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative*, or VA Form 21-22a, *Appointment of Individual As Claimant's Representative*, indicating the appropriate POA is of record with VA.

37A. POA/AUTHORIZED REPRESENTATIVE SIGNATURE *(Sign in ink)*	37B. DATE SIGNED *(MM,DD,YYYY)*

PRIVACY ACT NOTICE: The form will be used to determine allowance to compensation benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses 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. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: 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. Your obligation to respond is required in order to obtain or retain benefits. Information that you furnish may be utilized in computer matching programs with other Federal or State agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.

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 25 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.

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.

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 01/12/2021

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)*

Gary A Ludlum

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

TRA – 46 – 3793

3. VA FILE NUMBER *(If applicable)*

TRA46379 3

4. VETERAN'S DATE OF BIRTH

Month 05 – Day 25 – Year 1955

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

6Y2XX0

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)*

Jacob French

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

NSO

17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15

JFrench.dav@email.com

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

01/10/2021

VETERAN'S SOCIAL SECURITY NUMBER T R A – 4 6 – 3 7 9 3

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)*
Gary Albert Ludlum	01/10/2021
23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A *(Do Not Print)*	23B. DATE SIGNED *(MM/DD/YYYY)*
Jacob French	01/10/2021

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

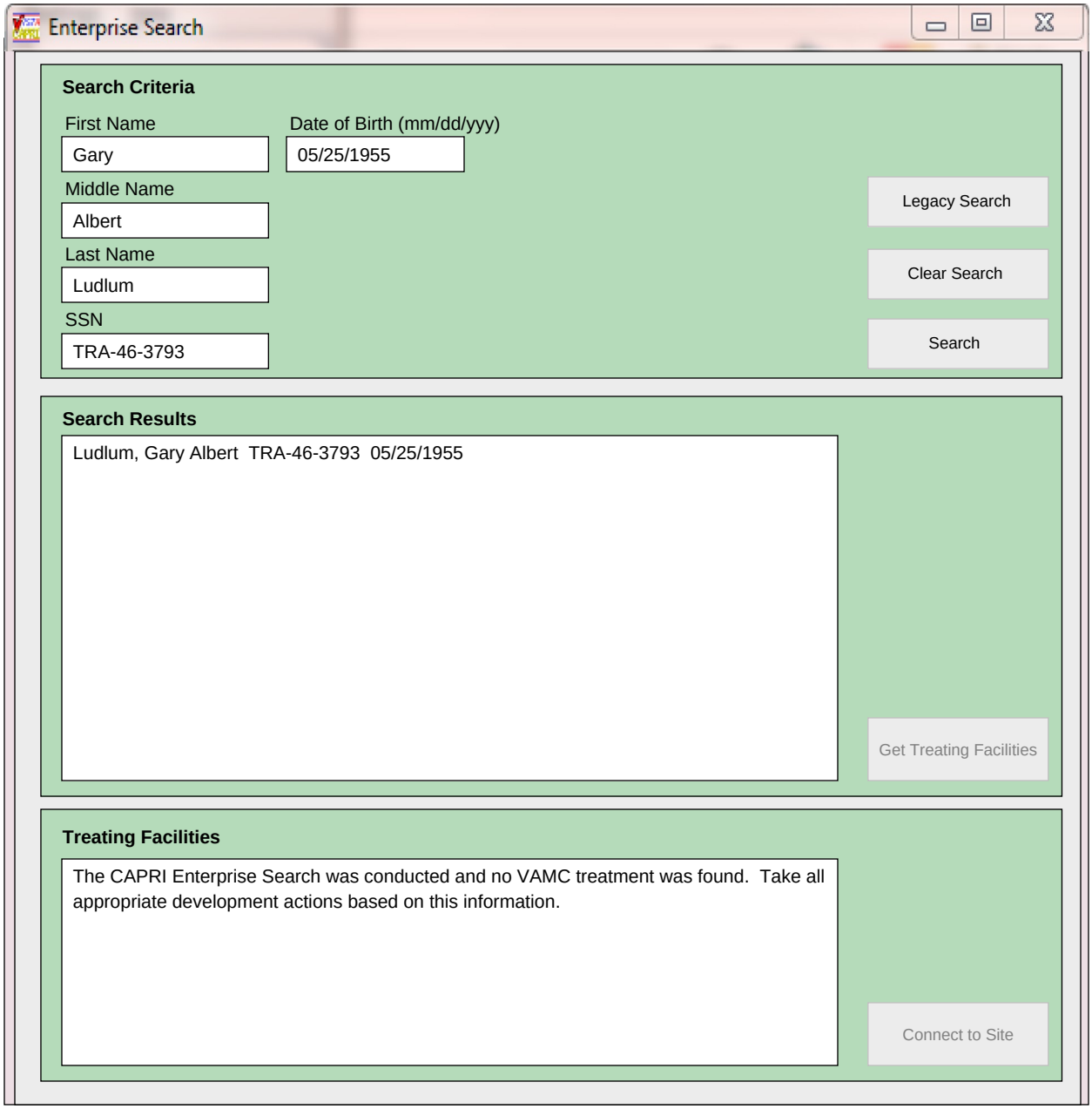
This Pension Center Serves The Following:

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			


Enterprise Search
Search Criteria
First Name
Gary
Date of Birth (mm/dd/yyy)
05/25/1955
Middle Name
Albert
Last Name
Ludlum
SSN
TRA-46-3793
Legacy Search
Clear Search
Search
Search Results
Ludlum, Gary Albert TRA-46-3793 05/25/1955
Get Treating Facilities
Treating Facilities
The CAPRI Enterprise Search was conducted and no VAMC treatment was found. Take all appropriate development actions based on this information.
Connect to Site

DEPARTMENT OF VETERANS AFFAIRS
Veterans Benefits Administration
Regional Office

Gary Ludlum

VA File Number
TRA-46-3793

Represented by:
DISABLED AMERICAN VETERANS

Rating Decision
February 22, 2018

INTRODUCTION

The records reflect that you are a Veteran of the Vietnam Era. You served in the Navy from June 10, 1973, to June 09, 1976. You filed an original disability claim that was received on January 13, 2018. Based on a review of the evidence listed below, we have made the following decision(s) on your claim.

DECISION

1. Service connection for right shoulder strain is granted with an evaluation of 20 percent effective January 13, 2018.

EVIDENCE

- DD Form 214, Certificate of Release or Discharge from Active Duty received January 28, 2018, for the period June 10, 1973, to June 09, 1976.
- Service treatment records received January 28, 2018, for the period June 10, 1973, to June 09, 1976.
- VA Form 21-526EZ, Application for Disability Compensation and Related Compensation Benefits, received January 13, 2018.
- Disability Benefits Questionnaire, Baltimore VAMC, dated February 12, 2018.

REASONS FOR DECISION

1. Service connection for right shoulder strain.

Service connection for right shoulder strain has been established as directly related to military service.

An evaluation of 20 percent is assigned from January 13, 2018.

We have assigned a 20 percent evaluation for your right shoulder strain based on:

• Painful motion of the shoulder. (38 CFR §4.59 allows consideration of functional loss due to painful motion to be rated to at least the minimum compensable rating for a particular joint. Since you demonstrate painful motion of the arm at the shoulder, the minimum compensable evaluation of 20 percent is assigned.)

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 30 percent is not warranted for limitation of motion of the arm unless the evidence shows:

• Limited motion of the arm midway between the side and shoulder level.

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		02/22/2018

NAME OF VETERAN	VA FILE NUMBER	SOCIAL SECURITY NR	POA	COPY TO
Gary Ludlum	TRA-46-3793	TRA-46-3793	DISABLED AMERICAN VETERANS	

ACTIVE DUTY			
EOD	**RAD**	**BRANCH**	**CHARACTER OF DISCHARGE**
06/10/1973	06/09/1976	Navy	Honorable

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

JURISDICATION: Original Disability Claim Received 01/13/2018

ASSOCIATED CLAIM(s): 110; Original Disability Claim; 01/13/2018

SUBJECT TO COMPENSATION (1.SC)

5201 RIGHT SHOULDER STRAIN
Service Connected, Peacetime, Incurred
Static Disability
20% from 01/13/2018

COMBINED EVALUATION FOR COMPENSATION:

20% from 01/13/2018

eSign: certified by VBADENJOHNSD, RVSR
Training Consultant

Reviewer

1. LAST NAME - FIRST NAME -MIDDLE NAME	2. SEX	3. SOCIAL SECURITY NUMBER	4. DATE OF BIRTH	YEAR	MONTH	DAY
Ludlum, Gary Albert	M	TRA 46 3793		55	05	25

5. DEPARTMENT, COMPONENT AND BRANCH OR CLASS	6a. GRADE, RATE OR RANK	6b. PAY GRADE	7. DATE OF RANK	YEAR	MONTH	DAY
Navy	Petty Officer 2nd Class	E-5		76	04	25

8a. SELECTIVE SERVICE NUMBER	b. SELECTIVE SERVICE LOCAL BOARD NUMBER, CITY, STATE AND ZIP CODE	c. HOME OF RECORD AT TIME OF ENTRY INTO ACTIVE SERVICE *(Street, RFD, City, State and Zip Code)*
		31 Hopkins Plaza, Baltimore, MD 21201 (US)

9a. TYPE OF SEPARATION	b. STATION OR INSTALLATION AT WHICH EFFECTED
Discharge	Norfolk Naval Shipyard Virginia

c. AUTHORITY AND REASON	d. EFFECTIVE DATE	YEAR	MONTH	DAY
MILPERSMAN 3620150		76	06	09

e. CHARACTER OF SERVICE	f. TYPE OF CERTIFICATE ISSUED	10. REENLISTMENT CODE
Honorable		RE-1

11. LAST DUTY ASSIGNMENT AND MAJOR COMMAND	12. COMMAND TO WHICH TRANSFERRED
Norfolk Naval Shipyard	

13. TERMINAL DATE OF RESERVE/ MSS OBLIGATION YEAR	MONTH	DAY	14. PLACE OF ENTRY INTO CURRENT ACTIVE SERVICE *(City, State and ZIP Code)*	15. DATE ENTERED ACTIVE DUTY THIS PERIOD YEAR	MONTH	DAY
			Baltimore, MD	73	06	10

16a. PRIMARY SPECIALTY NUMBER AND TITLE	b. RELATED CIVILIAN OCCUPATION AND D.O.T. NUMBER	18. RECORD OF SERVICE	YEARS	MONTHS	DAYS
MM - Machinist Mate (2 years)	Machinist	(a) NET ACTIVE SERVICE THIS PERIOD	03	01	01
		(b) PRIOR ACTIVE SERVICE	00	00	00
17a. SECONDARY SPECIALTY NUMBER AND TITLE	b. RELATED CIVILIAN OCCUPATION AND D.O.T. NUMBER	(c) TOTAL ACTIVE SERVICE (a & b)	03	01	01
		(d) PRIOR INACTIVE SERVICE	00	00	00
		(e) TOTAL SERVICE FOR PAY (c & d)	03	01	01
		(f) FOREIGN AND/OR SEA SERVICE THIS PERIOD	00	00	00

19. INDOCHINA OR KOREA SERVICE SINCE AUGUST 5, 1964	20. HIGHEST EDUCATION LEVEL SUCCESSFULLY COMPLETED *(In Years)*
	SECONDARY/HIGH SCHOOL _____ YRS (1-12 grades) COLLEGE _____ YRS

21. TIME LOST *(Preceding Two Yrs)*	22. DAYS ACCRUED LEAVE PAID	23. SERVICEMEN'S GROUP LIFE INSURANCE COVERAGE	24. DISABILITY SEVERANCE PAY	25. PERSONNEL SECURITY INVESTIGATION a. TYPE	b. DATE COMPLETED
		☐ $15,000 ☐ $5,000 ☐ $10,000 ☐ NONE	☐ NO ☐ YES AMOUNT _____		

26. DECORATIONS, MEDALS, BADGES, COMMENDATIONS, CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED
National Defense Service Medal
Navy Acheivement Medal

27. REMARKS

Received Centralized Mail Processing, Janesville, WI
Date Received 01/28/2018

I HEREBY CERITFY THAT THIS IS A TRUE AND EXACT COPY OF THE ORIGINAL DOCUMENT.
Certified by Klara Mikelson this 10 day of January, 2018.

28. MAILING ADDRESS AFTER SEPARATION *(Street, RFD, City, County, State, ZIP)*	29. SIGNATURE OF PERSON BEING SEPARATED
31 Hopkins Plaza Baltimore, MD 21201 (US)	*Gary Albert Ludlum*
30. TYPED NAME, GRADE AND TITLE OF AUTHORIZING OFFICER	**31. SIGNATURE OF OFFICER AUTHORIZED TO SIGN**
SAMUEL D. HAWKINS, CAPT. ADMIN OFFICER	Samuel D. Hawkins

DD FORM 1 NOV 72 214 **PREVIOUS EDITIONS OF THIS FORM ARE OBSOLETE.**

THIS IS AN IMPORTANT RECORD SAFEGUARD IT.

REPORT OF SEPARATION FROM ACTIVE DUTY

HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
08/05/74	Petty Officer Ludlum hurt his right shoulder while lifting heavy equipment. He must wear a sling for at least one month. He must return to the clinic for an eval at the end of the month. Dr Tim Eagle

PATIENT'S IDENTIFICATION *(Use this space for medical imprint)*

Ludlum, Gary Albert
TRA-46-3793

PATIENT'S NAME *(Last, First Initial)*			SEX
Ludlum, Gary Albert			M
YEAR OF BIRTH	**RELATIONSHIP TO SPONSOR**	**COMPONENT/STATUS**	**DEPART/SERVICE**
1955	Self		USN
SPONSOR'S NAME			**RANK/GRADE**
Self			E-5
SSAN OF IDENTIFICATION NO.		**ORGANIZATION**	
TRA-46-3793		Dallas MTF	

CHRONOLOGICAL RECORD OF MEDICAL CARE

Standard Form 600
September 1971
General Services Administration and
Interagency Comm. on Medical records
FPMR 101-11.809-3

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

REPORT OF MEDICAL EXAMINATION

1. LAST NAME - FIRST NAME - MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
Ludlum, Gary Albert	E-5	TRA-46-3793

4. HOME ADDRESS *(Number, street or RFD, city or town, State and ZIP Code)*	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
31 Hopkins Plaza Baltimore, MD 21201 (US)	Physical	10/05/75

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
Male	Puerto Rican	3		USN	

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
05/25/1955	Dallas, TX	Elsa Ludlum, Sister 2575 West 2700 South, Salt Lake City, UT 84101 (US)

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
Baltimore MEPS, Maryland	

17. RATING OR SPECIALTY	TIME IN THIS CAPACITY *(Total)*	LAST SIX MONTHS
MD - General Practitioner		

CLINICAL EVALUATION

NORMAL	*(Check each item in appropriate column, enter "NE" if not evaluated.)*	ABNORMAL
×	18. HEAD, FACE, NECK AND SCALP	
×	19. NOSE	
×	20. SINUSES	
×	21. MOUTH AND THROAT	
×	22. EARS-GENERAL *(INTERNAL CANALS) (Auditory) acuity under items 70 and 71)*	
×	23. DRUMS *(Perforation)*	
×	24. EYES-GENERAL *(Visual acuity and refraction under items 59, 60 and 67)*	
×	25. OPHTHALMOSCOPIC-	
×	26. PUPILS (Equality and reaction)	
×	27. OCULAR MOTILITY (Associated parallel movements nystagmus)	
×	28. LUNGS AND CHEST *(Include breasts)*	
×	29. HEART *(Thrust, size, rhyhm, sounds)*	
×	30. VASCULAR SYSTEM *(Varicosities, etc.)*	
×	31. ABDOMEN AND VISCERA *(Include hernia)*	
×	32. ANUS AND RECTUM *(Hemorrhoids, Fistular) (Prostate, if indicated)*	
×	33. ENDOCRINE SYSTEM	
×	34. G-U SYSTEM	
×	35. UPPER EXTREMITIES *(Strength, range of motion)*	×
×	36. FEET	
×	37. LOWER EXTREMITIES *(Except feet) (Strength, range of motion)*	
×	38. SPINE, OTHER MUSCULOSKELETAL	
×	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
×	40. SKIN, LYMPHATICS	
×	41. NEUROLOGIC *(Equilibrium tests under item 72)*	
×	42. PSYCHIATRIC *(Specify any personality deviation)*	
	43. PELVIC *(Females only) (Check how done)* ☐ VAGINAL ☐ RECTAL	

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary)

Right shoulder pain

(Continue in item 73)

44. DENTAL *(Place appropriate symbols, shown in examples, above or below numer of upper and lower teeth.)*

	Restorable Teeth	Non-Restorable Teeth	Missing Teeth	Replaced by Dentures	Fixed Partial dentures
Upper	0 / 1 2 3	/ 1 2 3	x 1 2 3	xxx 1 2 3	(x) 1 2 3
Lower	32 31 30 / 0	32 31 30 /	32 31 30 x	32 31 30 xxx	32 31 30 (x)

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	x															x	
	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

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY		46. CHEST X-RAY *(Place, date, film number and result)*
B. ALBUMIN	D. MICROSCOPIC	
C. SUGAR		

47. SEROLOGY *(Specify test used and result)*	48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS
		B+	

NSN 7540-00-634-4038
88-122

STANDARD FORM 88
General Services Administration
Interagency Comm. on Medical Records
FIRMR (41 CFR) 201-45.505

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD:	56. TEMPERATURE
69	173	Black	Brown	☐ SLENDER ☐ MEDIUM ☐ HEAVY ☐ OBESE	

57. BLOOD PRESSURE *(Arm at heart level)*						58. PULSE *(Arm at heart level)*				
A. SITTING	SYS. / DIAS.	B. RECUMBENT	SYS. / DIAS.	C. STANDING *(5 min.)*	SYS. / DIAS.	A. SITTING	B. AFTER EXERCISE	C. 2 MIN. AFTER	D. RECUMBENT E.	AFTER STANDING 3 MIN.

59. DISTANT VISION		60. REFRACTION			61. NEAR VISION	
RIGHT 20/	CORR. TO 20/	BY	S.	CX	CORR. TO	BY
LEFT 20/	CORR. TO 20/	BY	S.	CX	CORR. TO	BY

62. HETEROPHORIA *(Specify distance)*

ES°	EX°	R.H.	L.H.	PRISM DIV.	PRISM CONV. CT	PC	PD

63. ACCOMMODATION		64. COLOR VISION *(Test used and result)*	65. DEPTH PERCEPTION *(Test used and score)*	UNCORRECTED
RIGHT	LEFT			CORRECTED
66. FIELD OF VISION		65. TEST VISION *(Test used and score)*	66. RED LENS TEST	69. INTRAOCULAR TENSION

70. HEARING			71. AUDIOMETER								72. PSYCHOLOGICAL AND PSYCHOMOTOR *(Test used and score)*
RIGHT WV	/15 SV	/15		250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
LEFT WV	/15 SV	/15	RIGHT									
			LEFT									

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

(Use additional sheets if necessary)

74. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnosis with item numbers)*

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

76. A. PHYSICAL PROFILE					
P	U	L	H	E	S

77. EXAMINEE *(Check)*

A. ☐ IS QUALIFIED FOR

B. ☐ IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY

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

A	B	C	E

79. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
Meredith Gray	Meredith Gray
80. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)*	SIGNATURE
82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE / NUMBER OF ATTACHED SHEETS

*U.S. Government Printing Office: 1991 - 281-782/40135

REPORT OF MEDICAL EXAMINATION

1. DATE OF EXAMINATION (YYYYMMDD)	2. SOCIAL SECURITY NUMBER
19730608	TRA-46-3793

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.
PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.
ROUTINE USE(S): None.
DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

3. LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	4. HOME ADDRESS (Street, Apartment Number, City, State and ZIP Code)	5. HOME TELEPHONE NUMBER (Include Area Code)
Ludlum, Gary Albert	31 Hopkins Plaza Baltimore, MD 21201 (US)	(555)555-1212

6. GRADE	7. DATE OF BIRTH (YYYYMMDD)	8. AGE	9. SEX	10. RACE
N/A	19550525		[ ] Female [ ] Male	[ ] American Indian/Alaskan Native [ ] Asian/Pacific Islander [ ] Black [ ] White

11. TOTAL YEARS GOVERNMENT SERVICE		12. AGENCY (Non-Service Members Only)	13. ORGANIZATION UNIT AND UIC/CODE
a. MILITARY	b. CIVILIAN		
	Civilian		

14.a. RATING OR SPECIALTY (Aviators Only)	b. TOTAL FLYING TIME	c. LAST SIX MONTHS

15.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION	16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include ZIP Code)
[ ] Army [ ] Coast Guard [x] Navy [ ] Marine Corps [ ] Air Force	[ ] Active Duty [ ] Reserve [ ] National Guard	[x] Enlistment [ ] Medical Board [ ] Other [ ] Commission [ ] Retirement [ ] Retention [ ] U.S. Service Academy [ ] Separation [ ] ROTC Scholarship Program	MEPS Baltimore, MD

CLINICAL EVALUATION *(Check each item in appropriate column. Enter "NE" if not evaluated.)*

	Normal	Abnorm	NE
17. Head, face, neck, and scalp	×		
18. Nose	×		
19. Sinuses	×		
20. Mouth and throat	×		
21. Ears - General *(Int. and ext. canals/Auditory acuity under item)*	×		
22. Drum *(Perforation)*	×		
23. Eyes - General *(Visual acuity and refraction under items 62 - 71)*	×		
24. Ophthalmoscopic	×		
25. Pupils *(Equality and reaction)*	×		
26. Ocular motility *(Associated parallel movements, nystagmus)*	×		
27. Heart *(Thrust, size, rhythm, sounds)*	×		
28. Lungs and chest *(Include breasts)*	×		
29. Vascular system *(Varicosities, etc.)*	×		
30. Anus and rectum *(Hemorrhoids, Fistulae) (Prostate if indicated)*	×		
31. Abdomen and viscera *(Include hernia)*	×		
32. External genitalia *(Genitourinary)*	×		
33. Upper extremities	×		
34. Lower extremities *(Except feet)*	×		
35. Feet	×		
36. Spine, other musculoskeletal	×		
37. Identifying body marks, scars, tattoos	×		
38. Skin, lymphatics	×		
39. Neurologic	×		
40. Psychiatric *(Specify any personality deviation)*	×		
41. Pelvic *(Females only)*	×		

42. NOTES: *(Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)*

43. DENTAL DEFECTS AND DISEASE *(Please explain. Use dental form if completed by dentist.)*

[×] Acceptable
[ ] Not Acceptable Class _____

(Dental examination not done by dental officer)

44. FEET *(Check category)*

[×] Normal Arch
[ ] Pes Cavus
[ ] Pes Planus
[ ] Mild
[ ] Moderate
[ ] Severe
[ ] Asymptomatic
[ ] Symptomatic

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER
Ludlum, Gary Albert	TRA-46-3793

LABORATORY FINDINGS

45. URINALYSIS	a. Albumin	46. URINE HCG	47. H/H	48. BLOOD TYPE
	b. Sugar			B+

TESTS	RESULTS	HIV SPECIMEN ID LABEL	DRUG TEST SPECIMEN ID LABEL
49. HIV			
50. DRUGS			
51. ALCOHOL			
52. OTHER			
a. PAP SMEAR			
b.			
c.			

MEASUREMENTS AND OTHER FINDINGS

53. HEIGHT	54. WEIGHT	55. MIN WGT - MAX WGT MAX BF %	56. TEMPERATURE	57. PULSE
69	173 lbs.		98.6	67

58. BLOOD PRESSURE			59. RED/GREEN *(Army Only)*	60. OTHER VISION TEST
a. 1ST	b. 2ND	c. 3RD		
SYS. 110	SYS. 111	SYS. 110		
DIAS. 72	DIAS. 80	DIAS. 70		

61. DISTANT VISION	62. REFRACTION BY AUTOREFRACTION OR MANIFEST	63. NEAR VISION
Right 20/ 20 Corr. to 20/	By S. CX by	Right 20/ 20 Corr. to 20/ by
Left 20/ 20 Corr. to 20/	By S. CX by	Left 20/ 20 Corr. to 20/ by

64. HETEROPHORIA *(Specify distance)*

ES° EX° R.H. L.H. Prism div. Prism Conv CT NP PD

65. ACCOMMODATION		66. COLOR VISION *(Test used and result)*	67. DEPTH PERCEPTION *(Test used and score)* AFVT	
Right	Left		Uncorrected	Corrected

68. FIELD OF VISION	69. NIGHT VISION *(Test used and score)*	70. INTRAOCULAR TENSION	
		O.D.	O.S.

71a. AUDIOMETER	Unit Serial Number 432689	71b. Unit Serial Number	72a. READING ALOUD TEST
Date Calibrated *(YYYYMMDD)*	19730117	Date Calibrated *(YYYYMMDD)*	

HZ	500	1000	2000	3000	4000	6000
Right	0	0	0	0	0	0
Left	0	0	0	0	0	0

HZ	500	1000	2000	3000	4000	6000
Right						
Left						

72a. READING ALOUD TEST: × SAT ☐ UNSAT

72b. VALSALVA: ☐ SAT ☐ UNSAT

73. NOTES *(Continued)* **AND SIGNIFICANT OR INTERVAL HISTORY** *(Use additional sheets if necessary.)*

No significant issues, fit for duty.

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER
Ludlum, Gary Albert	TRA-46-3793

74.a. EXAMINEE/APPLICANT *(check one)*

- ☐ IS QUALIFIED FOR SERVICE
- ☐ IS NOT QUALIFIED FOR SERVICE

75. I have been advised of my disqualifying condition.

a. SIGNATURE OF EXAMINEE	b. DATE *(YYYYMMDD)*

b. PHYSICAL PROFILE

P	U	L	H	E	S	X	PROFILER INITIALS	DATE *(YYYYMMDD)*

76. SIGNIFICANT OR DISQUALIFYING DEFECTS

ITEM NO.	MEDICAL CONDITION/DIAGNOSIS	ICD CODE	PROFILE SERIAL	RBJ DATE *(YYYYMMDD)*	QUALI-FIED	DIS-QUALI-FIED	EXAMINER INITIALS	WAIVER RECEIVED	
								SERVICE	DATE *(YYYYMMDD)*

77. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers) (Use additional sheets if necessary.)*

78. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED *(Specify) (Use additional sheets if necessary.)*

79. MEPS WORKLOAD *(For MEPS use only)*

WKID	ST	DATE *(YYYYMMDD)*	INITIAL	WKID	ST	DATE *(YYYYMMDD)*	INITIAL

80. MEDICAL INSPECTION DATE	HT	WT	%BF	MAX WT	HCG	QUAL	DISQ	PHYSICIAN'S SIGNATURE

81.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE
M.Welby, MD	Marcus Welby, MD
82.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	**b. SIGNATURE**
83.a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)*	**b. SIGNATURE**
84.a. TYPED OR PRINTED NAME OF REVIEWING OFFICER/APPROVING AUTHORITY	**b. SIGNATURE**

85. This examination has been administratively reviewed for completeness and accuracy.

a. SIGNATURE	b. GRADE	c. DATE *(YYYYMMDD)*
Steven Kiley, LT/MD/USN	O-3	05/10/1973

86. WAIVER GRANTED *(If yes, date and by whom)*

- ☐ **YES**
- ☐ **NO**

87. NUMBER OF ATTACHED SHEETS

REPORT OF MEDICAL EXAMINATION

1. DATE OF EXAMINATION (YYYYMMDD)	2. SOCIAL SECURITY NUMBER
19760430	TRA-46-3793

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.
PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.
ROUTINE USE(S): None.
DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

3. LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	4. HOME ADDRESS (Street, Apartment Number, City, State and ZIP Code)	5. HOME TELEPHONE NUMBER (Include Area Code)
Ludlum, Gary Albert	31 Hopkins Plaza Baltimore, MD 21201 (US)	(555)555-1212

6. GRADE	7. DATE OF BIRTH (YYYYMMDD)	8. AGE	9. SEX	10. RACE
E-5	19550525		[ ] Female [x] Male	[ ] American Indian/Alaskan Native [ ] Asian/Pacific Islander [ ] Black [x] White

11. TOTAL YEARS GOVERNMENT SERVICE		12. AGENCY (Non-Service Members Only)	13. ORGANIZATION UNIT AND UIC/CODE
a. MILITARY	b. CIVILIAN		Navy, MM
3			

14.a. RATING OR SPECIALTY (Aviators Only)	b. TOTAL FLYING TIME	c. LAST SIX MONTHS

15.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION	16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include ZIP Code)
[ ] Army [ ] Coast Guard [x] Navy [ ] Marine Corps [ ] Air Force	[x] Active Duty [ ] Reserve [ ] National Guard	[ ] Enlistment [ ] Medical Board [ ] Other [ ] Commission [ ] Retirement [ ] Retention [ ] U.S. Service Academy [x] Separation [ ] ROTC Scholarship Program	Norfolk Naval Shipyard Clinic U.S. Naval Station, Norfolk, VA 23511

CLINICAL EVALUATION *(Check each item in appropriate column. Enter "NE" if not evaluated.)*

	Normal	Abnorm	NE
17. Head, face, neck, and scalp	×		
18. Nose	×		
19. Sinuses	×		
20. Mouth and throat	×		
21. Ears - General *(Int. and ext. canals/Auditory acuity under item)*	×		
22. Drum *(Perforation)*	×		
23. Eyes - General *(Visual acuity and refraction under items 62 - 71)*	×		
24. Ophthalmoscopic	×		
25. Pupils *(Equality and reaction)*	×		
26. Ocular motility *(Associated parallel movements, nystagmus)*	×		
27. Heart *(Thrust, size, rhythm, sounds)*	×		
28. Lungs and chest *(Include breasts)*	×		
29. Vascular system *(Varicosities, etc.)*	×		
30. Anus and rectum *(Hemorrhoids, Fistulae) (Prostate if indicated)*	×		
31. Abdomen and viscera *(Include hernia)*	×		
32. External genitalia *(Genitourinary)*	×		
33. Upper extremities		×	
34. Lower extremities *(Except feet)*	×		
35. Feet	×		
36. Spine, other musculoskeletal	×		
37. Identifying body marks, scars, tattoos	×		
38. Skin, lymphatics	×		
39. Neurologic	×		
40. Psychiatric *(Specify any personality deviation)*	×		
41. Pelvic *(Females only)*	×		

42. NOTES: *(Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)*
33 - Hurt right shoulder

43. DENTAL DEFECTS AND DISEASE *(Please explain. Use dental form if completed by dentist.)*
[×] Acceptable
[ ] Not Acceptable Class _____
(Dental examination not done by dental officer)

44. FEET *(Check category)*
[×] Normal Arch
[ ] Pes Cavus
[ ] Pes Planus
[ ] Mild [ ] Moderate [ ] Severe
[ ] Asymptomatic [ ] Symptomatic

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER
Ludlum, Gary Albert	TRA-46-3793

LABORATORY FINDINGS

45. URINALYSIS	a. Albumin	46. URINE HCG	47. H/H	48. BLOOD TYPE
	b. Sugar			B+

TESTS	RESULTS	HIV SPECIMEN ID LABEL	DRUG TEST SPECIMEN ID LABEL
49. HIV			
50. DRUGS			
51. ALCOHOL			
52. OTHER			
a. PAP SMEAR			
b.			
c.			

MEASUREMENTS AND OTHER FINDINGS

53. HEIGHT	54. WEIGHT	55. MIN WGT - MAX WGT MAX BF %	56. TEMPERATURE	57. PULSE
69	173 lbs.			

58. BLOOD PRESSURE			59. RED/GREEN *(Army Only)*	60. OTHER VISION TEST
a. 1ST	b. 2ND	c. 3RD		
SYS.	SYS.	SYS.		
DIAS.	DIAS.	DIAS.		

61. DISTANT VISION	62. REFRACTION BY AUTOREFRACTION OR MANIFEST	63. NEAR VISION
Right 20/ Corr. to 20/	By S. CX by	Right 20/ Corr. to 20/ by
Left 20/ Corr. to 20/	By S. CX by	Left 20/ Corr. to 20/ by

64. HETEROPHORIA *(Specify distance)*

ES° EX° R.H. L.H. Prism div. Prism Conv CT NP PD

65. ACCOMMODATION		66. COLOR VISION *(Test used and result)*	67. DEPTH PERCEPTION *(Test used and score)* AFVT	
Right	Left		Uncorrected	Corrected

68. FIELD OF VISION	69. NIGHT VISION *(Test used and score)*	70. INTRAOCULAR TENSION	
		O.D.	O.S.

71a. AUDIOMETER	Unit Serial Number						71b. Unit Serial Number							72a. READING ALOUD TEST
Date Calibrated *(YYYYMMDD)*							Date Calibrated *(YYYYMMDD)*							
HZ	500	1000	2000	3000	4000	6000	HZ	500	1000	2000	3000	4000	6000	☐ SAT ☐ UNSAT
Right							Right							72b. VALSALVA
Left							Left							☐ SAT ☐ UNSAT

73. NOTES *(Continued)* **AND SIGNIFICANT OR INTERVAL HISTORY** *(Use additional sheets if necessary.)*

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER
Ludlum, Gary Albert	TRA-46-3793

74.a. EXAMINEE/APPLICANT *(check one)*

- ☐ IS QUALIFIED FOR SERVICE
- ☐ IS NOT QUALIFIED FOR SERVICE

75. I have been advised of my disqualifying condition.

a. SIGNATURE OF EXAMINEE	b. DATE *(YYYYMMDD)*

b. PHYSICAL PROFILE

P	U	L	H	E	S	X	PROFILER INITIALS	DATE *(YYYYMMDD)*

76. SIGNIFICANT OR DISQUALIFYING DEFECTS

ITEM NO.	MEDICAL CONDITION/DIAGNOSIS	ICD CODE	PROFILE SERIAL	RBJ DATE *(YYYYMMDD)*	QUALI-FIED	DIS-QUALI-FIED	EXAMINER INITIALS	WAIVER RECEIVED	
								SERVICE	DATE *(YYYYMMDD)*

77. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers) (Use additional sheets if necessary.)*

78. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED *(Specify) (Use additional sheets if necessary.)*

79. MEPS WORKLOAD *(For MEPS use only)*

WKID	ST	DATE *(YYYYMMDD)*	INITIAL	WKID	ST	DATE *(YYYYMMDD)*	INITIAL

80. MEDICAL INSPECTION DATE	HT	WT	%BF	MAX WT	HCG	QUAL	DISQ	PHYSICIAN'S SIGNATURE

81.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE
Leonard B. McCoy, LT/MD/USN	Leonard B McCoy, LT/MD/USN
82.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	**b. SIGNATURE**
83.a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)*	**b. SIGNATURE**
84.a. TYPED OR PRINTED NAME OF REVIEWING OFFICER/APPROVING AUTHORITY	**b. SIGNATURE**

85. This examination has been administratively reviewed for completeness and accuracy.

a. SIGNATURE	b. GRADE	c. DATE *(YYYYMMDD)*
B.F. Pierce LCDR/MD/USN	O-4	19760430

86. WAIVER GRANTED *(If yes, date and by whom)*

- ☐ **YES**
- ☐ **NO**

87. NUMBER OF ATTACHED SHEETS

DD FORM 2808