***For Training Purposes Only***

# APPLICATION FOR DISABILITY COMPENSATION AND RELATED COMPENSATION BENEFITS

**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)*

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

**VA DATE STAMP**

**(DO NOT WRITE IN THIS SPACE)**

Received Centralized Mail Processing, Janesville, WI

Date Received 01/10/2021

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)

**SECTION I: IDENTIFICATION AND CLAIM INFORMATION**

**(If claim is not an original claim, only Section I, IV, and a signature are required)**

**NOTE**: You may *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/SERVICE MEMBER NAME *(First, Middle Initial, Last)*

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

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

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1. HAVE YOU EVER FILED A CLAIM WITH VA?

YES NO *(If "Yes," provide your file number in Item 5)*

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

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1. VA FILE NUMBER

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1. SEX

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

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1. TELEPHONE NUMBER *(Optional) (Include Area Code)*

Enter International Phone Number *(If applicable)*

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1. CURRENT MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

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State/Province

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ZIP Code/Postal Code

1. EMAIL ADDRESS *(Optional)* I agree to receive electronic correspondence from VA in regards to my claim.

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1. 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

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Apt./Unit Number City

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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)*

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**BEGINNING DATE:**

Month Day Year

**ENDING DATE:**

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Month Day Year

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SEP 2019



***For Training Purposes Only***

VETERANS SOCIAL SECURITY NO.

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| **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. | PTSD | car accident in service | | I still get nightmares. | | | | | |  | | | | |
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1. 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.

* 1. ENTER THE DISABILITY TREATED AND NAME/LOCATION OF THE TREATMENT FACILITY

VAMC Baltimore

* 1. DATE OF TREATMENT (MM-YYYY)

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* 1. CHECK THE BOX IF YOU DO NOT HAVE

DATE(S) OF TREATMENT

Don't have date Don't have date Don't have date

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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**)](http://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 or 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? 18B. LIST THE OTHER NAME(S) YOU SERVED UNDER:

YES *(If "Yes," complete Item 18B)*

19A. BRANCH OF SERVICE

NO *(If "No," skip to Item 19A)*

19B. COMPONENT

ARMY

AIR FORCE

NAVY

COAST GUARD

MARINE CORPS

SPACE FORCE

ACTIVE RESERVES NATIONAL GUARD

20A. MOST RECENT ACTIVE SERVICE DATES *(MM,DD,YYYY)* 20B. PLACE OF LAST OR ANTICIPATED

Month Day Year

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EXIT DATE: 0 6 1 1

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20C. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001?

YES NO

20D. ADDITIONAL PERIODS OF SERVICE *(Indicate*

*enlistment and discharge date(s), if applicable)*

From: To:

Month Day Year

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

Month Day Year

From:

To:

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

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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)*

22B. DATE OF ACTIVATION:

Month Day Year

22C. ANTICIPATED SEPARATION DATE:

Month Day Year

NO

23A. HAVE YOU EVER BEEN A PRISONER OF WAR?

From:

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23B. DATES OF CONFINEMENT

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To:

YES *(If "Yes," complete Item 23B)*

Month Day Year

Month Day Year

NO

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###### 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)*

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NO

24C. BRANCH OF SERVICE ARMY

AIR FORCE NAVY

MARINE CORPS COAST GUARD SPACE FORCE

24D. MONTHLY AMOUNT

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1. 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.**

1. **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)*

|  |  |  |  |
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27C. BRANCH OF SERVICE

ARMY NAVY MARINE CORPS

AIR FORCE COAST GUARD SPACE FORCE

27D. AMOUNT RECEIVED

*(Provide pre-tax amount)*

$ , .00

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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.

1. **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 the Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. To enroll in direct deposit, provide the information requested below, ***and*** attach either a voided personal check ***or*** a deposit slip. If you ***do not*** have a bank account, please visit [https://www.](http://www/) benefits.va.gov/benefits/banking.asp. This website provides information about the Veterans Benefits Banking Program (VBBP), and a link to banks and credit unions that may fit your needs. You may also call 1-800-827-1000. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of the Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

1. 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)*
2. ACCOUNT NUMBER *(Check only* ***one*** *box below and provide the account number)*

Account No.:

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1. NAME OF FINANCIAL INSTITUTION *(Provide the name of the bank where you want your direct deposit)*

CHECKING SAVINGS

1. ROUTING OR TRANSIT NUMBER *(The first nine numbers located at the bottom left of your check)*



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VETERANS SOCIAL SECURITY NO.

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###### SECTION VIII: CLAIM CERTIFICATION AND SIGNATURE

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**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. For the limited purpose of providing VA with this information as it may relate to my claim, I waive any privilege that may apply and would otherwise make the information confidential and not disclosable.

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**) 33B. DATE SIGNED *(MM-DD-YYYY)*

*Darryl R. Baxter*

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###### SECTION IX: WITNESSES TO SIGNATURE

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

35A. 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

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35B. PRINTED NAME AND ADDRESS OF WITNESS

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###### 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**) 36B. DATE SIGNED *(MM-DD-YYYY)*

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###### 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 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 37B. DATE SIGNED *(MM-DD-YYYY)*

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**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**.](http://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.

VA FORM 21-526EZ, SEP 2019

#### *For Training Purposes Only*

Page 12

# 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.

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

**VA DATE STAMP**

**(DO NOT WRITE IN THIS SPACE)**

Received Centralized Mail Processing, Janesville, WI

Date Received 01/10/2021

**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.](http://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)*

**D a r r y l R B a x t e r**

1. VETERAN'S SOCIAL SECURITY NUMBER *(SSN)* 3. VA FILE NUMBER *(If applicable)* 4. VETERAN'S DATE OF BIRTH

Month Day Year

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5. VETERAN'S SERVICE NUMBER *(If applicable)* 6. INSURANCE NUMBER(S) *(If applicable) (Include letter prefix)*

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

No. & Street

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Country **U S**

ZIP Code/Postal Code

1. VETERAN'S TELEPHONE NUMBER *(Include Area Code)* 9. VETERAN'S EMAIL ADDRESS *(Optional)*

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

1. CLAIMANT'S NAME *(First, Middle Initial, Last)*
2. CLAIMANT'S MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

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State/Province

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ZIP Code/Postal Code

1. CLAIMANT'S TELEPHONE NUMBER *(Include Area Code)*
2. CLAIMANT'S EMAIL ADDRESS *(Optional)*
3. RELATIONSHIP TO VETERAN

###### SECTION III: SERVICE ORGANIZATION INFORMATION

1. 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)*

**Julie W. Steadmen**

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

**NSO**

1. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15

[**jwsteadmen.dav@email.com**](mailto:jwsteadmen.dav@email.com)

**21-22**

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

**01/08/2021**

VA FORM FEB 2019



SUPERSEDES VA FORM 21-22, AUG 2015. **Page 1**

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| VETERAN'S SOCIAL SECURITY NUMBER | | **T** | **R** | **A** |  | | **8** | **8** |  | **9** | **6** | | **6** | **1** |  | |
| **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)*  *Darryl R. Baxter* | | | | | | | | | | | | | | | | 22B. DATE SIGNED *(MM/DD/YYYY)*  01/08/2021 |
| 23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A  *(Do Not Print)*  Julie W. Steadmen | | | | | | | | | | | | | | | | 23B. DATE SIGNED *(MM/DD/YYYY)*  01/08/2021 |
| **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. | | | | | | | | | | | | | | | | |

VA FORM 21-22, FEB 2019 **Page 2**

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

VA FORM 21-22, FEB 2019 **Page 3**

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

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| 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:

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| 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 |

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| 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 |  | | |

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| 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 | | | |

VA Form 21-22, FEB 2019 **Page 4**

**Department of Veterans Affairs**

### STATEMENT IN SUPPORT OF CLAIM FOR SERVICE CONNECTION FOR POST-TRAUMATIC STRESS DISORDER (PTSD)

**IMPORTANT:** If you or someone you know is in crisis, call the Veterans Crisis Line at 1-800-273-8255 and press 1, or visit [https://www.veteranscrisisline.net/](http://www.veteranscrisisline.net/) to chat online, or send a text message to **838255** to receive confidential support 24 hours a day, 7 days a week, 365 days a year. Support for deaf and hard of hearing individuals is available.

**INSTRUCTIONS:** List the stressful incident or incidents that occurred in service that you feel contributed to your current condition. For each incident, provide a description of what happened, the date, the geographic location, your unit assignment and dates of assignment. Please complete the form in detail and be as specific as possible so that research of military records and other sources you identify can be thoroughly conducted. If more space is needed, attach a separate sheet, indicating the item number to which the answers apply.

OMB Approved No. 2900-0659 Respondent Burden: 1 hour 10 minutes Expiration Date: 7/31/2020

**VA DATE STAMP**

**DO NOT WRITE IN THIS SPACE**

Baltimore Regional Office Received 01/10/2021

**SECTION I: VETERAN'S IDENTIFICATION INFORMATION**

**NOTE:** You can *either* complete the form online or by hand. Please print the information requested in ink, neatly and legibly to help process the form.

1. VETERAN/BENEFICARY NAME *(First, Middle Initial, Last)*

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1. SOCIAL SECURITY NUMBER 3. VA FILE NUMBER *(If applicable)* 4. DATE OF BIRTH *(MM/DD/YYYY)*

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1. VETERAN'S SERVICE NUMBER *(If applicable)* 6. PREFERRED E-MAIL ADDRESS *(Optional)*

7A. PRIMARY TELEPHONE NUMBER *(Include Area Code)*

##### (555)555-1212

7B. SECONDARY TELEPHONE NUMBER *(Include Area Code)*

8A. DATE ***FIRST*** INCIDENT OCCURRED *(MM,DD,YYYY)*

Month Day Year

**SECTION II: STRESSFUL INCIDENTS**

8B. DATES OF UNIT ASSIGNMENT (MM/DD/YYYY)

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8C. LOCATION OF INCIDENT *(City, State, Country, Province, landmark or military installation)*

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8D.UNIT ASSIGNMENT DURING INCIDENT *(Such as, DIVISION, WING, BATTALION, CAVALRY, SHIP)*

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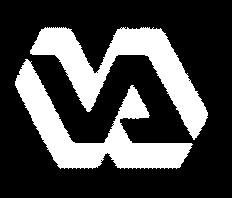
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8E. DESCRIPTION OF THE INCIDENT

##### I was rear ended by a drunk driver while taking my friend out, who wasn't wearing a seat belt and suffered a really bad head injury. I have nightmares, flashbacks, guilt, have avoided driving since this accident. I'm being treated for PTSD.

8F. MEDALS OR CITATIONS YOU RECEIVED BECAUSE OF THE INCIDENT

VA FORM JUL 2017



**21-0781**

SUPERSEDES VA FORM 21-0781, AUG 2014, WHICH WILL NOT BE USED.

**PAGE 1**

VETERAN'S SOCIAL SECURITY NO.

**SECTION II: STRESSFUL INCIDENTS *(Continued*)**

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**NOTE:** Information about persons who were killed or injured during the first incident *(attach a separate sheet if more space is needed.)*

9A. NAME OF PERSON *(First, Middle Initial, Last)*

9B. RANK *(If applicable)*

R

9C. DATE OF INJURY/DEATH *(MM/DD/YYYY)*

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9D. PLEASE CHECK ONE

Month Day Year

Killed In Action Killed Non-Battle

Wounded In Action Injuried Non-Battle

Other

9E. UNIT ASSIGNMENT DURING INCIDENT *(Such as, DIVISION, WING, BATTALION,CAVALRY, SHIP)*

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10A. NAME OF PERSON *(First, Middle Initial, Last)*

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10B. RANK *(If applicable)* 10C. DATE OF INJURY/DEATH *(MM/DD/YYYY)*

Month Day Year

10D. PLEASE CHECK ONE

Killed In Action Killed Non-Battle

Wounded In Action Injuried Non-Battle

Other

10E.UNIT ASSIGNMENT DURING INCIDENT *(Such as, DIVISION, WING, BATTALION, CAVALRY, SHIP)*

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11A. DATE *SECOND* INCIDENT OCCURRED *(MM,DD,YYYY)*

FROM

11B. DATES OF UNIT ASSIGNMENT (MM/DD/YYYY)

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11C. LOCATION OF INCIDENT *(City, State, Country, Province, landmark or military installation)*

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11D.UNIT ASSIGNMENT DURING INCIDENT *(Such as, DIVISION, WING, BATTALION, CAVALRY, SHIP)*

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11E. DESCRIPTION OF THE INCIDENT

11F. MEDALS OR CITATIONS YOU RECEIVED BECAUSE OF THE INCIDENT

VA FORM 21-0781a, JUL 2017 **PAGE 2**

VETERAN'S SOCIAL SECURITY NO.

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| **SECTION II: STRESSFUL INCIDENTS *(Continued*)** | | | |
| **NOTE:** Information about persons who were killed or injured during the first incident *(attach a separate sheet if more space is needed.)* | | | |
| 12A. NAME OF PERSON *(First, Middle Initial, Last)* | | | |
| 12B. RANK *(If applicable)* | 12C. DATE OF INJURY/DEATH *(MM/DD/YYYY)*  Month Day Year | 12D. PLEASE CHECK ONE  Killed In Action  Wounded In Action  Other  Killed Non-Battle  Injuried Non-Battle | |
| 12E. UNIT ASSIGNMENT DURING INCIDENT *(Such as, DIVISION, WING, BATTALION,CAVALRY, SHIP)* | | | |
| 13A. NAME OF PERSON *(First, Middle Initial, Last)* | | | |
| 13B. RANK *(If applicable)* | 13C. DATE OF INJURY/DEATH *(MM/DD/YYYY)*  Month Day Year | 13D. PLEASE CHECK ONE  Killed In Action  Wounded In Action  Other  Killed Non-Battle  Injuried Non-Battle | |
| 13E.UNIT ASSIGNMENT DURING INCIDENT *(Such as, DIVISION, WING, BATTALION, CAVALRY, SHIP)* | | | |
| 14. REMARKS | | | |
| **SECTION III: VETERAN SIGNATURE** | | | |
| **I HEREBY CERTIFY THAT** the information I have given on this form is true and correct to the best of my knowledge and belief. | | | |
| 15. SIGNATURE  *Darryl R. Baxter* | | | 16. DATE SIGNED *(MM/DD/YYYY)*  01/10/2021 |
| **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 is false, or fraudulent acceptance of any payment to which you are not entitled. | | | |
| **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 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 necessary to obtain supporting evidence of stressful incidents in service. If the information is not furnished completely or accurately, VA will not be able to thoroughly research your military records and other sources for supporting evidence. The responses you submit are considered confidential (38 U.S.C. 5701). | | | |
| **RESPONDENT BURDEN**: We need this information in order to assist you in supporting your claim for post-traumatic stress disorder (38 U.S.C. 5107 (a)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 1 hour and 10 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/**](http://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. | | | |

VA FORM 21-0781a, JUL 2017 **PAGE 3**

**Commonwealth of Virginia - Department of Motor Vehicles**

**Police Crash Report**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CRASH** | | Crash Date: 02/14/1984 | | Military Time: 22:30 | |
| City of: | | Hopewell | | | |
| Location of Crash: | | Winston Churchill Dr. and E. Randolph Rd. | | | |
| Local Case #: R543-1984 | | Number of Vehicles: 2 | | | |
| **VEHICLE #: 1** | | | **VEHICLE #: 2** | | |
| Driver's Name: | Bagwell, Scott | | Driver's Name: | | Baxter, Darryl R. |
| Gender: | Male | | Gender: | | Male |
| DOB: | 05/05/1960 | | DOB: | | 06/16/1964 |
| Driver's License #: | 10-468199 | | Driver's License #: | | 11-325045 |
| Safety Equipment Used: | No restraint used | | Safety Equipment Used: | | Lap and shoulder belt |
| EMS Transport: | Yes | | EMS Transport: | | Yes |
| **VEHICLE** | | | **VEHICLE** | | |
| Owner's Name: | Bagwell, Scott | | Owner's Name: | | Baxter, Darryl R. |
| Year/Make/Model: | 1980 Buick LeSabre | | Year/Make/Model: | | 1982 Ford Mustang |
| Vehicle Plate: | GHG-457 | | Vehicle Plate: | | AVN-124 |
| Speed Before Crash: | 50 mph | | Speed Before Crash: | | 10 mph |
| Speed Limit: | 40 mph | | Speed Limit: | | 40 mph |
| Type of Collision: | Rear end | | Type of Collision: | | Rear end |
| Driver's Action: | Exceeding speed limit,  Disregarded traffic signal | | Driver's Action: | | None |
| Drinking: | Drinking - Obviously drunk | | Drinking: | | Had not been drinking |
| Passenger Count: | 0 | | Passenger Count: | | 1 |
| **PASSENGER (only if injured or killed)** | | | **PASSENGER (only if injured or killed)** | | |
| Name of Injured: |  | | Name of Injured: | | Hannah, Lori |
| EMS Transport: |  | | EMS Transport: | | Yes |
| Position in/on Vehicle: |  | | Position in/on Vehicle: | | Front passenger |
| Safety Equipment Used: |  | | Safety Equipment Used: | | No restraint used |
| Birthdate: |  | | Birthdate: | | 11/27/1964 |
| Gender: |  | | Gender: | | Female |

**CRASH DESCRIPTION:**

Multiple witnesses observed vehicle 1 disregarding the traffic signal heading SE and rear-ending vehicle 2 that had turned right heading SE on E Randolph Rd. traffic signal was found to be properly working. Road conditions were dry.

Vehicle 1 - Major impact to front right hood. Six empty beer cans found in front seat. Driver 1 was unconscious and unresponsive at arrival after sustained head injury upon impact to front windshield. Notable alcohol smell from driver 1. EMS transport was provided. Inoperable vehicle removed by ACE Towing.

Vehicle 2 - Major impact to rear left trunk. Driver 1 was conscious and coherent. Passenger 1 was unconscious and unresponsive, sustaining head injury upon impact to fron windshield. EMS transport provided to passenger and driver. Inoperable vehicle removed by ACE Towing.

**Officer:** S. Samson **Badge Number:** 1539



**Search Criteria**

First Name

Date of Birth (mm/dd/yyy)

Middle Name

Last Name

SSN

**Treating Facilities**

Connect to Site

CAPRI Enterprise Search was conducted and all records were uploaded to the file. Baltimore VAMC treatment 1/5/2020 to present:

pg. 6-9 diagnosis of PTSD with alcohol abuse. Veteran history discusses nightmares, anxiety, guilt, and avoidance of driving after a major car accident in 1984. Veteran reports being rear ended by a drunk driver and his friend suffering a severe head injury.

Take all appropriate development actions based on this information.

**Search Results**

Get Treating Facilities

Baxter, Darryl R. TRA-88-9661 06/16/1964

TRA-88-9661

Search

Baxter

Clear Search

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Legacy Search

06/16/1964

Darryl

# DEPARTMENT OF VETERANS AFFAIRS

**Veterans Benefits Administration Regional Office**

# Darryl Baxter

**VA File Number 6Y19XX00**

# Rating Decision February 20, 2018

**INTRODUCTION**

The records reflect that you are a Veteran of the peactime. You served in the Army from June 12, 1982, to June 11, 1984. You filed an original disability claim that was received on October 03, 2017. Based on a review of the evidence listed below, we have made the following decision(s) on your claim.

**DECISION**

* 1. Service connection for gastroesophageal reflux disease is granted with an evaluation of 10 percent effective October 03, 2017.

**EVIDENCE**

* DD Form 214, Certificate of Release or Discharge from Active Duty received October 18, 2017, for the period June 12, 1982, to June 11, 1984.
* Service treatment records received October 18, 2017, for the period June 12, 1982,

to June 11, 1984.

* VA Form 21-526EZ, Application for Disability Compensation and Related Compensation Benefits, received October 03, 2017.
* Disability Benefits Questionnaire, Baltimore VAMC, dated February 10, 2018.

***For Training Purposes Only***

Darryl Baxter TRA-88-9661

Page 2 of 4

**REASONS FOR DECISION**

1. Service connection for gastroesophageal reflux disease.

Service connection for gastroesophageal reflux disease has been established as directly related to military service.

An evaluation of 10 percent is assigned from October 03, 2017.

We have assigned a 10 percent evaluation for your gastroesophageal reflux disease based on:

* Arm pain
* Regurgitation

A higher evaluation of 30 percent is not warranted for hiatal hernia unless the evidence shows persistently recurrent epigastric distress with dysphagia, pyrosis, and regurgitation, accompanied by substernal or arm or shoulder pain, productive of considerable impairment of health.

This disability is not specifically listed in the rating schedule; therefore, it is rated analogous to a disability in which not only the functions affected, but anatomical localization and symptoms, are closely related.

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.](http://www.va.gov/)

***For Training Purposes Only***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Rating Decision** | ***Department of Veterans Affairs***  ***Veterans Benefits Administration*** | | Page 1 of 1  02/20/2018 | |
| NAME OF VETERAN  Darryl Baxter | VA FILE NUMBER  6Y19XX00 | SOCIAL SECURITY NR  TRA-88-9661 | POA | COPY TO |

|  |  |  |  |
| --- | --- | --- | --- |
| **ACTIVE DUTY** | | | |
| **EOD** | **RAD** | **BRANCH** | **CHARACTER OF DISCHARGE** |
| 06/12/1982 | 06/11/1984 | Army | Honorable |

|  |  |  |  |
| --- | --- | --- | --- |
| **LEGACY CODES** | | | |
| **ADD'L SVC CODE** | **COMBAT CODE** | **SPECIAL PROV CODE** | **FUTURE EXAM DATE** |
|  | 1 |  | None |

JURISDICATION: Original Disability Claim Received 10/03/2017

ASSOCIATED CLAIM(s): 110; Original Disability Claim; 10/03/2017

**SUBJECT TO COMPENSATION (1.SC)**

7399-7346 GASTROESOPHAGEAL REFLUX DISEASE

Service Connected, Peacetime, Incurred Static Disability

10% from 10/03/2017

***COMBINED EVALUATION FOR COMPENSATION:***

10% from 10/03/2017

eSign: certified by VBADENJOHNSD, RVSR Reviewer Training Consultant

***For Training Purposes Only***

*THIS IS AN IMPORTANT RECORD SAFEGUARD IT*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. LAST NAME - FIRST NAME -MIDDLE NAME  Baxter, Darryl R. | | | | | | | | | | | | 2. SEX  M | | 3. SOCIAL SECURITY NUMBER | | | | | | 4.  DATE OF BIRTH | | YEAR  64 | | MONTH  06 | DAY  16 |
| TRA | 88 | | 9661 | | |
| 5. DEPARTMENT, COMPONENT AND BRANCH OR CLASS  Army | | | | | | | | | | | | 6a. GRADE, RATE OR RANK  Private First Class | | | | | 6b. PAY  GRADE  E-3 | | | 7.  DATE OF RANK | | YEAR  84 | | MONTH  04 | DAY  27 |
| 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 | | | | | |  | Discharge | | | | | | b. STATION OR INSTALLATION AT WHICH EFFECTED  Fort Lee, VA | | | | | | | | | | | | |
| c. AUTHORITY AND REASON | | | | | |  | Completion of required active service | | | | | |  | |  | | | | d.  EFFECTIVE DATE | | | YEAR  84 | | MONTH  06 | DAY  11 |
| e. CHARACTER OF SERVICE | | | | | |  |  | Honorable | |  |  | |  |  | f. TYPE OF CERTIFICATE ISSUED | | | | | | | 10. REENLISTMENT CODE  RE-1 | | | |
| 11. LAST DUTY ASSIGNMENT AND MAJOR COMMAND  Fort Lee, VA | | | | | | | | | | | | | 12. COMMAND TO WHICH TRANSFERRED  US Army Reserve | | | | | | | | | | | | |
| 13. TERMINAL DATE OF RESERVE/  MSS OBLIGATION | | | | | | | 14. PLACE OF ENTRY INTO CURRENT ACTIVE SERVICE *(City, State and ZIP Code)*  Baltimore, MD | | | | | | | | | | | | | | | 15. DATE ENTERED ACTIVE DUTY THIS PERIOD | | | |
| YEAR | | MONTH | | DAY | | | YEAR  82 | | MONTH  06 | DAY  12 |
| 16a. PRIMARY SPECIALTY NUMBER AND TITLE  92Y10 - Unit Supply Specialist 10 (1 | | | | | | | | b. RELATED CIVILIAN OCCUPATION AND  D.O.T. NUMBER  Supply Clerk | | | | | 18. | | RECORD OF SERVICE | | | | | |  | YEARS | | MONTHS | DAYS |
| years) | | | | | | | |  | | | | |
| (a) NET ACTIVE SERVICE THIS PERIOD | | | | | | | | | 02 | | 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) | | | | | | | | | 02 | | 01 | 01 |
| (d) PRIOR INACTIVE SERVICE | | | | | | | | | 00 | | 00 | 00 |
| (e) TOTAL SERVICE FOR PAY (c & d) | | | | | | | | | 02 | | 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)*  0 | | | | | | 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 | |  | NO |  | YES | |  | | |  |  |  | | |
| 0 | | |  | $10,000 | NONE | | AMOUNT | | | | |  | | | N/A |  |  | | |
| 26. DECORATIONS, MEDALS, BADGES, COMMENDATIONS, CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED  Expert Rifleman Badge | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. REMARKS | | | | | | | | | | | | | | | | | | | | | | | | | |
| 28. MAILING ADDRESS AFTER SEPARATION *(Street, RFD, City, County, State, ZIP)*  31 Hopkins Plaza Baltimore, MD 21201 (US) | | | | | | | | | | | | | 29. SIGNATURE OF PERSON BEING SEPARATED  *Darryl R. Baxter* | | | | | | | | | | | | |
| 30. TYPED NAME, GRADE AND TITLE OF AUTHORIZING OFFICER  SAMUEL D. HAWKINS, CAPT. ADMIN OFFICER | | | | | | | | | | | | | 31. SIGNATURE OF OFFICER AUTHORIZED TO SIGN  Samuel D. Hawkins | | | | | | | | | | | | |

**FORM 1 NOV 72**

**DD**

**214**

**PREVIOUS EDITIONS OF THIS FORM ARE OBSOLETE.**

*THIS IS AN IMPORTANT RECORD SAFEGUARD IT.*

**REPORT OF SEPARATION FROM ACTIVE DUTY**

#### *For Training Purposes Only*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **REPORT OF MEDICAL EXAMINATION** | | | | | | | | **1. DATE OF EXAMINATION**  *(YYYYMMDD)*  19840517 | | | | | **2. SOCIAL SECURITY NUMBER**  6Y19XX00 | | |
| **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)**  Baxter, Darryl R. | | | | | **4. HOME ADDRESS** *(Street, Apartment Number, City, State and ZIP Code)*  31 Hopkins Plaza Baltimore, MD 21201 (US) | | | | | | | | | **5. HOME TELEPHONE NUMBER**  *(Include Area Code)*  (555)555-1212 | |
| **6. GRADE**  E-3 | | **7. DATE OF BIRTH**  *(YYYYMMDD)*  19640616 | | | **8. AGE** | | **9. SEX** | | | **10. RACE** | | | | | |
|  | Female  Male | |  | American Indian/Alaskan Native  Black | | |  | Asian/Pacific Islander  White |
| ✖ |  | ✖ |
| **11. TOTAL YEARS GOVERNMENT SERVICE** | | | | | **12. AGENCY** *(Non-Service Members Only)* | | | | | | | **13. ORGANIZATION UNIT AND UIC/CODE**  Army, 92Y10 | | | |
| **a. MILITARY**  2 | | **b. 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)*  Kenner Army Health Clinic Fort Lee, VA | | | |
| ✖ | Army Coast  Guard  Navy  Marine Corps Air Force | | ✖ | Active Duty  Reserve National Guard |  | Enlistment Commission Retention  Separation |  | Medical Board Other Retirement  U.S. Service Academy  ROTC Scholarship Program | | | |
|  |  |  |  |
|  |  |  |
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|  | ✖ |  |
| **CLINICAL EVALUATION** *(Check each item in appropriate column. Enter "NE" if not evaluated.)* | | | | | | | | | | | | | | | |
|  | | | | | | | **Nor-**  **mal** | **Ab-**  **norm** | **NE** | **42. NOTES:** *(Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)*  20. GERD   1. Neck strain, car accident 1984 2. Skull, right shoulder | | | | | |
| **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)* | | | | | | |  |  |  |
| **43. DENTAL DEFECTS AND DISEASE** *(Please explain. Use dental form if completed* | | | | | | | | | | **44. FEET** *(Check category)*  Normal Arch Mild Asymptomatic  Pes Cavus Moderate  Pes Planus Severe Symptomatic | | | | | |
|  | Acceptable *by dentist.)*  Not Acceptable Class | | | | | | | | |
|  |
| *(Dental examination not done by dental officer)* | | | | | | | | | |

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| **LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)**  Baxter, Darryl R. | | | | | | | | | | | | | | | | | | | | | | | | | | | | **SOCIAL SECURITY NUMBER**  6Y19XX00 | | | | | | | | | | |
| **LABORATORY FINDINGS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **45. URINALYSIS** | | | | | | | | | **a. Albumin** | | | | | | | | | **46. URINE HCG** | | | | | | | **47. H/H** | | | | | | **48. BLOOD TYPE**  O+ | | | | | | | |
| **b. Sugar** | | | | | | | | |
| **TESTS** | | | | | | | | | **RESULTS** | | | | | | | | | | | | | **HIV SPECIMEN ID LABEL** | | | | | | | | | **DRUG TEST SPECIMEN ID LABEL** | | | | | | | |
| **49. HIV** | | | | | | | | | Negative | | | | | | | | | | | | |
| **50. DRUGS** | | | | | | | | | Negative | | | | | | | | | | | | |
| **51. ALCOHOL** | | | | | | | | | Negative | | | | | | | | | | | | |
| **52. OTHER** | | | | | | | | |  | | | | | | | | | | | | |
| **a. PAP SMEAR** | | | | | | | | | N/A | | | | | | | | | | | | |
| **b.** | | | | | | | | |  | | | | | | | | | | | | |
| **c.** | | | | | | | | |  | | | | | | | | | | | | |
| **MEASUREMENTS AND OTHER FINDINGS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **53. HEIGHT**  70 | | | | **54. WEIGHT**  175 lbs. | | | | | **55. MIN WGT - MAX WGT** | | | | | | | |  |  |  | **MAX BF %** | | |  |  |  | **56. TEMPERATURE**  98.8 | | | | | | **57. PULSE** | | |  | 65 | |  |
| **58. BLOOD PRESSURE** | | | | | | | | | | | | | | | | | | **59. RED/GREEN** *(Army Only)*  WNL | | | | | | | | **60. OTHER VISION TEST**  WNL | | | | | | | | | | | | |
| **a. 1ST** | | | | **b. 2ND** | | | | | | **c. 3RD** | | | | | | | |
| SYS. 100 | | | | SYS. 110 | | | | | | SYS. | | 105 | | | | |  |
| DIAS. 60 | | | | DIAS. 70 | | | | | | DIAS. | | 65 | | | | |  |
| **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)*  14/14 | | | | | | | | | | | | **70. INTRAOCULAR TENSION** | | | | | | | | | | | |
| O.D. WNL | | | | | | O.S. WNL | | | | | |
| **71a. AUDIOMETER** | | | | | | Unit Serial Number | | | | | | JN38927W | | | | |  | | **71b. Unit Serial Number** | | | | | | | | | | | | | | **72a. READING ALOUD**  **TEST** | | | | | |
| Date Calibrated *(YYYYMMDD)* | | | | | | | | | | | | 19840222 | | | | |  | | Date Calibrated *(YYYYMMDD)* | | | | | | | | | | | | | |
| HZ | | 500 | | | | 1000 | | 2000 | | | 3000 | | | 4000 | | 6000 | | | HZ | | 500 | 1000 | | 2000 | | 3000 | | 4000 | | 6000 | | |  | SAT | | |  | UNSAT |
| Right | | 5 | | | | 5 | | 5 | | | 5 | | | 5 | | 5 | | | Right | |  |  | |  | |  | |  | |  | | | **72b. VALSALVA** | | | | | |
| Left | | 5 | | | | 5 | | 5 | | | 5 | | | 5 | | 5 | | | Left | |  |  | |  | |  | |  | |  | | |  | SAT | | |  | UNSAT |
| **73. NOTES** *(Continued)* **AND SIGNIFICANT OR INTERVAL HISTORY** *(Use additional sheets if necessary.)*  Veteran report neck strain from car accident Feb. 1984. Resolved. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| **LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)**  Baxter, Darryl R. | | | | | | | | | | | | | | | | | | | | **SOCIAL SECURITY NUMBER**  6Y19XX00 | | | | | | |
| **74.a. EXAMINEE/APPLICANT** *(check one)* | | | | | | | | | | | | | | | **75. I have been advised of my disqualifying condition.** | | | | | | | | | | | |
| ✖ | IS QUALIFIED FOR SERVICE  IS NOT QUALIFIED FOR SERVICE | | | | | | | | | | | | | | **a. SIGNATURE OF EXAMINEE** | | | | | | | | | **b. DATE** *(YYYYMMDD)* | | |
|  |
| **b. PHYSICAL PROFILE** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| P | | | U | | L | | | H | | | E | | | | S | | X | | | PROFILER INITIALS | | | | DATE *(YYYYMMDD)* | | |
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| **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)* | |
|  | |  | | | | | | |  | | | |  | |  | |  |  | |  | |  | | |  | |
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| **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 |
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| **80. MEDICAL INSPECTION DATE** | | | | | | HT | WT | | | %BF | MAX WT | | | HCG | | QUAL | DISQ | | PHYSICIAN'S SIGNATURE | | | | | | | |
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| **81.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER**  Martin Siegel, MD | | | | | | | | | | | | | | | | **b. SIGNATURE**  Martin Siegel, 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)*  Aline Towne, DDS | | | | | | | | | | | | | | | | **b. SIGNATURE**  Aline Towne, DDS | | | | | | | | | | |
| **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**  P Walton, MD | | | | | | | | | | | | | | | | **b. GRADE**  CAPT/USA | | | | | **c. DATE** *(YYYYMMDD)*  19840517 | | | | | |
| **86. WAIVER GRANTED** *(If yes, date and by whom)* | | | | | | | | | | | | | | | | | | | | | | | **87. NUMBER OF ATTACHED SHEETS** | | | |
|  | **YES**  **NO** | | | | | | | | | | | | | | | | | | | | | |
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| **REPORT OF MEDICAL EXAMINATION** | | | | | | | | **1. DATE OF EXAMINATION**  *(YYYYMMDD)*  19820611 | | | | | **2. SOCIAL SECURITY NUMBER**  6Y19XX00 | | |
| **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)**  Baxter, Darryl R. | | | | | **4. HOME ADDRESS** *(Street, Apartment Number, City, State and ZIP Code)*  31 Hopkins Plaza Baltimore, MD 21201 (US) | | | | | | | | | **5. HOME TELEPHONE NUMBER**  *(Include Area Code)*  (555)555-1212 | |
| **6. GRADE** | | **7. DATE OF BIRTH**  *(YYYYMMDD)*  19640616 | | | **8. AGE** | | **9. SEX** | | | **10. RACE** | | | | | |
|  | Female  Male | |  | American Indian/Alaskan Native  Black | | |  | Asian/Pacific Islander  White |
| ✖ |  | ✖ |
| **11. TOTAL YEARS GOVERNMENT SERVICE** | | | | | **12. AGENCY** *(Non-Service Members Only)* | | | | | | | **13. ORGANIZATION UNIT AND UIC/CODE**  Army, 92Y10 | | | |
| **a. MILITARY**  0 | | **b. 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)*  MEPS, Baltimore, MD 21203 | | | |
| ✖ | Army Coast  Guard  Navy  Marine Corps Air Force | | ✖ | Active Duty  Reserve National Guard | ✖ | Enlistment Commission Retention  Separation |  | Medical Board Other Retirement  U.S. Service Academy  ROTC Scholarship Program | | | |
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| **CLINICAL EVALUATION** *(Check each item in appropriate column. Enter "NE" if not evaluated.)* | | | | | | | | | | | | | | | |
|  | | | | | | | **Nor-**  **mal** | **Ab-**  **norm** | **NE** | **42. NOTES:** *(Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)* | | | | | |
| **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)* | | | | | | |  |  |  |
| **43. DENTAL DEFECTS AND DISEASE** *(Please explain. Use dental form if completed* | | | | | | | | | | **44. FEET** *(Check category)*  Normal Arch Mild Asymptomatic  Pes Cavus Moderate  Pes Planus Severe Symptomatic | | | | | |
|  | Acceptable *by dentist.)*  Not Acceptable Class | | | | | | | | |
|  |
| *(Dental examination not done by dental officer)* | | | | | | | | | |

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| **LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)**  Baxter, Darryl R. | | | | | | | | | | | | | | | | | | | | | | | | | | | **SOCIAL SECURITY NUMBER**  6Y19XX00 | | | | | | | | | | |
| **LABORATORY FINDINGS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **45. URINALYSIS** | | | | | | | | | **a. Albumin** | | | WNL | | | | | **46. URINE HCG**  WNL | | | | | | | **47. H/H**  WNL | | | | | | **48. BLOOD TYPE**  O+ | | | | | | | |
| **b. Sugar** | | | WNL | | | | |
| **TESTS** | | | | | | | | | **RESULTS** | | | | | | | | | | | | **HIV SPECIMEN ID LABEL** | | | | | | | | | **DRUG TEST SPECIMEN ID LABEL** | | | | | | | |
| **49. HIV** | | | | | | | | | Negative | | | | | | | | | | | |
| **50. DRUGS** | | | | | | | | | Negative | | | | | | | | | | | |
| **51. ALCOHOL** | | | | | | | | | Negative | | | | | | | | | | | |
| **52. OTHER** | | | | | | | | |  | | | | | | | | | | | |
| **a. PAP SMEAR** | | | | | | | | | N/A | | | | | | | | | | | |
| **b.** | | | | | | | | |  | | | | | | | | | | | |
| **c.** | | | | | | | | |  | | | | | | | | | | | |
| **MEASUREMENTS AND OTHER FINDINGS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **53. HEIGHT**  70 | | | | **54. WEIGHT**  175 lbs. | | | | | **55. MIN WGT - MAX WGT** | | | | | | | |  |  | **MAX BF %** | | |  |  |  | **56. TEMPERATURE**  98.6 | | | | | | **57. PULSE** | | |  | 68 | |  |
| **58. BLOOD PRESSURE** | | | | | | | | | | | | | | | | | **59. RED/GREEN** *(Army Only)* | | | | | | | | **60. OTHER VISION TEST** | | | | | | | | | | | | |
| **a. 1ST** | | | | **b. 2ND** | | | | | | **c. 3RD** | | | | | | |
| SYS. 110 | | | | SYS. 105 | | | | | | SYS. | | 115 | | | | |
| DIAS. 70 | | | | DIAS. 65 | | | | | | DIAS. | | 75 | | | | |
| **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 | | | | | | 74A379UN32 | | | | |  | **71b. Unit Serial Number** | | | | | | | | | | | | | | **72a. READING ALOUD**  **TEST** | | | | | |
| Date Calibrated *(YYYYMMDD)* | | | | | | | | | | | | 19820317 | | | | |  | Date Calibrated *(YYYYMMDD)* | | | | | | | | | | | | | |
| HZ | | 500 | | | | 1000 | | 2000 | | | 3000 | | | 4000 | | 6000 | | HZ | | 500 | 1000 | | 2000 | | 3000 | | 4000 | | 6000 | | |  | SAT | | |  | UNSAT |
| Right | | 5 | | | | 5 | | 5 | | | 5 | | | 5 | | 5 | | Right | |  |  | |  | |  | |  | |  | | | **72b. VALSALVA** | | | | | |
| Left | | 5 | | | | 5 | | 5 | | | 5 | | | 5 | | 5 | | Left | |  |  | |  | |  | |  | |  | | |  | SAT | | |  | UNSAT |
| **73. NOTES** *(Continued)* **AND SIGNIFICANT OR INTERVAL HISTORY** *(Use additional sheets if necessary.)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| **LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)**  Baxter, Darryl R. | | | | | | | | | | | | | | | | | | | | **SOCIAL SECURITY NUMBER**  TRA-88-9661 | | | | | | |
| **74.a. EXAMINEE/APPLICANT** *(check one)* | | | | | | | | | | | | | | | **75. I have been advised of my disqualifying condition.** | | | | | | | | | | | |
| ✖ | IS QUALIFIED FOR SERVICE  IS NOT QUALIFIED FOR SERVICE | | | | | | | | | | | | | | **a. SIGNATURE OF EXAMINEE** | | | | | | | | | **b. DATE** *(YYYYMMDD)* | | |
|  |
| **b. PHYSICAL PROFILE** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| P | | | U | | L | | | H | | | E | | | | S | | X | | | PROFILER INITIALS | | | | DATE *(YYYYMMDD)* | | |
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| **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)* | |
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| **77. SUMMARY OF DEFECTS AND DIAGNOSES** *(List diagnoses with item numbers) (Use additional sheets if necessary.)*  None | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **78. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED** *(Specify) (Use additional sheets if necessary.)*  None | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **79. MEPS WORKLOAD** *(For MEPS use only)* | | | | | | | | | | | | | | | | | | | | | | | | | | |
| WKID | | | | ST | | | DATE *(YYYYMMDD)* | | | | | INITIAL | | | WKID | | | ST | | | | DATE *(YYYYMMDD)* | | | | INITIAL |
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| **80. MEDICAL INSPECTION DATE** | | | | | | HT | WT | | | %BF | MAX WT | | | HCG | | QUAL | DISQ | | PHYSICIAN'S SIGNATURE | | | | | | | |
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| **81.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER**  Roy Clyburn, MD | | | | | | | | | | | | | | | | **b. SIGNATURE**  Roy Clyburn M.D. | | | | | | | | | | |
| **82.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER** | | | | | | | | | | | | | | | | **b. SIGNATURE** | | | | | | | | | | |
| **83.a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN** *(Indicate which)*  Jack McNeil, DDS | | | | | | | | | | | | | | | | **b. SIGNATURE**  Jack McNeil D.D.S. | | | | | | | | | | |
| **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**  Maya Dutta | | | | | | | | | | | | | | | | **b. GRADE**  LT/MD/USN | | | | | **c. DATE** *(YYYYMMDD)*  19820611 | | | | | |
| **86. WAIVER GRANTED** *(If yes, date and by whom)* | | | | | | | | | | | | | | | | | | | | | | | **87. NUMBER OF ATTACHED SHEETS** | | | |
|  | **YES**  **NO** | | | | | | | | | | | | | | | | | | | | | |
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| **PERSONNEL QUALIFICATION RECORD**  For use of this form, see AR 600-8-104; the proponent agency is DCS, G-1. | | | | | | | | | | | | | **SECTION II - CLASSIFICATION AND ASSIGNMENT DATA *(Continued)*** | | | | | | | | | | | | | | |
| 6. MILITARY OCCUPATIONAL SPECIALTIE S | | | | | | | | | | | |  | CONT | |
| MOSC | | | TITLE | | | | | | | | | DATE | | |
| **SECTION I - IDENTIFICATION DATA** | | | | | | | | | | | | | 92Y | | | Unit Supply Specialist | | | | | | | | | 12/21/82 | | |
| 1. NAME *(Last, First, MI)*  Baxter, Darryl R. | | | | 2. S.S.N. | TRA-88-9661 | | | | |  |  |  |  | | |  | | | | | | | | |  | | |
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| **SECTION II - CLASSIFICATION AND ASSIGNMENT DATA** | | | | | | | | | | | | |  | | |  | | | | | | | | |  | | |
| 3. MOS EVALUATION SCORES | | | | |  | | | | |  |  | CONT |  | | |  | | | | | | | | |  | | |
| MOSC | YR & MO | SCORE | YR & MO | SCORE | | YR & MO | | | | SCORE | | |  | | |  | | | | | | | | |  | | |
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| 4. ASSIGNMENT CONSIDERATIONS | | | | | | | | | |  | CONT | | 7. AVIATION ASI & GUNNERY QUALIFICATION | | | | |  | CONT | 8. A PTITUDE AREA SCORES | | | | | |  | CONT |
|  | | | | | | | | | | | | | AIRCRAFT | | INSTR PILOT | | GUNNERY SYSTEM | | | AREA | SCORE | | AREA | | | SCORE | |
| F/ W | R/W | F/ W | R/W | TNG | INSTR | |  |  | |  | | |  | |
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| 9. AWARDS, DECORATIONS & CAMPAIGNS | | | | |  | CONT |  |  | |  | | |  | |
| 5. OVERSEA SERVICE | | | | | | | |  | CONT | | | DEPN ARROS |  | | | | | | |  |  | |  | | |  | |
| FROM | THRU | AREA AND COUNTRY | | | MO | | TYPE | | NTC | | |  | | | | | | |  |  | |  | | |  | |
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|  |  |  | | |  | |  | |  | | |  | 11. AMERICAN BOARD CERTIFICATION & LICENSES OR CERTIFICATES HELD | | | | |  | CONT |  | |  | | | |  | |
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|  |  |  | | |  | |  | |  | | |  |  | | | | | | | 12. LANGUAGE PROFICIENCY | | | | | | | |
|  |  |  | | |  | |  | |  | | |  |  | | | | | | | DA FORM 330  SUBMITTED | | | | DATE | | | |
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**DA FORM 2-1** EDITION OF JAN 1973 IS OBSOLETE. APD PE v2.00

#### *For Training Purposes Only*

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| **PERSONNEL QUALIFICATION RECORD *(Cont.)*** NAME: Darryl R. Baxter | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SECTION II - CLASSIFICATION AND ASSIGNMENT DATA *(Cont.)*** | | | | | | | | | | | | **SECTION III - SERVICE, TRAINING AND OTHER DATES** | | | | | | | | | | | | | | | | | |
| 13. PILOT RATINGS | | | | | | | | | | | | 18. APPOINTMENTS AND REDUCTIONS | | | | | | | | | | |  | CONT | 19. SPECIALIZED TRAINING | | |  | CONT |
| ORIGINAL | | | DATE | | CURRENT | | | | DATE | | | GRADE | COMP | | | | EFFECTIVE DATE | | | | | DATE OF ELIG./RANK | | | SUBJECT | | DATE | | |
|  | | |  | |  | | | |  | | | ATP 21-114 *(BCT)* | |  | | |
| 14. FLYING STATUS | | | | | | | | | |  | CONT |  |  | | | |  | | | | |  | | | Geneva-Hague Conventions | |  | | |
|  | | | | | | | | | | | |  |  | | | |  | | | | |  | | |
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| INSTRUMENT CERTIFICATION | | | | | | | | | | | |  |  | | | |  | | | | |  | | | Benefits of  Honorable Discharge | |  | | |
| 15. INTERNSHIPS, RESIDENCIES AND FELLOWSHIPS | | | | | | | | | |  | CONT |  |  | | | |  | | | | |  | | |
| HOSPITAL | | | | TYPE OF SERVICE | | | | MONTHS | | | YEAR |  |  | | | |  | | | | |  | | |  | |  | | |
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| 16. HOSPITAL/TEACHING APPOINTMENTS AND PRIVATE PRACTICE | | | | | | | | | | | CONT | 20. BASIC ENLISTED SERVICE DATE *(BESD)* | | | | | | | | | |  | | |  | |  | | |
| FROM | THRU | INSTITUTION/LOCATION | | | | | TYPE | | | | DURAT | 21. TIME LOST *(Sec. 972, Title 10, USC)* | | | | | | | | | | | | | | | |  | CONT |
|  |  |  | | | | |  | | | |  | FROM | | | THRU | | | | DAYS | | | REASON | | | | | | | |
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|  |  |  | | | | |  | | | |  | **SECTION IV - PERSONAL AND FAMILY DATA** | | | | | | | | | | | | | | | | | |
| 17. CIVILIAN EDUCATION AND MILITARY SCHOOLS | | | | | | | | | |  | CONT | 22. PHYSICAL STATUS | | | | | | | | | | 23. PLACE OF BIRTH AND CITIZENSHIP | | | | | | | |
| SCHOOL | | | | MAJOR/COURSE/MOSC | | DURAT | | COMP | | | YEAR | HEIGHT | | WEIGHT | | | | GLASSES | | | | SELF 06/16/1964 | | | | | | | |
|  | | | |  | |  | |  | | |  | 5' 10" | | 175 | | | | YE | S |  | NO | SPOUSE | | | | | | | |
|  | | | |  | |  | |  | | |  | DATE OF EXAM | | | | | | | | | | CITIZENSHIP OF SPOUSE | | | | | | | |
|  | | | |  | |  | |  | | |  | 24. NUMBER OF DEPENDENTS | | | | | | | | | | 25. HOME OF RECORD/ADDRESS | | | | | | | |
|  | | | |  | |  | |  | | |  | ADULT | | | | CHILDREN | | | | | | 31 Hopkins Plaza Baltimore, MD 21201 (US) | | | | | | | |
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|  | | | |  | |  | |  | | |  | 26. CIVILIAN OCCUPATION | | | | | | | | | | | | | | | | | |
|  | | | |  | |  | |  | | |  | JOB TITLE: | | | | | | | | | | | | | | | | | |
|  | | | |  | |  | |  | | |  | DOT CODE  92Y10 | | | | | | | CRITICAL OCCUPATION | | | | | | NO. MONTHS  EMPLOYED | MOSC | | | |
|  | | | |  | |  | |  | | |  |  |  | YES | |  | NO |
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| **PERSONNEL QUALIFICATION RECORD *(Cont.)*** | | NAME: Darryl | | | | R. | Baxter | |
| **SECTION V - MISCELLANEOUS** | | | | | | | | |
| 27. REMARKS | 28. ITEM CONTINUATION | | | | | | | |
|  | ITEM NO. | | DATA | | | | | |
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|  | **SECTION VI - RESERVE COMPONENT DATA** | | | | *(YYYYMMDD)* | |  |
| 31a. | READY RESERVE OBLIGATION EXPIRATION DATE: | | | |  | |  |
| b. READY RESERVE START DATE: | | | | | | | |
| c. SERVICE OBLIGATION EXPIRATION DATE: | | | | | | | |
| d. MANDATORY REMOVAL FROM ACTIVE STATUS: | | | | | | | |
| e. RETIREMENT YEAR ENDING DATE: | | | | | | | |
| 32. DATE | | | | 33. SIGNATURE | | | |
| 29. DATE DA FORM 20B OR DA FORM 2-2 PREPARED: *(YYYYMMDD)* | PREPARED | | | REVIEWED |
| 30. DATE DUPLICATE DA FORM 2-1 SUBMITTED: *(YYYYMMDD)* |
| ***DA FORM 2-1*** |  |  | | | |  | | APD PE v2.00  PAGE 3 OF 4 |

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|  | **PERSONNEL QUALIFICATION RECORD *(Cont. )*** | | NAME: | Darryl R. Baxter | | |  |  |  |  |
| **SECTION VII - CURRENT AND PREVIOUS ASSIGNMENTS** | | | | | | | | | |
| 34. RECORD OF ASSIGNMENTS | | | | | | | |  | CONT |
| EFFECTIVE DATE  *(YYYYMMDD)* | DUTY MOSC | PRINCIPAL DUTY | ORGANIZATION AND STATION OR OVERSEA COUNTRY | | NON - DUTY DAYS | NON - RATED DAYS | TYPE REPORT | | |  |
| BP  *YYYY/MM* | EP  *YYYY/MM* |
| 19820612 | 0000 | Recruit Traing | Fort Benning, GA | |  |  |  | | |
| 19821022 | 92Y | Quartermaster School | Fort Lee, VA | |  |  |  | | |
| 19830107 | 92Y | For Duty | Fort Lee, VA | |  |  |  | | |
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#### *For Training Purposes Only*

***For Training Purposes Only***

**Department of Veteran Affairs Request for Information**

**General Information**

Address Code: 13

File No.: 6Y19XX00

VA Requesting Office: Baltimore, MD RO

Insurance No.: Requestor ID: BR549 Submit Date: 10/13/2017

PIES ID: 56565656

Veteran Name: Darryl R. Baxter

SSN: TRA-88-9661

Date of Birth: 06/16/1964

Date of Death:

Place of Birth:

Oxnard, DE

Claim Date: 10/03/2017

Receipt Date: 10/13/2017

Branch Completion Date: 10/17/2017 Branch Completed By: TR826

Overall Status: SU Overall Completion Date: 10/17/2017

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Period of Service** | **Date for Branch:** |  | | | | |
| Name | SSN EOD | RAD | Duty  COD Status | RT  Date | RT  Date | Pay Grade |
| Baxter, Darryl R. TRA-88-9661 06/12/1982 06/11/1984 Honorable SAT E-3 | | | | | | |

## Request/Response Information

Request O50

FURNISH COMPLETE MEDICAL/DENTAL RECORDS <STRS> AND ALL PERSONNEL RECORDS

1

Response ALL AVAILABLE REQUESTED RECORDS <<MAILED>>

**VA Form 3101** Printable Form

#### *For Training Purposes Only*