OMB Approved No. 2900-0881
Respondent Burden: 10 Minutes
Expiration Date: 02/28/2021

Department of Veterans Affairs

LAY/WITNESS STATEMENT

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 3. Use this form to submit a statement as a veteran/claimant or someone writing on your behalf to support a claim. If you or someone else writing on your behalf are providing additional statement(s) to support your claim(s) please submit this form with your application. For more information, contact us at https://iris.custhelp.va.gov, or call us toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal relay number is 711. VA forms are available at www.va.gov/vaforms. After completing the form, mail to: **Department of Veterans Affairs, Evidence Intake Center, P.O. Box 4444, Janesville, WI, 53547-4444.**

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly, insert one letter per box, and completely fill in each applicable circle to help expedite processing of the form.

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

Anthony L Morton

2. SOCIAL SECURITY NUMBER

601-92-5109

3. VA FILE NUMBER (If applicable)

4. DATE OF BIRTH

Month 08 – Day 24 – Year 1988

5. VA INSURANCE FILE NUMBER (If applicable)

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

No. & Street: 5015 Del Pueblo Ave

Apt./Unit Number:

City: Las Vegas

State/Province: NV

Country: US

ZIP Code/Postal Code: 89141 –

7. TELEPHONE NUMBER (Include Area Code)

760-207-6587

Enter International Phone Number (If applicable)

8. E-MAIL ADDRESS

(●) I agree to receive electronic correspondence from VA in regards to my claim.

anthonymorton760@gmail.com

SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION
(Complete this section ONLY IF the claimant is NOT the veteran)

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

10. SOCIAL SECURITY NUMBER

– –

11. VA FILE NUMBER (If applicable)

12. DATE OF BIRTH

Month – Day – Year

13. VA INSURANCE FILE NUMBER (If applicable)

14. CURRENT 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: –

15. TELEPHONE NUMBER (Include Area Code)

– –

Enter International Phone Number (If applicable)

16. E-MAIL ADDRESS

( ) I agree to receive electronic correspondence from VA in regards to my claim.

SOCIAL SECURITY NUMBER 6 0 1 – 9 2 – 5 1 0 9

SECTION III: STATEMENT

(Use this section to submit your statement, or a statement from someone else writing on your behalf)

NOTE: Please indicate the claimed issue that you are addressing. If you would like to submit an additional statement on your own behalf or if you have more than one witness writing on your behalf, use a separate form (VA Form 21-10210) for each statement.

17. STATEMENT (Note: Describe what you yourself know or have observed about the facts or circumstances relevant to this claim before VA)

My request to have my entitlement date for headaches to be moved to an earlier date was denied, because I did not submit "a timely appeal". However, I was unable to do so, because I needed a copy of my medical record which I did not have. My medical record contained complaints of headaches, which the VA initially claimed it did not. I did not receive my medical records from the Navy until my appeal period was over, so this was not possible. However, as I stated in my informal phone conference, I did not submit any new evidence, I just "pointed out" evidence that the VA already had in my medical records. Therefore, it never should have been denied when I first filed. It was out of my control to submit an appeal within the alloted time and the VA made an oversight when reviewing my medical records. I believe the VA should move the entitlement date to when I first filed for headaches, as no new evidence was presented on my half, and I could not submit a supplemental claim during the appeal period because I needed my medical record to do so.

Additionally, my claim to have my insomia disorder connected to my tinnitus under my tinnitus rating and not my other mental disorders. The decision letter states, "Separate evaluations cannot be assigned for multiple mental conditions if it is not possible to differentiate what symptoms are attributable to each diagnosis." However, in my consultation and in the letter from the VA, the doctor did in fact state that she believes that my insomnia was directly related to my tinnitus and not from my PTSD. I ask that the VA reverse their earlier desicion and have my insomnia related to tinnitus be seperate evaluations.

Furthermore, there seems to be some confusion between the VA, myself, and the examining doctor. When I first went to my consultation, they believed that it was an examine for PTSD. However, I stated that it was not as I already had a diagnosis for PTSD, but the VA setup the consultation as a PTSD examine and not an examine for insomnia/sleep disturbance as I had initially filed for.

SOCIAL SECURITY NUMBER

SECTION III: STATEMENT (Continued)
(Use this section to submit your statement, or a statement from someone else writing on your behalf)

17. STATEMENT (Note: Describe what you yourself know or have observed about the facts or circumstances relevant to this claim before VA)

SECTION IV: WITNESS CONTACT INFORMATION
(Complete Section IV and V if the statement in Section III is from someone else writing on your behalf)

18. WITNESS NAME (First, Middle Initial, Last)

19. RELATIONSHIP TO VETERAN/CLAIMANT (Check all that apply)

SERVED WITH VETERAN/CLAIMANT FAMILY/FRIEND OF VETERAN/CLAIMANT COWORKER/SUPERVISOR OF VETERAN/CLAIMANT

OTHER (Specify)

20. TELEPHONE NUMBER (Include Area Code)

Enter International Phone Number
(If applicable)

21. E-MAIL ADDRESS

SECTION V: CERTIFICATION OF STATEMENT AND SIGNATURE

I CERTIFY THAT I have completed this statement and that its information is true and correct to the best of my knowledge and belief.

22A. VETERAN/CLAIMANT/WITNESS SIGNATURE ***(REQUIRED)***

22B. DATE SIGNED

Month Day Year

06 – 30 – 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 to be false, or for fraudulent receipt of any document to which you are not entitled.

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of 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, Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary.

RESPONDENT BURDEN: This form is used to submit a statement that supports a claim already pending or already established with VA. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 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/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.