

APPLICATION FOR ENLISTMENT - ARMED FORCES OF THE UNITED STATES

OMB 29 R 0331

INSTRUCTIONS

1. The information in this document is to determine your eligibility for enlistment in the Armed Forces of the United States. Some of the information required by law is mandatory. You must answer all questions to provide the information necessary to determine your eligibility in the Armed Forces of the United States.

2. The authority to request the information contained in this document is Title 10, U.S.C., § 501 of title 10, United States Code, which provides qualifications for enlistment in the Armed Forces of the United States. You are requested to read on this application, without answers to all questions except those in items 12, 29, 33 and 37.

3. Your answers to questions in items 27 may be given orally in a personal interview as provided in the instructions for that item. Failure to answer completely any of the required questions in the application may result in your being refused enlistment in the Armed Forces.

4. If your application is accepted, it is your responsibility to furnish the information contained in this application to the appropriate component of the Armed Forces of the United States. The information

provided by you on this application becomes a part of your military personnel records which are used to process your request to enlist. You are subject to personnel management actions if you fail to meet the OFFICIAL REQUIREMENTS of the Armed Forces. The laws, regulations, and policies of the Armed Forces are contained in the Federal Law and Regulation.

5. Mail inquiries concerning this form to: Director, Personnel Management, Department of Defense, Washington, D.C. 20330-0001. Requests for interpretation of other sections of title 10, United States Code, should be addressed to the Office of the General Counsel, Department of Defense, Washington, D.C. 20330-0001.

6. You are informed of the information required by you when enlisting, including physical fitness, education, experience, and your military career, in situations such as consideration for medical discharge, security clearances, and court-martial and administrative proceedings.

7. If you do not fully answer all the above questions, or if not applicable, so state.

8. If additional space is needed for any answer, continue on item 11, Remarks.

I. PERSONAL DATA

6. RACE <input checked="" type="checkbox"/> CAUC. <input checked="" type="checkbox"/> NEGRO <input type="checkbox"/> OTHER	7. ETHNIC GROUP C	8. PRESENT ADDRESS (Street, City, State, County, Zip Code) [REDACTED]		
9. MARITAL STATUS M	10. NUMBER OF DEPENDENTS 0	11. DATE OF BIRTH 1 Aug 1942	12. RELIGIOUS PREFERENCE Catholic	13. HIGHEST GRADE COMPLETED 4
14. SELECTIVE SERVICE SYSTEM DATA [REDACTED]		15. FOREIGN LANGUAGE PROFICIENCY [REDACTED]	16. DIVERSITY INFORMATION [REDACTED]	

II. EXAMINATION AND ENLISTMENT DATA PROCESSING CODES - FOR OFFICE USE ONLY

17. MENTAL AND APTITUDE RESULTS

a. HEET ID	b. PERCENT SCORED	c. GROUP	d. APTITUDE SCORES
42	63	3	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

18. MEDICAL RESULTS

a.	b.	c.	d.	e.	f.	g.	h.	i.	j.	k.	l.	m.	n.	o.	p.	q.	r.	s.	t.	u.	v.	w.	x.	y.	z.
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	

a. DATE OF ENL	b. ADSD	c. PERD	d. TERM	e. WALTER INFO	f. PAY GRADE	g. DATE OF GRADE	h. ENTRY STAFF
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	301	[REDACTED]	1

19. SERVICE RECORD DATA
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

III. VERIFICATION OF PERSONAL DATA

23. If Preferred Enrollment Name (name given in block 1) is not the same as stated on birth certificate and has not been changed by legal procedure prescribed by state law, complete the following:

a. NAME AS SHOWN ON BIRTH CERTIFICATE

I hereby state that I have not changed my name through any court procedure, and that I prefer to use the name by which I am known in the community as a matter of convenience and with no criminal or fraudulent intent. I further state that I am the same person as the one whose name is shown in block 1.

b. WITNESS (Name, grade, and signature)**c. SIGNATURE OF APPLICANT****24. EDUCATION**

YEAR & MONTH FROM		NAME AND LOCATION OF SCHOOL	GRADUATE YES	DEGREE RECEIVED
			A	BACHELOR

25. CITIZENSHIP VERIFICATION (To be completed in presence of your recruiter)**a. PLACE OF BIRTH (City, State and (if not in USA) Country)****b. BIRTH CERTIFICATE ISSUED BY (County and State)****c. PARENTS' CERTIFICATE NUMBER, DATE, PLACE AND COUNTRY****d. IF ALIEN, ALIEN REGISTRATION NUMBER****e. NATIVE COUNTRY****f. DATE AND PORT OF ENTRY****26. MILITARY SERVICE**

a. Are you now or have ever been in the Regular, Reserve or National Guard of the United States?

No Yes. If "yes", complete the following:

b. PAY GRADE AND SERVICE NUMBER	c. SERVICE AND COMPONENT	d. DATE OF ENTRY	e. DATE OF DISCH	f. TYPE DISCH REC	g. TIME LOST (NO. OF DAYS)

b. If you are now a member of a US Reserve or National Guard organization, fill in organization name and unit address:

27a. PREVIOUS MILITARY SERVICE

**DO NOT WRITE
IN THIS BLOCK**

Total Active Military Service	Year	Months	Days	g. PERIOD	e. ADDRESS
Total Inactive Military Service					

IV. OTHER BACKGROUND DATA

29. COMMERCIAL LIFE INSURANCE POLICY YOU OWN ON YOUR LIFE - Optional entry - used to assist your survivors in filing claims should you die while on active duty.

32. EMPLOYMENT - Show every employment you have had and all periods of unemployment
 a. YEAR & MONTH b. Company name and address (Street, City, State, and Zip Code) c. JOB TITLE d. SUPERVISOR NAME

No Yes. If "yes," give date(s) of employment, government you worked for, location and nature of your duties.

33. MEMBERSHIP IN YOUTH PROGRAMS - Optional entry - you may be eligible for a hip or paygrade based on membership and participation in the youth programs listed below.

No membership

ORGANIZATION	MEMBERSHIP HELD FROM	TO	CONDUCTED BY (SPONSOR)	LOCATION (CITY AND ADDRESS)	YEARS COMPLETED OR LEVEL REACHED
ROTC					YEARS
JROTC					YEARS
CAP			AIR FORCE		LEVEL
SEA CADET			NAVY		LEVEL
OTHER (Specify)					

34. FOREIGN TRAVEL - Other than as a direct result of military service

YEAR & MONTH FROM	COUNTRY VISITED	PURPOSE OF TRAVEL
TO		

35. DECLARATIONS - Explain "Yes" answers in item 41.

- a. HAVE YOU EVER BEEN REJECTED FOR ENLISTMENT, REENLISTMENT, OR INDUCTION INTO ANY BRANCH OF THE ARMED FORCES OF THE UNITED STATES? NO YES
- b. ARE YOU A CONSCIENTIOUS OBJECTOR? NO YES
- c. ARE YOU NOW OR HAVE YOU EVER BEEN A DESERTER FROM ANY BRANCH OF THE ARMED FORCES OF THE UNITED STATES? NO YES
- d. ARE YOU NOW DRAWING, OR DID YOU HAVE AN APPLICATION PENDING, OR APPROVAL FOR, RETIRED PAY, DISABILITY ALLOWANCE, OR SURVIVOR PAY, OR A PENSION FROM THE GOVERNMENT OF THE UNITED STATES? NO YES
- e. ARE YOU THE ONLY LIVING CHILD OF YOUR PARENTS? NO YES

36. UNDERSTANDINGS

37. CHARACTER AND SOCIAL ADJUSTMENT (6 of 6) Consider the following questions as fully as you can, giving your answers in the space provided.

1. If your answer to every question is "truthfully - NO", please indicate in the appropriate space.
2. If your answer to any question in this section is "YES", or you have reservations about answering questions of this nature, you are not required to answer, or explain any of these questions on writing test, as you may request a personal interview, whereupon you may provide the required information for each question orally.
3. If you choose the personal interview, the information you supply may be transcribed, however, any statement made at the interview shall not be retained more than six months after entry upon active duty, and it will not become a part of your personnel military personnel service record.
4. If you ended this interview, the information may be requested from you again at some future date and may become a part of your security investigation at that time. This could occur as a result of your being considered for duties involving access to classified information or other types of duty requiring a personnel security investigation.
5. A "YES" answer will not necessarily disqualify you for enlistment. It will depend on the circumstances surrounding the situation involved.

INITIAL HERE IF YOU PREFER A PERSONAL INTERVIEW

APPLICANT HAS BEEN INTERVIEWED AND IS ELIGIBLE FOR ENLISTMENT INELIGIBLE FOR ENLISTMENT

DATE OF INTERVIEW

NAM, ORGANIZATION & TITLE

INITIALS OR INTERVIEWER

NA

NA

NA

EXPLAIN "YES" ANSWERS IN ITEM 37:

- a. HAVE YOU EVER TAKEN ANY NARCOTIC SUBSTANCE, SEDATIVE, STIMULANT, OR TRANQUILIZER DRUGS EXCEPT AS PRESCRIBED BY A LICENSED PHYSICIAN?
- b. HAVE YOU EVER INTENTIONALLY SNIFLED GLUE, PAINT, THINSPRUC, OR OTHER CHEMICAL FUMES?
- c. HAVE YOU EVER BEEN INVOLVED IN THE USE, PURCHASE, CONSUMPTION, OR SALE OF MARIJUANA, LSD, OR ANY HARMFUL OR HABIT FORMING DRUGS AND/OR CHEMICALS, EXCEPT AS PRESCRIBED BY A LICENSED PHYSICIAN?
- d. HAS YOUR USE OF ALCOHOLIC BEVERAGES CAUSED YOU OR BEEN INVOLVED IN THE LOSS OF A JOB, ARREST BY POLICE, OR TREATMENT FOR ALCOHOLISM?
- e. HAVE YOU EVER BEEN A PATIENT (WHETHER OR NOT VOLUNTARILY) COMMITTED TO ANY INSTITUTION, PRIMARILY DEVOTED TO THE TREATMENT OF MENTAL, NERVOUS, EMOTIONAL, PSYCHOLOGICAL, OR PERSONALITY DISORDERS?
- f. HAVE YOU EVER ENGAGED IN HOMOSEXUAL ACTIVITY (SEXUAL RELATIONS WITH ANOTHER MEMBER OF THE SAME SEX)?

38. MARITAL STATUS AND DEPENDENCY

- a. ARE YOU NOW, OR HAVE YOU EVER BEEN MARRIED?
- b. IF YOU HAVE BEEN MARRIED, ARE YOU NOW LIVING WITH YOUR SPOUSE?
- c. HAVE YOU EVER BEEN DIVORCED? (If yes, enter date, place and court which granted divorce or legal separation)

- d. IS ANY COURT ORDER OR JUDGEMENT BEING MAINTAINED FOR CHILDREN OF ANYONE? (Enter date, place, and court which granted alimony, decree, or support as the result of a paternity suit)

- e. IS ANYONE OTHER THAN YOUR SPOUSE AND/OR CHILDREN SOLELY OR PARTIALLY DEPENDENT UPON YOU? (first name & address)

39. Do you, or have, or either the past ten years, taken you had, belong to, or belong with the specific object of furthering the army of, or adherence to, and active participation in any foreign or domestic organization, movement, group, or combination of persons, places, after referred to as "sabotage", who, usually, advocate or practice the use of acts of force or violence to prevent others from exercising their rights or in the Constitution or laws of the United States, or any State, or which seeks to overthrow the Government of the United States, or any State, established by constitutional means?

If you answered "yes", give the names of the organizations and include, when known, and year of your membership. Describe the nature of your activities as a member of the organization in the Remarks section Item 41.

40. INVOLVEMENT WITH POLICE OR JUDICIAL AUTHORITIES

YOUR ANSWERS TO THE FOLLOWING QUESTIONS WILL BE PROVIDED TO THE FEDERAL BUREAU OF INVESTIGATION (FBI) & OTHER AGENCIES, TO DETERMINE ANY PREVIOUS RECORDS OF ARREST, CONVICTION, OR JUVENILE COURT ADMISSIONS IN YOUR CONCERNED RECORDS AT THE TIME YOU MAY, UPON ENLISTMENT, BE SUBJECT TO DETERMINATION AS TO WHETHER YOU ARE UNFIT FOR MILITARY SERVICE AND/OR DISCHARGE FROM THE MILITARY SERVICE WITH OTHER THAN AN HONORABLE DISCHARGE.

- a. Have you ever been arrested, charged, cited, or held by Federal, State, or other law enforcement agencies, regardless of whether the citation or charge was dropped or dismissed? If you were tried and not guilty?
- b. As a result of being arrested, charged, cited, or held by law enforcement or other public authorities, have you ever been convicted, fined, or forfeited bond to a Federal, State, or other public authority adjudicated a youthful offender or juvenile delinquent regardless of whether the record in your case has been sealed or otherwise struck from the criminal record?
- c. Has you ever been detained, held, or segregated from an educational institution, vocational school, or industrial school or any other facility or institution under the jurisdiction of any city, County, State, Federal or foreign country?
- d. Have you ever been awarded, or are you now under suspended sentence, parole, or probation or awaiting any action on charges against you?

NO YES

✓ ✓

✓ ✓

✓ ✓



CERTIFICATION OF APPEAL

1A. NAME OF APPELLANT (<i>If other than veteran</i>). [REDACTED]	1B. RELATIONSHIP TO VETERAN [REDACTED]	2. FILE NUMBER [REDACTED]		
3. LAST NAME - F RST NAME - MIDDLE NAME OF VETERAN) [REDACTED]	4. INSURANCE FILE NO OR LOAN NO. (<i>If pertinent</i>) [REDACTED]			
THE APPEAL IS FOR (State the question(s) at issue clearly and concisely)				
5A. SERVICE CONNECTION FOR left shoulder disability	5B. DATE OF NOTIFICATION OF ACTION APPEALED 04-30-09			
6A. INCREASED RATING FOR DJD, lumbar spine in excess of 20% from 6-27-08 to 4-16-09; in excess of 10% from 5-14-10 to 9-4-11; in excess of 10% from 9-11-12 to 9-30-13 and in excess of 20% from 09-30-13	6B. DATE OF NOTIFICATION OF ACTION APPEALED 06-17-10			
7A. OTHER [REDACTED]	7B. DATE OF NOTIFICATION OF ACTION APPEALED [REDACTED]			
8A. APPELLANT REPRESENTED IN THIS APPEAL BY (Name of Organization, attorney, or agent) Disabled American Veterans				
8B. ONE OF THE FOLLOWING IS ON FILE AS AUTHORITY FOR RECOGNIZING SUCH REPRESENTATIVE IN THIS APPEAL <input checked="" type="checkbox"/> POWER OF ATTORNEY (VA Form 21-22 or VA Form 21-22a) <input type="checkbox"/> CERTIFICATION THAT VALID POWER OF ATTORNEY IS IN ANOTHER VA FILE (<i>If so, specify the file</i>)		8C. IF AGENT DESIGNATED, IS HE/SHE ON ACCREDITED LIST? <input type="checkbox"/> YES <input type="checkbox"/> NO		
9A. IF REPRESENTATIVE IS SERVICE ORGANIZATION IS VA FORM 646, OR EQUIVALENT, OF RECORD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	9B. IF VA FORM 646 IS NOT OF RECORD, EXPLAIN [REDACTED]			
10A. WAS HEARING REQUESTED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	10B. IF HELD, IS TRANSCRIPT IN FILE? <input type="checkbox"/> YES <input type="checkbox"/> NO			
10C. IF REQUESTED BUT NOT HELD, EXPLAIN BVA Travel Board hearing requested				
11A. ARE CONTESTED CLAIMS PROCEDURES APPLICABLE IN THIS CASE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (<i>If "YES", complete item 11B</i>).	11B. HAVE THE REQUIREMENTS OF 38 U.S.C. 7105A BEEN FOLLOWED? <input type="checkbox"/> YES <input type="checkbox"/> NO			
12A. DATE STATEMENT OF THE CASE FURNISHED. 02-06-12	12B. SUPPLEMENTAL STATEMENT OF THE CASE <input checked="" type="checkbox"/> REQUIRED AND FURNISHED <input type="checkbox"/> NOT REQUIRED			
13. RECORDS TO BE FORWARDED TO BOARD OF VETERANS APPEALS				
<input type="checkbox"/> CF OR XCF <input type="checkbox"/> INACTIVE CF	<input type="checkbox"/> R&E F <input type="checkbox"/> TRA N NG SUB-F <input type="checkbox"/> DEP. ED. F (Ch. 35)	<input type="checkbox"/> LOAN GUAR. F <input type="checkbox"/> INSURANCE F <input type="checkbox"/> DENTAL F	<input type="checkbox"/> OUTPATIENT F <input type="checkbox"/> HOSPITAL COR. <input type="checkbox"/> CLINICAL REC.	<input type="checkbox"/> X-RAYS <input type="checkbox"/> SLIDES <input type="checkbox"/> TISSUE BLOCKS
<input checked="" type="checkbox"/> OTHER (<i>Specify</i>) VBMS electronic file				
14. REMARKS (Continue on reverse) Ready for BVA Travel Board hearing Re-certification of remand, dated 11-26-14.				
CERTIFICATION: It is hereby certified that all material evidence is of record, that all contentions advanced by and on behalf of the appellant have been considered under all pertinent laws, and the issues determined.				
15. NAME AND LOCATION OF CERTIFYING OFFICE VA Regional Office St. Louis, MO	16. ORGANIZATIONAL ELEMENT CERTIFYING APPEAL Veterans Service Center			
17A. SIGNATURE OF CERTIFYING OFFICIAL [REDACTED]	17B. TITLE Decision Review Officer	17C. DATE 04-01-15		
18A. SIGNATURE OF MEDICAL MEMBER (<i>Insurance use only</i>)	18B. TITLE	18C. DATE		

64 APS PATIENT IDENTIFICATION

HEALTH RECORD OUTPATIENT	Specify Service & Grade for Military & Retired Military Member
	MILITARY USAF/SSG <input checked="" type="checkbox"/>
	RETIRED MILITARY <input type="checkbox"/>
	NONMILITARY <input type="checkbox"/>

RECEIVED

NOV 18 2002

RMC ST. LOUIS
MAIL CLERK #18

1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998

RECORDS MAINTAINED AT
 459 AEROSPACE MEDICINE SQ
 3757 OREGON CIRCLE
 ANDREWS AFB MD 20762-4814

	SENSITIVE DUTIES PROGRAM (SDP)
	FOOD HANDLER

ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET

8. OCCUPATIONAL HISTORY/RISK

a. PRP		YES	NO
b. FLYING STATUS		YES	NO

9. IMMUNIZATIONS (Enter numeric class in sub block)

(1) IMMUNIZATION	(2) DATE (DDMMYYYY)	(1) IMMUNIZATION	(2) DATE (DDMMYYYY)	(1) IMMUNIZATION	(2) DATE (DDMMYYYY)	(1) IMMUNIZATION	(2) DATE (DDMMYYYY)						
a. HEP A #1		f. MMR #1		j. TD (q 10 yrs) (last)									
b. HEP A #2		g. MMR #2		k. TD (Due)									
c. HEP B #1		h. PNEUMOCOCCUS		i. YELLOW FEVER (last)									
d. HEP B #2		i. POLIO OPV = O IPV = I		m. YELLOW FEVER (Due)									
e. HEP B #3													
n. TYPHOID (Enter numeric class in sub block) ORAL = 0 TYPHUM VI = 1, TYPHOID USP = 2		(1) DATE		(2) DATE		(3) DATE		(4) DATE		(5) DATE		(6) DATE	
o. ANTHRAX	(1) INITIAL DATE	(2) 2 WEEK DATE	(3) 4 WEEK DATE	(4) 6 MONTH DATE	(5) 12 MONTH DATE	(6) 18 MONTH DATE							
p. PPD (Enter mm and date)	(1)(a) mm (b) DATE	(2)(a) mm (b) DATE	(3)(a) mm (b) DATE	(4)(a) mm (b) DATE	(5)(a) mm (b) DATE	(6)(a) mm (b) DATE							
q. INFLUENZA	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE (7) DATE							
r. VARICELLA	(1) DATE	(2) DATE	u. JAPANESE B ENCEPHALITIS	(1) DATE	(2) DATE	(3) DATE (4) DATE							
s. MENINGO	(1) DATE	(2) DATE	v. OTHER (Specify)	(1) DATE	(2) DATE	(3) DATE							
t. ADENO	(1) DATE	(2) DATE	w. OTHER (Specify)	(1) DATE	(2) DATE	(3) DATE							

10. READINESS

* (Glucose-6-phosphate dehydrogenase)

a. DNA	DATE: Nov 97	b. BLOOD TYPE	DATE:	RESULT: Apos	c. G6PD*	DATE:	RESULT: N/NL	d. SICKLE CELL	DATE: Jul 87	RESULT: Pos
e. PERMANENT PROFILE CHANGE		(1) DATE Jan 97	(2) YR: /	(3) U: /	(4) L: /	(5) H: /	(6) E: /	(7) S: /		
f. GLASSES/GAS MASK Rx:		(1) DATE		(2) DATE		(3) DATE		(4) DATE		(5) DATE
g. DENTAL EXAM (Enter numeric class in sub block)		(1) DATE		(2) DATE		(3) DATE		(4) DATE		(5) DATE
h. HIV TESTING		(1) DATE May 96		(2) DATE		(3) DATE		(4) DATE		(5) DATE
i. FITNESS (In sub block enter P=Pass, F=Fail, W=Waiver)		(1) DATE		(2) DATE		(3) DATE		(4) DATE		(5) DATE
Physical Exam		(1) DATE May 96		(2) DATE		(3) DATE		(4) DATE		(5) DATE
		(1) DATE		(2) DATE		(3) DATE		(4) DATE		(6) DATE

11. PRE/POST DEPLOYMENT HISTORY

a. LOCATION						
(1) PREDEPLOYMENT	(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE
(2) POSTDEPLOYMENT	(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE
b. LOCATION						
(1) PREDEPLOYMENT	(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE
(2) POSTDEPLOYMENT	(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE
c. CHART AUDIT	O	O	O	O	O	O

ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET

AMILY HISTORY (M = Mother, F = Father, S = Sibling, MGM = Maternal Grandmother, MGF = Maternal Grandfather, EM = Paternal Grandmother, PGF = Paternal Grandfather)

CANCER (Specify)	
ARTIOVASCULAR DISEASE (Specify)	
DIABETES (Specify)	
ENTAL ILLNESS/CHEMICAL DEPENDENCY (Specify)	

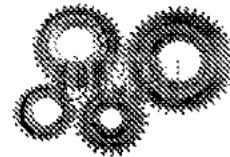
CREENING EXAMS (* = Actual Result, ** = Tricare Benefit, N = Normal, X = Abnormal, E = Done Elsewhere, R = Refused, N = Not Indicated) (● = Next Due)

a. TEST	b. FREQUENCY	c. YEAR	d. AGE	e. DATES					
CLINICAL DISEASE PREV EVAL/PHA (HEAR)	ANNUAL			○	○	○	○	○	○
WEIGHT	ANNUAL FOR ACTIVE DUTY			○	○	○	○	○	○
HEIGHT	ANNUAL FOR ACTIVE DUTY			○	○	○	○	○	○
BLOOD PRESSURE	ONCE q 2 YRS FOR BP < 130/85, ANNUAL IF GREATER			○	○	○	○	○	○
CHOLESTEROL**	q 5 YRS FOR AGE \geq 18 q YR IF PREV ABN			○	○	○	○	○	○
HEARING	CLINICIAN'S DISCRETION			○	○	○	○	○	○
SKIN EXAM (Cancer)	ANNUAL IF AT RISK			○	○	○	○	○	○
ORAL/DENTAL**	ANNUAL			○	○	○	○	○	○
EYE/VISION**	ROUTINE ACUITY WITH PERIODIC ASSESSMENT DIABETES ANNUALLY GLAUCOMA CHECK: Blacks q 3-5 yrs age 20-39 All q 2-4 yrs age 40-64			○	○	○	○	○	○
BREAST EXAM	ANNUAL: $>$ 40 YRS			○	○	○	○	○	○
MAMMOGRAM**	BASELINE @40, q 2 YRS 40-50, ANNUALLY $>$ 50			○	○	○	○	○	○
PAP ** (Digital Rectal Exam)	BASELINE: AGE 18 OR ONSET OF SEXUAL ACTIVITY AFTER 3 NL ANNUAL EXAMS, PERFORM q 1-3 YEARS			○	○	○	○	○	○
FECAL OCCULT BLOOD	ANNUAL: $>$ 50 YRS			○	○	○	○	○	○
SIGMOID	EVERY 3-5 YRS: $>$ 50 YRS			○	○	○	○	○	○
COLONOSCOPY**	HIGH RISK q 5 YRS: $>$ 40 YRS			○	○	○	○	○	○
TESTICULAR**	HIGH RISK ANNUAL 13-39 YRS			○	○	○	○	○	○
PROSTATE** ** (Digital Rectal Exam)	WITH P.E. \geq 40 YRS (Presently recommended annually)			○	○	○	○	○	○
ROSELLA SCREEN (Female)	ONCE BETWEEN AGES 12-18 YRS (Unless prev vaccinated)			○	○	○	○	○	○
OCCUPATIONAL SCREENING EXAMS	APPROPRIATE TO EXPOSURES			○	○	○	○	○	○
				○	○	○	○	○	○
				○	○	○	○	○	○
				○	○	○	○	○	○

USE THIS COVER SHEET TO FAX CLAIMS TO THE VA'S CLAIMS AND EVIDENCE INTAKE CENTERS



(Eastern and Southern Areas)



VBA's Office of Business Process
Integration

Fax Coversheet and Checklist

To: VBA Claims and Evidence Intake Center
Fax: 844-531-7818
Veterans Claims Intake Program

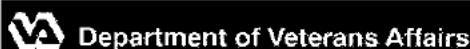
- Veteran First** _____
- Veteran C File** _____
- Claimant Zip** _____
- Fax Date:** 11/24/2015
- # of Pages to include Coversheet:** 5
- Forms Included:**

DOUBLE CHECK: Check Confirmation sheet and ensure fax is to

Disclaimer: Incorrect input of fax number, such as dialing the prefix "9" unnecessarily will result in failed submission to VA. Due to similarities in numbers, multiple parties have submitted to the wrong VA department. AVP Metro Petroleum is destroying any faxed Veterans records.

VA Directive 6609, NOVEMBER 9, 2007: NOTICE! Access to Veterans records is limited to Authorized Personnel Only. Information may not be disclosed unless permitted pursuant to 38 CFR 1.500-1.599. The Privacy Act contains provisions for criminal penalties for knowingly and willingly disclosing information from the file unless properly authorized to do so.

OMB Control No. 2900-0747
 Respondent Burden: 25 minutes
 Expiration Date: 11/30/2017



APPLICATION FOR DISABILITY COMPENSATION AND RELATED COMPENSATION BENEFITS

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 10 before completing the form.

SECTION I: IDENTIFICATION AND CLAIM INFORMATION

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

[REDACTED] YYYY)

4. SEX

MALE

FEMALE

5. HAVE YOU EVER FILED A CLAIM WITH VA?

YES NO (If "Yes," provide your file number in Item 6)

6. VA FILE NUMBER

7A. ARE YOU CURRENTLY HOMELESS OR AT RISK OF BECOMING HOMELESS?

YES NO (If "Yes," complete Items 7B & 7C)

7B. POINT OF CONTACT (Name of person that VA can contact in order to get in touch with you)

7C. POINT OF CONTACT TELEPHONE NUMBER (Include Area Code)

8A. SERVICE (Check all that apply)

ARMY NAVY MARINE CORPS

AIR FORCE COAST GUARD

8B. COMPONENT (Check all that apply)

ACTIVE RESERVES NATIONAL GUARD

9A. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

Number and Street
or Rural Route, P.O.
Box

City, State, ZIP Code

Country

Apt./Unit Number

9B. FORWARDING ADDRESS AND EFFECTIVE DATE

Number and Street
or Rural Route, P.O.
Box

City, State, ZIP Code

Country

Effective Date (MM/DD/YYYY):

9C. PREFERRED TELEPHONE NUMBER

10A. PREFERRED E-MAIL ADDRESS (If applicable)

10B. ALTERNATE E-MAIL ADDRESS (If applicable)

11. LIST THE DISABILITY(IES) YOU ARE CLAIMING (If applicable, identify whether a disability is due to a service-connected disability, is due to confinement as a Prisoner of War, is due to exposure to Agent Orange, Asbestos, Mustard Gas, Ionizing Radiation, or Gulf War Environmental Hazards, or is related to benefits under 38 U.S.C. 1151).

Please list your contentions below. See the following examples, for more information:

- Example 1: Hearing loss
- Example 2: Diabetes-Agent Orange (exposed 12/72, Da Nang)
- Example 3: Left knee - secondary to right knee

DISABILITIES

1.	RT knee pain /range of motion
2.	LT knee secondary to RT knee pain
3.	RT hip pain
4.	Lower Back
5.	depression
6.	anxiety
7.	adding to claim-Esophagitis
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
16.	
17.	
18.	
19.	
20.	

12. 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) AND PROVIDE TREATMENT DATES:

A. NAME AND LOCATION	B. DATE(S) OF TREATMENT
[REDACTED]	08/01/2015
[REDACTED]	08/26/2015
[REDACTED]	

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

For:	Required Form(s):
Dependents	VA Form 21-686c and, if claiming a child aged 18-23 years and in school, VA Form 21-674
Individual Unemployability	VA Form 21-8940 and 21-4192
Post-Traumatic Stress Disorder	VA Form 21-0781 and 21-0781a
Specially Adapted Housing or Special Home Adaptation	VA Form 28-4555
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 II: SERVICE INFORMATION

14A. DID YOU SERVE UNDER ANOTHER NAME?
 YES (If "Yes," complete Item 14B) NO (If "No," skip to Item 15A)

14B. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER:

15A. MOST RECENT ACTIVE SERVICE ENTRY (MM,DD,YYYY)	15B. SERVICE NUMBER (Fill out this item only if assigned a service number)	15C. RELEASE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE SERVICE
[REDACTED]		

15D. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	15E. PLACE OF LAST OR ANTICIPATED SEPARATION Offutt Air Force Base Omaha	
16A. ARE YOU CURRENTLY SERVING OR HAVE YOU EVER SERVED IN THE RESERVES OR NATIONAL GUARD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If "Yes," complete Items 16B thru 16F) (If "No," skip to Item 17A)	16B. COMPONENT <input type="checkbox"/> NATIONAL <input type="checkbox"/> GUARD <input type="checkbox"/> RESERVES	16C. OBLIGATION TERM OF SERVICE From: To:

16D. CURRENT OR LAST ASSIGNED NAME AND ADDRESS OF UNIT:	16E. CURRENT OR ASSIGNED PHONE NUMBER OF UNIT (Include Area Code) ()	16F. ARE YOU CURRENTLY RECEIVING INACTIVE DUTY TRAINING PAY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
17A. ARE YOU CURRENTLY ACTIVATED ON FEDERAL ORDERS WITHIN THE NATIONAL GUARD OR RESERVES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If "Yes," complete Items 17B & 17C)	17B. DATE OF ACTIVATION: (MM,DD,YYYY)	17C. ANTICIPATED SEPARATION DATE: (MM,DD,YYYY)

18A. HAVE YOU EVER BEEN A PRISONER OF WAR? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If "Yes," complete Item 18B)	18B. DATES OF CONFINEMENT (MM,DD,YYYY) From: To:

SECTION III: SERVICE PAY

19A. DID/DO YOU RECEIVE ANY TYPE OF SEPARATION/SEVERANCE/RETIRIED PAY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes," complete Items 19B and 19C)	19B. LIST AMOUNT (If known) \$ 701.00	19C. LIST TYPE (If known) Retired
[REDACTED]		

IMPORTANT: Submission of this application constitutes an election of VA compensation in lieu of military retired pay if it is determined you are entitled to both benefits. If you are entitled to receive military retired pay, your retired pay may be reduced by the amount of any VA compensation that you are awarded. VA will notify the Military Retired Pay Center of all benefit changes. Receipt of military retired pay or Voluntary Separation Incentive (VSI) and VA compensation at the same time may result in an overpayment which may be subject to collection. However, if you do not want to receive VA compensation in lieu of military retired pay, you should check the box in **Item 20**. Please note that if you check the box in **Item 20**, you *will not* receive VA compensation, if granted.

20. I want military retired pay instead of VA compensation

IMPORTANT: You may elect to keep the training pay for inactive duty training days 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 21**, VA will adjust your VA award to withhold future benefits equal to the total number of inactive duty for training days waived and at the monthly rate in effect for the fiscal year period for which you received training pay. Your normal VA rate will be restored when the sufficient numbers of days' benefits have been withheld.

21. I elect to waive VA benefits for the days I accrued inactive duty training pay in order to retain my inactive duty training pay.

SECTION IV: DIRECT DEPOSIT INFORMATION

The Department of Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. Please attach a voided personal check or deposit slip or provide the information requested below in **Items 22, 23 and 24** to enroll in direct deposit. If you do not have a bank account, you must receive your payment through Direct Express Debit MasterCard. To request a Direct Express Debit MasterCard you must apply at www.usdirectexpress.com or by telephone at 1-800-333-1795. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

22. ACCOUNT NUMBER (*Check the appropriate box and provide the account number, or simply write "Established" if you have a direct deposit with VA*)

I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL CERTIFIED PAYMENT AGENT

23. ACH/ATM NUMBER (*The first nine numbers located at the bottom of your check*)

SECTION V: CLAIM CERTIFICATION AND SIGNATURE

I certify and authorize the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me, and I waive any privilege which makes the information confidential.

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

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility such as a VA medical center; OR, I have no information or evidence to give VA to support my claim; OR, I have checked the box in **Item 25**, indicating that I do not want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.

ALTERNATE SIGNER: By signing on behalf of the claimant, I certify 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 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.

25. The FDC Program is designed to rapidly process compensation or pension claims received with the evidence necessary to decide the claim. VA will automatically consider a claim submitted on this form for rapid processing under the FDC Program. Check the box below **ONLY IF YOU DO NOT WANT YOUR CLAIM CONSIDERED FOR RAPID PROCESSING** under the FDC Program because you plan on submitting further evidence in support of your claim.

evidence in support of my claim.

SECTION VI: WITNESSES TO SIGNATURE

27A. SIGNATURE OF WITNESS (*If veteran signed above using an "X"*)

27B. PRINTED NAME AND ADDRESS OF WITNESS

28A. SIGNATURE OF WITNESS (*If veteran signed above using an "X"*)

28B. PRINTED NAME AND ADDRESS OF WITNESS

SECTION VII: POWER OF ATTORNEY (POA) SIGNATURE

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

NOTE: A POA's signature **will not** be accepted unless at the time of submission of this claim a valid VA Form 21-22, *Appointment of Veterans Service Organization as Claim Agent*, is filed with VA. This form is available at www.vba.va.gov/forms/21-22.html. The claim agent listed on the form must be the appropriate POA is of record with VA.

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(e)(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.regulations.gov/OMB/PRAM/. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.



DEPARTMENT OF VETERANS AFFAIRS

January 20, 2016

In Reply Refer To: **314/MN**
File Number:
[REDACTED]

IMPORTANT – REPLY NEEDED WITHIN 10 DAYS

Dear [REDACTED]

We are continuing to work on your claim.

What Is The Current Status Of Your Claim?

We have requested your Service Treatment Records and determined that your Service Treatment Records cannot be located and therefore are unavailable for review. All efforts to obtain the needed information have been exhausted, and based on these facts, we have determined that further attempts to obtain the records would be unsuccessful.

We have taken the following actions in an effort to obtain these records:

- We contacted NRPC on November 13, 2015 to obtain your Service Treatment Records. However, they responded stating they 'can't identify record based on information received.'

What Do We Still Need From You?

Please submit any relevant documents in your possession including:

- Any available copies of Service Treatment Records as listed above.
- Any other relevant evidence or information that you think will support your claim, to include such things as buddy statements.

If you are unable to submit records, you may also advise us of possible locations(s) of these records.

How Soon Should You Send What We Need?

We strongly encourage you to send any information or evidence as soon as you can. However, if we do not hear from you within **10 days**, we will make a determination on the evidence of record.

How Should You Submit What We Need?

Please note that the quickest, easiest, and most secure way to submit any documents to us is via the eBenefits website. Just visit www.eBenefits.va.gov to register. Please also refer to the ‘What is eBenefits?’ section of this letter for more information.

You can also send what we need to the appropriate address listed on the attached “Where to Send Your Written Correspondence” chart.

What is eBenefits?

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

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

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

Do You Have Questions Or Need Assistance?

If you have any questions, you may contact us by telephone, e-mail, or letter.

If you	Here is what to do.
Telephone	Call us at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal number is 711.
Use the Internet	Send electronic inquiries through the Internet at https://iris.va.gov .
Write	VA now uses a centralized mail system. For all written communications, put your full name and VA file number on the letter. Please mail or fax all written correspondence to the appropriate address listed on the attached <i>Where to Send Your Written Correspondence</i> .

[REDACTED]

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

In all cases, be sure to refer to your VA file [REDACTED]

If you are looking for general information about benefits and eligibility, you should visit our website at <https://www.va.gov>, or search the Frequently Asked Questions (FAQs) at <https://iris.va.gov>.

We have no record of you appointing a service organization or representative to assist you. We have also enclosed information on how Veterans' Service Organizations can help you. You can contact us for a list of the VA recognized Veterans Service Organizations and/or representatives. Veterans Service Organizations which are recognized by VA to provide services to the Veteran community can also help you with questions.

Sincerely yours,

RO Director
VA Regional Office

Enclosures: VA Form 21-4138
VA Form 21-4142
Where to Send Your Written Correspondence



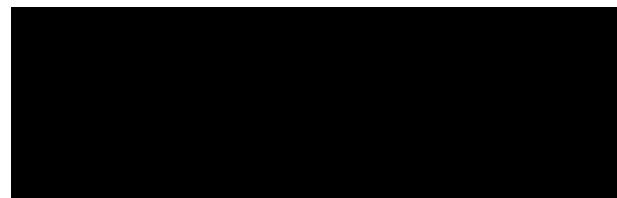
DEPARTMENT OF VETERANS AFFAIRS

Where to Send Your Written Correspondence

Location of Residence	Address to Send all Written Correspondence
Alabama	Ohio
Connecticut	Pennsylvania
Delaware	Rhode Island
District of Columbia	South Carolina
Florida	Tennessee
Georgia	Vermont
Indiana	Virginia
Kentucky	West Virginia
Maine	Puerto Rico
Maryland	
Massachusetts	Europe
Michigan	Asia
Mississippi	Australia
New Hampshire	Africa
New Jersey	Palau
New York	Marshall Islands
North Carolina	Federated States of Micronesia
Alaska	South Dakota
Arizona	Texas
Arkansas	Utah
California	Washington
Colorado	Wisconsin
Louisiana	Wyoming
Hawaii	
Idaho	Canada
Illinois	Mexico
Iowa	Central America
Kansas	South America
Oklahoma	The Caribbean
Oregon	The U.S. Virgin Islands
Minnesota	The Philippines
Missouri	American Samoa
Montana	Guam
Nebraska	Northern Mariana Islands
Nevada	U.S. Virgin Islands
New Mexico	
North Dakota	



**DEPARTMENT OF VETERANS AFFAIRS
Roanoke VA Regional Office
210 FRANKLIN ROAD SW
Roanoke VA
24011**



Represented By:

**Rating Decision
03/01/2016**

INTRODUCTION

[REDACTED] Peacetime. You served in the Air Force from [REDACTED] filed an original disability claim that was received on October 19, 2015. Based on a review of the evidence listed below, we have made the following decision(s) on your claim.

DECISION

1. Service connection for Esophagitis is denied.
2. Service connection for Left knee condition is denied.
3. Service connection for Right knee condition is denied.
4. Service connection for anxiety is denied.
5. Service connection for depression is denied.

[REDACTED]

6. Service connection for lower back is denied.

EVIDENCE

- Service treatment records (STRS) were not available. If records become available in the future we will review the records and this decision at that time.
- VA Form 21-526 received October 19, 2015.
- Washington DC VA Medical Center records dating from August of 2015.
- VA Form 21-4138 received November 19, 2015.
- Exam received November 19, 2015.
- VA letter dated January 19, 2016.
- VA Form 21-4138 received February 5, 2016.
- TRICARE immunization records.

REASONS FOR DECISION

1. Service connection for Esophagitis.

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

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

The evidence does not show an event, disease or injury in service.

We did not find a link between your medical condition and military service.

2. Service connection for Left knee condition.

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

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

The evidence does not show an event, disease or injury in service.



We did not find a link between your medical condition and military service.

3. Service connection for Right knee condition.

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

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

The evidence does not show an event, disease or injury in service.

We did not find a link between your medical condition and military service.

4. Service connection for anxiety.

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

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

The evidence does not show an event, disease or injury in service.

We did not find a link between your medical condition and military service.

5. Service connection for depression.

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

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

The evidence does not show an event, disease or injury in service.

We did not find a link between your medical condition and military service.



6. Service connection for lower back.

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

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

The evidence does not show an event, disease or injury in service.

We did not find a link between your medical condition and military service.

REFERENCES:

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

Rating Decision	<i>Department of Veterans Affairs Roanoke VA Regional Office</i>	Page 1 of 1 03/01/2016
		POA
		COPY TO

ACTIVE DUTY		
	BRANCH	CHARACTER OF DISCHARGE
	Air Force	Honorable

LEGACY CODES			
ADD'L SVC CODE	COMBAT CODE	SPECIAL PROV CDE	FUTURE EXAM DATE
	1		None

JURISDICTION: Original Disability Claim Received 10/19/2015

ASSOCIATED CLAIM(s): 110; Initial Live Comp < 8 issues; 10/19/2015

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

- 5237 LOWER BACK
Not Service Connected, Not Incurred/Caused by Service
- 5257 LEFT KNEE CONDITION
Not Service Connected, Not Incurred/Caused by Service
- 5257 RIGHT KNEE CONDITION
Not Service Connected, Not Incurred/Caused by Service
- 7203 ESOPHAGITIS
Not Service Connected, Not Incurred/Caused by Service
- 9400 ANXIETY
Not Service Connected, Not Incurred/Caused by Service
- 9434 DEPRESSION
Not Service Connected, Not Incurred/Caused by Service

I certify that I have reviewed and electronically signed
this decision."

FAX

To: varo

Company:

Fax:

Phone:

From:

Fax:

Phone:

E-mail:

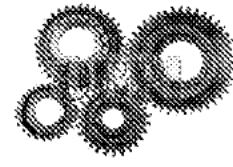
NOTES:

[REDACTED]

USE THIS COVER SHEET TO FAX CLAIMS TO THE VA'S CLAIMS AND EVIDENCE INTAKE CENTERS



(Eastern and Southern Areas)



VBA's Office of Business Process
Integration

Fax Coversheet and Checklist

To: VBA Claims and Evidence Intake Center
Fax: [REDACTED]
Veterans Claims Intake Program

- Veteran First and Last Name: [REDACTED]
- Veteran C File #: C [REDACTED]
- Claimant Zip Code: [REDACTED]
- Fax Date: 04/04/2016
- # of Pages to include Coversheet: 7
- Forms Included:
[REDACTED]

DOUBLE CHECK: Check Confirmation sheet and ensure fax is to

[REDACTED] co [REDACTED] q [REDACTED] o [REDACTED] x [REDACTED] q [REDACTED] q [REDACTED] prefix "9" unnecessarily will result in failed submission to VA. Due to similarities in numbers, multiple parties have submitted to the wrong VA department. AVP Metro Petroleum is destroying any faxed Veterans records.

VA Directive 6609, NOVEMBER 9, 2007: NOTICE! Access to Veterans records is limited to Authorized Personnel Only. Information may not be disclosed unless permitted pursuant to 38 CFR 1.500-1.599. The Privacy Act contains provisions for criminal penalties for knowingly and willingly disclosing information from the file unless properly authorized to do so.

 Department of Veterans Affairs		NOTICE OF DISAGREEMENT	
<p>A CLAIMANT OR HIS OR HER DULY APPOINTED REPRESENTATIVE MAY FILE NOTICE EXPRESSING THEIR DISSATISFACTION OR DISAGREEMENT WITH AN ADJUDICATIVE DETERMINATION BY THE VA REGIONAL OFFICE. A DESIRE TO CONTEST THE RESULT WILL CONSTITUTE A NOTICE OF DISAGREEMENT (NOD). WHILE SPECIAL WORDING IS NOT REQUIRED, THE NOD MUST BE IN TERMS WHICH CAN BE REASONABLY CONSTRUED AS DISAGREEMENT WITH THAT DETERMINATION AND A DESIRE FOR APPELLATE REVIEW. (AUTHORITY: 38 U.S.C. 7105)</p> <p>TO FILE A VALID NOD, THERE IS A TIME LIMIT OF ONE YEAR FROM THE DATE VA MAILED THE NOTIFICATION OF THE DECISION TO THE CLAIMANT. FOR CONTESTED CLAIMS INCLUDING CLAIMS OF APPORTIONMENT, THIS TIME LIMIT IS 60 DAYS FROM THE DATE VA MAILED THE NOTIFICATION OF THE DECISION TO THE CLAIMANT.</p>		<p>(DO NOT WRITE IN THIS SPACE) (VA DATE STAMP)</p>	
<p>NOTE: You can <i>either</i> complete the form online or by hand. Please print information using blue or black ink, neatly, and legibly to help process the form.</p>			
PART I - PERSONAL INFORMATION			
<p>1. VETERAN'S NAME (<i>First, middle initial, last</i>) [REDACTED]</p>			
<p>2. VETERAN'S SOCIAL SECURITY NUMBER [REDACTED]</p>		<p>3. VA FILE NUMBER [REDACTED]</p>	
CLAIMANT'S PERSONAL INFORMATION			
<p>4. CLAIMANT'S NAME (<i>First, middle initial, last</i>) [REDACTED]</p>			
<p>5. CURRENT MAILING ADDRESS (<i>Number and street or rural route, P.O. Box, City, State, ZIP Code and Country</i>) [REDACTED]</p>			
<p>6. PREFERRED TELEPHONE NUMBER (<i>Include Area Code</i>) [REDACTED]</p>		<p>7. PREFERRED E-MAIL ADDRESS [REDACTED]</p>	
PART II - TELEPHONE CONTACT			
<p>8. WOULD YOU LIKE TO RECEIVE A TELEPHONE CALL OR E-MAIL FROM A REPRESENTATIVE AT YOUR LOCAL REGIONAL OFFICE REGARDING YOUR NOD?</p>			
<p><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><i>(If you answered "Yes," VA will make up to two attempts to call you between 8:00 a.m. and 4:30 p.m. local time at the telephone number and time period you select below. Please select up to two time periods you are available to receive a phone call.)</i></p>			
<p><input type="checkbox"/> 8:00 a.m. - 10:00 a.m. <input type="checkbox"/> 10:00 a.m. - 12:30 p.m. <input checked="" type="checkbox"/> 12:30 p.m. - 2:00 p.m. <input type="checkbox"/> 2:00 p.m. - 4:30 p.m.</p>			
<p>Phone number I can be reached at the above checked time [REDACTED]</p>			
PART III - APPEAL PROCESS ELECTION			
<p>9. SELECT ONE OF THE APPEALS PROCESSING METHODS BELOW (See <i>Specific Instructions, Page 2, Part III</i> for additional information)</p>			
<p><input checked="" type="checkbox"/> Decision Review Officer (DRO) Review Process</p>			
<p><input type="checkbox"/> Traditional Appellate Review Process</p>			

VETERAN'S SSN

PART IV - SPECIFIC ISSUES OF DISAGREEMENT**10. NOTIFICATION/DECISION LETTER DATE**

03/03/2016

11. PLEASE LIST EACH SPECIFIC ISSUE OF DISAGREEMENT AND NOTE THE AREA OF DISAGREEMENT. IF YOU DISAGREE ON THE EVALUATION OF A DISABILITY, SPECIFY PERCENTAGE EVALUATION SOUGHT, IF KNOWN. PLEASE LIST ONLY ONE DISABILITY IN EACH BOX. YOU MAY ATTACH ADDITIONAL SHEETS IF NECESSARY.

A. Specific Issue of Disagreement	B. Area of Disagreement	C. Percentage (%) Evaluation Sought (If known)
Depression	<input checked="" type="checkbox"/> Service Connection <input type="checkbox"/> Effective Date of Award <input type="checkbox"/> Evaluation of Disability <input type="checkbox"/> Other (Please specify below) <hr/>	
LT & RT knee condition	<input checked="" type="checkbox"/> Service Connection <input type="checkbox"/> Effective Date of Award <input type="checkbox"/> Evaluation of Disability <input type="checkbox"/> Other (Please specify below) <hr/>	
Lower back condition	<input checked="" type="checkbox"/> Service Connection <input type="checkbox"/> Effective Date of Award <input type="checkbox"/> Evaluation of Disability <input type="checkbox"/> Other (Please specify below) <hr/>	
Anxiety	<input checked="" type="checkbox"/> Service Connection <input type="checkbox"/> Effective Date of Award <input type="checkbox"/> Evaluation of Disability <input type="checkbox"/> Other (Please specify below) <hr/>	
Esophagitis	<input checked="" type="checkbox"/> Service Connection <input type="checkbox"/> Effective Date of Award <input type="checkbox"/> Evaluation of Disability <input type="checkbox"/> Other (Please specify below) <hr/>	

12A. IN THE SPACE BELOW, OR ON A SEPARATE PAGE, PLEASE EXPLAIN WHY YOU FEEL WE INCORRECTLY DECIDED YOUR CLAIM, AND LIST ANY DISAGREEMENT(S) NOT COVERED ABOVE:

Please reference attached 21-4138

12B. DID YOU ATTACH ADDITIONAL PAGES TO THIS NOD?

YES NO (If so, how many?) 2

PART V - CERTIFICATION AND SIGNATURE

I CERTIFY THAT THE STATEMENTS ON THIS FORM ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

PENALTY. THE LAW PROVIDES SEVERE PENALTIES WHICH INCLUDE A FINE, IMPRISONMENT, OR BOTH, FOR THE WILLFUL SUBMISSION OF ANY STATEMENT OR EVIDENCE OF A MATERIAL FACT, KNOWING IT TO BE FALSE.

** PROGRESS NOTES *****

LOCAL TITLE: PRIMARY CARE SECURE MESSAGING
STANDARD TITLE: PRIMARY CARE SECURE MESSAGING

DATE OF NOTE:

AUTHOR:

INSTITUTION:

DIVISION:

URGENCY:

-----Original Message-----

Sent: 03/03/2016 03:30 PM

From:

To: *

Subjec

Dr. [REDACTED]

[REDACTED] a prescription renewal of Omeprazole (20mg) should have noted that I did increase the dosage from 1 per day to 2 per day as you recommended during our last discussion (if 1 per day did not improve my swallowing difficulties). So, the new prescription should reflect this increase.

-----Original Message-----

Sent: 03/04/2016 04:06 PM

RN STAFF

Signed: 03/04/2016 16:06

Receipt Acknowledged By:

03/05/2016 18:05 /es/

LOCAL TITLE: PRIMARY CARE SECURE MESSAGING
STANDARD TITLE: PRIMARY CARE SECURE MESSAGING
DATE OF NOTE: MAR 03, 2016@15:01:29 ENTRY DATE: MAR 03, 2016@15:01:31

AUTHOR: [REDACTED] EXP COSIGNER:
INSTITUTION: FORT BELVOIR VA CLINIC
DIVISION: ALEXANDRIA CBOC
URGENCY: STATUS: COMPLETED

-----Original Message-----

Sent: 03/02/2016 04:14 PM

[REDACTED]
Subject: Medication Refills

I have requested me last refills of Omeprazole (20mg), Hydrochlorothiazide (12.5mg), and Metoprolol Tartrate (100mg). Please provide additional refills for these medications, or advise if I need an appointment to do this.

-----Original Message-----

Sent: 03/03/2016 03:01 PM

[REDACTED]
Subject: Medication Refills

Forwarding your request for medication renewal to [REDACTED]

Please make a convenience. D [REDACTED] at your earliest 15.

[REDACTED]
RN STAFF
Signed: 03/03/2016 15:01

Receipt Acknowledged By:
03/03/2016 16:39 /es/ [REDACTED]
MD

LOCAL TITLE: PRIMARY CARE SECURE MESSAGING
STANDARD TITLE: PRIMARY CARE SECURE MESSAGING
DATE OF NOT [REDACTED] MAR 03, 2016@14:57:37
AUTHO [REDACTED]
INSTITUTIO [REDACTED]
DIVISION: ALEXANDRIA CBOC
URGENCY: STATUS: COMPLETED

-----Original Message-----
Sent: 03/02/2016 04:30 PM
[REDACTED]

[REDACTED]
[REDACTED] rding my depression in September 2015, and she provided [REDACTED] for Duloxetine (60mg/1 per day). This is a medication I [REDACTED] g VA health services. I have an appointment with Dr. [REDACTED] but I will be out of the prescription before then. I didn't know that I wouldn't have the option to communicate my needs, or renew prescriptions except with an appointment with her until now. Are you able to help at all with this circumstance? Please advise how you think I should proceed.
[REDACTED]

-----Original Message-----
Sent: 03/03/2016 02:57 PM
From: [REDACTED]
To: [REDACTED]
Subject: [REDACTED]

Forwarding your concerns [REDACTED]
[REDACTED]
[REDACTED]

Signed: 03/03/2016 14:57

Receipt Acknowledged By:
03/03/2016 16:41 /es/ [REDACTED]
MD
03/07/2016 06:06 /es/ [REDACTED]
NURSE PRACTITIONER

LOCAL TITLE: PCC - TELEPHONE NOTE
STANDARD TITLE: PRIMARY CARE TELEPHONE ENCOUNTER NOTE
DATE OF NOTE: NOV 25, 2015@16:51 ENTRY DATE: NOV 25, 2015@16:51:53
AUTHOR: [REDACTED] EXP COSIGNER:
INSTITUTION: FORT BELVOIR VA CLINIC
DIVISION: ALEXANDRIA CBOC
URGENCY:
STATUS: COMPLETED

Reason for call/Assessment/Plan:

Renewed BP meds.

Discussed in detail endoscopy findings, bx report and GI recommendations for further f/u. He will contact me in 4 weeks with progress of sx of dysphagia on QDaily PPI.

Signed: 11/25/2015 16:53

LOCAL TITLE: GASTROENTEROLOGY BIOPSY RESULTS LETTER

STANDARD TITLE: GASTROENTEROLOGY LETTERS

DATE OF NOTE: NOV 02, 2015@11:33 ENTRY DATE: NOV 02, 2015@11:33:37

AUTHOR: [REDACTED] EXP COSIGNER:

INSTITUTION: WASHINGTON

DIVISION: WASHINGTON VAMC

URGENCY:

STATUS: COMPLETED

The biopsy obtained during your endoscopic exam on Oct 29, 2015:
Did not reveal any sign of cancer., Showed:

DIAGNOSIS

1. ESOPHAGUS, 40 CM, BIOPSY:

GASTRIC MUCOSA WITH CHRONIC INFLAMMATION AND REACTIVE
CHANGES.

NO EVIDENCE OF INTESTINAL METAPLASIA OR DYSPLASIA.

2. PROXIMAL ESOPHAGUS, BIOPSY:

SQUAMOUS MUCOSA, NO SIGNIFICANT HISTOPATHOLOGIC
ABNORMALITY.

3. DISTAL ESOPHAGUS, BIOPSY:

CHRONIC ESOPHAGITIS CONSISTENT WITH REFLUX.

MINUTE SUPERFICIAL STRIPS OF BENIGN GASTRIC GLANDULAR
EPITHELIUM.

These findings are consistent with acid reflux.

Take the medication we prescribed and follow up with primary care.

[REDACTED]
ATTENDING

Signed: 11/02/2015 11:36

Receipt Acknowledged By:

11/02/2015 12:12 /es/ [REDACTED]

ssistant

Page: 4

Printed on: Apr 05, 2016 10:05:15 am

Division: 688



U.S. Department
of Veterans Affairs

Memorandum

Date: May 16, 2016

From: VA Records Management Center

RMC/cja

Subj: Memorandum for Record
Response to Records Request for
[REDACTED]

On 05/26/2016, the VA Records Management Center (RMC) received a request for the following records for the above-named Veteran:

- Clinical Records
- Official Military Personnel File (OMPF)
- Service Treatment Records
- VA Claims File
- Other:

The requested records are:

A search was conducted at the RMC for all records which may be associated with this Veteran, to include claims folder and Service Treatment Records.

All available records (for all periods of service) were pulled by our files activity on 05/16/2016, and delivered to RMC's mailroom to be shipped to the scan vendor (or routed for local scanning). Please allow up to 14 days for upload to VBMS; shipping information will be available in VBMS Intake. No further records are located at the RMC.

Sincerely,

Director
VA Records Management Center

FAX

To: [REDACTED]
Company: [REDACTED]
Fax: [REDACTED]
Phone: [REDACTED]

From: BENEVETS (DVS)

Fax:
Phone:
E-mail:

NOTES:

[REDACTED]

USE THIS COVER SHEET TO FAX CLAIMS TO THE VA'S CLAIMS AND EVIDENCE INTAKE CENTERS



(Eastern and Southern Areas)



VBA's Office of Business Process
Integration

Fax Coversheet and Checklist

To: VBA Claims and Evidence Intake Center
Fax: 844-531-7818
Veterans Claims Intake Program

Veteran First and Last Name _____

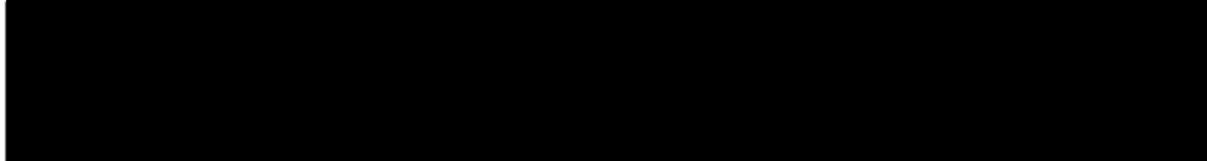
Veteran C File # _____

Claimant Zip Code _____

Fax Date: 05/20/2016

of Pages to include Coversheet: 5

Forms Included:

A large rectangular area of the page has been completely blacked out, obscuring several lines of text that were likely intended to be filled in or listed.

DOUBLE CHECK: Check Confirmation sheet and ensure fax is to

Disclaimer: Incorrect input of fax number, such as dialing the prefix "9" unnecessarily will result in failed submission to VA. Due to similarities in numbers, multiple parties have submitted to the wrong VA department. AVP Metro Petroleum is destroying any faxed Veterans records.

VA Directive 6609, NOVEMBER 9, 2007: NOTICE! Access to Veterans records is limited to Authorized Personnel Only. Information may not be disclosed unless permitted pursuant to 38 CFR 1.500-1.599. The Privacy Act contains provisions for criminal penalties for knowingly and willingly disclosing information from the file unless properly authorized to do so.



STATEMENT IN SUPPORT OF CLAIM

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

RESPONDENT BURDEN: We need this information to obtain evidence in support of your claim for benefits (38 U.S.C. 501(a) and (b)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 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.

FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN (*Type or print*)

SOCIAL SECURITY NO.

VA FILE NO.

The following statement is made in connection with a claim for benefits in the case of the above-named veteran:

Reference VA letter dated 4/27/2016 for additional information records to support my pending NOD. Please see the attached 21-4142.

I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the wilful submission of any statement of evidence of a material fact, knowing it to be false.

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



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

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

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

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

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

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

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

SECTION II - VETERAN IDENTIFICATION

SECTION III - PATIENT IDENTIFICATION FOR RECORDS VA IS REQUESTING

SECTION IV - INFORMATION REGARDING SOURCE OF RECORD(S)

SOURCE OF RECORD(S):

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

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

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

TO WHOM: The Department of Veterans Affairs (VA)

PURPOSE: Determining my eligibility for benefits and whether I can manage such benefits

EXPIRES: This authorization is good for 12 months from the date shown in Item 12

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

[Redacted], YYYY) (Required)

3 PRINTED NAME OF PERSON SIGNING (First, Middle Initial, Last)

4 TELEPHONE NUMBER (Include Area Code)

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

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

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



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

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

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

SECTION I - PATIENT IDENTIFICATION FOR RECORDS VA IS REQUESTING

SECTION II - MEDICAL PROVIDER INFORMATION

4A PROVIDER OR FACILITY NAME

4B DATE(S) OF TREATMENT
(Include the time period (month/day/year) for the treatment by the provider listed in Item 4A)

From 01 01 1995 To 12 31 2000

From To

5C PROVIDER/FACILITY STREET ADDRESS (Number and street, P.O. or rural route)

TELEPHONE NUMBER (Include Area Code)

5A PROVIDER OR FACILITY NAME

5B DATE(S) OF TREATMENT
(Include the time period (month/day/year) for the treatment by the provider listed in Item 5A)

From To

From To

5C PROVIDER/FACILITY STREET ADDRESS (Number and street, P.O. or rural route)

5D CITY

5E STATE AND ZIP CODE

5F PROVIDER OR FACILITY TELEPHONE NUMBER (Include Area Code)

6A PROVIDER OR FACILITY NAME

6B DATE(S) OF TREATMENT
(Include the time period (month/day/year) for the treatment by the provider listed in Item 6A)

From To

From To

6C PROVIDER/FACILITY STREET ADDRESS (Number and street, P.O. or rural route)

6D CITY

6E STATE AND ZIP CODE

6F PROVIDER OR FACILITY TELEPHONE NUMBER (Include Area Code)

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

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

User Name	Entry Time	Message
[REDACTED]	05/24/2016	RO: Request is illegible, unable to process.



Department of Veterans Affairs

APPEAL TO BOARD OF VETERANS' APPEALS

IMPORTANT: Read the attached instructions before you fill out this form. VA also encourages you to get assistance from your representative in filling out this form.

1. NAME OF VETERAN (Last Name, First Name, Middle Initial) [REDACTED]

2. CLAIM FILE NO. (Include prefix) [REDACTED]

3. INSURANCE FILE NO., OR LOAN NO. [REDACTED]

4. I AM THE:

- VETERAN VETERAN'S WIDOW/ER VETERAN'S CHILD VETERAN'S PARENT
 OTHER (Specify) [REDACTED]

5. TELEPHONE NUMBERS

A. HOME (Include Area Code) [REDACTED]

B. WORK (Include Area Code) [REDACTED]

7. IF I AM NOT THE VETERAN, MY NAME IS:

(Last Name, First Name, Middle Initial) [REDACTED]

6. MY ADDRESS IS:

(Number & Street or Post Office Box, City, State & ZIP Code) [REDACTED]

8. HEARING

IMPORTANT: Read the information about this block in paragraph 6 of the attached instructions. This block is used to request a Board of Veterans' Appeals hearing. DO NOT USE THIS FORM TO REQUEST A HEARING BEFORE VA REGIONAL OFFICE PERSONNEL. Check one (and only one) of the following boxes:

- A. I DO NOT WANT A BVA HEARING.
B. I WANT A BVA HEARING IN WASHINGTON, DC.
C. I WANT A BVA HEARING AT A LOCAL VA OFFICE BEFORE A MEMBER, OR MEMBERS, OF THE BVA.
(Not available at Washington, DC, or Baltimore, MD, Regional Offices.)

9. THESE ARE THE ISSUES I WANT TO APPEAL TO THE BVA: (Be sure to read the information about this block in paragraph 6 of the attached instructions.)

- A. I WANT TO APPEAL ALL OF THE ISSUES LISTED ON THE STATEMENT OF THE CASE AND ANY SUPPLEMENTAL STATEMENTS OF THE CASE THAT MY LOCAL VA OFFICE SENT TO ME.
B. I HAVE READ THE STATEMENT OF THE CASE AND ANY SUPPLEMENTAL STATEMENT OF THE CASE I RECEIVED. I AM ONLY APPEALING THESE ISSUES:
(List below.)

RECD. MAIL 04/02/2012
MAIL #751515/2012
5:58

10. HERE IS WHY I THINK THAT VA DECIDED MY CASE INCORRECTLY: (Be sure to read the information about this block in paragraph 6 of the attached instructions.)

recommend surgery, however, was deployed to OCONUS to serve this outstanding nation.

Thank you for your time in this matter.

(Continue on the back, or attach sheets of paper, if you need more space.)

11. SIGNATURE OF PERSON MAKING THIS APPEAL	12. DATE (MM/DD/YYYY)	13. SIGNATURE OF APPOINTED REPRESENTATIVE, IF ANY (Not required if signed by appellant. See paragraph 6 of the instructions.)	14. DATE (MM/DD/YYYY)
[REDACTED]			

04/02/2012

AdobeFormsDesigner

VACAS UPDATE 10/4/2012

DEPARTMENT OF VETERANS AFFAIRS

July 28, 2016

[REDACTED]

In reply, refer to:

[REDACTED]

IMPORTANT -- reply needed

To Whom It May Concern:

The Veteran [REDACTED] as applied for disability benefits and states he or she received [REDACTED] facility.

We would appreciate your sending us all treatment records, hospital summaries, findings and/or diagnoses during the following period(s):

Starting: January 1, 1995, Ending: December 31, 2000

VA has transitioned to a paperless claim processing system. We will no longer send original documents. The enclosed VA Form 21-4142, or its equivalent, is an official VA copy of the document received from the claimant. This letter is being sent in duplicate so that you may retain a copy. Attach the other copy of our letter to your reply to ensure proper identification.

Where To Send Records

Please mail or fax all responses to the appropriate address listed on the attached *Where to Send Your Written Correspondence* chart.

Please send a copy of the available records as soon as possible.

Please provide a negative response if you do not have any information concerning this Veteran.

Please note: We can't pay any fees for this information.



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

Thank you for your assistance.

Sincerely yours,

RO Director
VA Regional Office

Enclosures: Where to Send Your Written Correspondence Chart
 Signed Release
 Duplicate copy of this letter

DEPARTMENT OF VETERANS AFFAIRS

July 28, 2016

Dear Mr. [REDACTED]

We are working on your appeal.

How Should You Submit What We Need?

Please note that the quickest, easiest, and most secure way to submit any documents to us is via the eBenefits website. Just visit www.eBenefits.va.gov to register. Please also refer to the ‘What is eBenefits?’ section of this letter for more information.

You can also send what we need to the appropriate address listed on the attached Where to Send Your Written Correspondence chart.

How Soon Should You Send What We Need?

We strongly encourage you to send any information or evidence as soon as you can. **If we do not hear from you, we may make a decision on your claim after 30 days.**

What Have We Done?

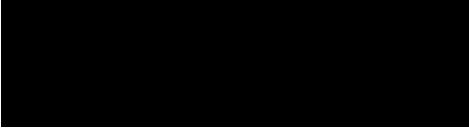
- We have requested copies of treatment records or other evidence from:

[REDACTED] ote: This is our first request for this information.)

Even though we have asked for this information, it is your responsibility to see that VA receives it (except for any evidence kept by the VA, military or any other federal government agency).

What is eBenefits?

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

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

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

How Can You Contact Us?

If you are looking for general information about benefits and eligibility, you should visit our web site at <http://www.va.gov>. Otherwise, you can contact us in several ways. Please give us your VA file number, **227 86 0971**, when you do contact us.

- Call us at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal number is 711 (international number is 1-800-829-4833).
- Send us an inquiry using the Internet at <https://iris.va.gov>.
- Please mail or fax all responses to the appropriate address listed on the attached *Where to Send Your Written Correspondence* chart.

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

Sincerely yours,

RO Director
VA Regional Office

Enclosures: Where to Send Your Written Correspondence





Arthritis [REDACTED]

**FAX COVER SHEET**

Please note the following confidential disclosures:

If medical record information has been faxed to you, be aware that HIPAA regulations and Virginia State Law prohibit you from making any further disclosures of this information without the written consent of the patient or as otherwise permitted under the HIPAA regulations or state law. A general authorization for release of medical information is not sufficient for this purpose.

If you receive this communication in error, please notify us immediately by phone so we can arrange for return of the transmitted documents. Thank you.

Number of Pages: Cover + 19.

Date: Aug 02 2016

If you do not receive the correct number of pages, please call us and let us know.



To: Dept. of Veterans Affairs

Phone: [REDACTED]

Fax: [REDACTED]

Medical Notes



Thank You!

CC

Patient is here for Rheumatology follow-up due to Chronic pain, Osteoarthritis, and elevated CPK levels

HPI

for further evaluation (appointment pending). NSAIDS don't help (meloxicam). Pte C/O pain "all over", with persistent stiffness "all day". He C/O recurrent right hip pain on-and-off for about 10 years with mild degenerative joint disease changes in 11-2011. EMG, MRI head and Lumbar spine were done recently, results not available. No new symptoms lately. No joint swelling or skin lesions.

Lumbar spine were normal and he also had negative HLA-B27. Because of his chronic pain and persistent elevation of with +ANA (SSA) he had a new rheumatology consult after 5 years in 11/2011. He C/O "overall body aches involving muscle and joints with stiffness but no focal muscle weakness. He C/O fatigue, chronic low back pain with occasional radiation into the right posterior thigh, right groin pain and muscle twitching. He has no sicca symptoms, skin lesions, joint swelling or Raynaud's. No major joint or muscle abnormalities have been found at exam. He C/O chronic low back pain that worsened over the years with occasional radiation the right buttocks area and down to the right leg with no distal motor or sensory loss. MRI L-spine in 5/2002 showed degenerative disc changes at L4-L5 and L5-S1, with normal MRI of the Thoracic spine. He received treatment with several antidepressants and opiates. He also had several spinal injections in the past. He has chronic elevation of the CPK. It was up to 1220 in 04/2004 with Aldolase 8.2, serum myoglobin 140, and Creat 1.5. CPK was 789 on 8/29/05 with similar creatinine value. On 1/4/2006 CPK was 1000, Creat 1.5, Myoglobin 226, Aldolase 8.4, and normal CRP & ESR.

metabolic myopathy.

ROS

Denies prolonged morning stiffness or gel phenomenon. No focal weakness, numbness, or tingling. No acute episodes of joint swelling or sausage digits. Denies weight loss, fever, chills, night sweating, anorexia, or abnormal lymph nodes. No snoring or sleep disturbances. No history of tick exposure, skin rash, photosensitivity, psoriasis or Raynaud's. Denies red or dry eyes, no oral or nasal ulcers. No chronic sinusitis or chronic cough. Denies shortness of breath, wheezing or chest pain. No urinary symptoms. Denies chronic diarrhea or constipation. No abdominal pain, nausea or vomiting. No memory loss, LOC or seizures. No easy bruising. Denies weakness, numbness, or tingling. No episodes of joint swelling or sausage digits.

PMH

Sickle cell trait, Depression, HTN, chronic pain syndrome, DJD, genital herpes. No clear H/O statins intake

SH

[Tobacco: Never smoker]
Patient denies any tobacco use. Occasional alcohol consumption.
Work: former sales manager (Engineering)

**Supplemental
Statement of the Case**

*Department of Veterans Affairs
Saint Louis Regional Office*

Page 1

POA
MVC

ISSUE:

1. Evaluation of lumbar spine degenerative joint disease with sclerosis and osteophyte formation currently evaluated as 10 percent disabling.
2. Service connection for left shoulder condition.

EVIDENCE:

- Statement of the Case dated February 6, 2012 and the evidence on which it was based.
- VA Form 9, Appeal to Board of Veteran's Appeals received April 5, 2012.
- VA Medical Center Columbia examination conducted on September 30, 2013.
- Treatment reports from VA Medical Center Columbia for the period June 1, 2010 to April 22, 2013.

ADJUDICATIVE ACTIONS:

- 02-06-2012 The veteran was furnished a Statement of the Case outlining actions taken on the claim.
- 04-03-2012 Substantive Appeal Received.
- 04-05-2012 Substantive Appeal Received.
- 11-07-2013 The veteran was furnished a Supplemental Statement of the Case outlining actions taken on the claim.

PERTINENT LAWS; REGULATIONS; RATING SCHEDULE PROVISIONS:

Unless otherwise indicated, the symbol “§” denotes a section from title 38 of the Code of Federal Regulations, Pensions, Bonuses and Veterans’ Relief. Title 38 contains the regulations of the Department of Veterans Affairs which govern entitlement to all veteran benefits.

38 USC Section 5107 (03/02) Claimant responsibility; benefit of the doubt

(a) CLAIMANT RESPONSIBILITY- Except as otherwise provided by law, a claimant has the responsibility to present and support a claim for benefits under laws administered by the Secretary.

(b) BENEFIT OF THE DOUBT- The Secretary shall consider all information and lay and medical evidence of record in a case before the Secretary with respect to benefits under laws administered by the Secretary. When there is an approximate balance of positive and negative

evidence regarding any issue material to the determination of a matter, the Secretary shall give the benefit of the doubt to the claimant.

DECISION:

1. Evaluation of lumbar spine degenerative joint disease with sclerosis and osteophyte formation, which is currently 10 percent disabling, is increased to 20 percent effective September 30, 2013.
2. Service connection for left shoulder condition remains denied.

REASONS AND BASES:

1. Evaluation of lumbar spine degenerative joint disease with sclerosis and osteophyte formation currently evaluated as 10 percent disabling.

The evaluation of lumbar spine degenerative joint disease with sclerosis and osteophyte formation is increased to 20 percent disabling effective September 30, 2013, date of the VA examination showing an increase in symptoms.

In the VA examination of September 30, 2013, you are noted to report that your back condition has worsened. You state that you currently have persistent pain in the lower back that is worse in the mornings. You report that you have shooting pain in the left thigh that is very brief. Range of the motion of your spine shows forward flexion of 45 degrees, extension of 15 degrees, right lateral flexion of 20 degrees, left lateral flexion of 25 degrees, right lateral rotation of 25 degrees and left lateral rotation of 25 degrees.

We have assigned a 20 percent evaluation for your thoracolumbar spine based on:

- o Forward flexion of the thoracolumbar spine greater than 30 degrees but not greater than 60 degrees

Additional symptom(s) include:

- o Painful motion upon examination
- o Combined range of motion of the thoracolumbar spine greater than 120 degrees but not greater than 235 degrees

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

A higher evaluation of 40 percent is not warranted for thoracolumbar spine unless there is:

- o Forward flexion of the thoracolumbar spine 30 degrees or less; or,
- o Favorable ankylosis of the entire thoracolumbar spine.

2. Service connection for left shoulder condition.

Service connection may be granted for a disability which began in military service or was caused by some event or experience in service. Service connection for left shoulder condition is denied since this condition neither occurred in nor was caused by service.

In the VA examination, the examiner opined that your left shoulder condition is less likely than not (less than 50 percent probability) incurred in or caused by the claimed in-service injury, event, or illness. The examiner noted that your service treatment records are negative for a left shoulder condition during service. The medical records indicate that you injured the left shoulder in January 2004 while not on active duty and that you required surgery shortly after that injury.

Absent evidence showing that this condition is related to military service or it is related to a service connected disability, service connection is denied.

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.

APPLICATION FOR ENLISTMENT - ARMED FORCES OF THE UNITED STATES

OMB 29 R 0331

INSTRUCTIONS

1. The information in this document is to determine your eligibility for enlistment in the Armed Forces of the United States. Some of the information required by law is mandatory. You must indicate clearly on the application for enlistment all the information requested by law in the Armed Forces of the United States.

2. The authority to request the information contained in this document is Title 10, U.S.C., § 501 of title 10, United States Code, which provides qualifications for enlistment in the Armed Forces of the United States. You are required to respond on this application without regard to all questions except those in items 12, 29, 33 and 37.

3. Your answers to questions in items 27 may be given orally or in writing and may be provided on the instructions for that item. Failure to answer completely any of the required questions in the application may result in your being refused enlistment in the Armed Forces.

4. If your application is accepted, it may subsequently be used as a component of the Armed Forces of the United States; the information

provided by you on this application becomes a part of your military personnel records which are used to provide you with medical treatment, pay, retirement, personnel management functions, etc. This form is an OFFICIAL FORM ONLY and will become a part of the files of the Armed Forces and conform with Federal laws and regulations.

5. Mail copies of completed AF 1067 applications to the appropriate command or city by the last day of the month of birth as shown on AF 1067, United States Code.

6. All information supplied by you will be used lawfully, except as required by law, for examination and other purposes by your command. They can be used in situations such as consideration for special assignment, security clearances and court-martial and administrative proceedings.

7. If you print, type or otherwise supply all answers of the above questions, do not apply to this state.

8. If additional space is needed for any answer, continue on item 11, Remarks.

I PERSONAL DATA

6. RACE <input checked="" type="checkbox"/> CAUC. <input type="checkbox"/> NEGRO <input type="checkbox"/> OTHER	7. ETHNIC GROUP C	8. PRESENT ADDRESS (Street, City, State, County, Zip Code) [REDACTED]		
9. MARITAL STATUS Widowed	10. NUMBER OF DEPENDENTS 0	11. DATE OF BIRTH Aug 1942	12. RELIGIOUS PREFERENCE Protestant	13. HIGHEST GRADE COMPLETED 4
14. SELECTIVE SERVICE SYSTEM DATA		15. FOREIGN LANGUAGE PROFICIENCY	16. DIVERSITY INFORMATION	

II EXAMINATION AND ENLISTMENT DATA PROCESSING CODES - FOR OFFICE USE ONLY

17. MENTAL AND APTITUDE RESULTS

a. HEET ID	b. PERCENT SCORED	c. GROUP	d. APTITUDE SCORES
42	63	3	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

18. MEDICAL RESULTS

a.	b.	c.	d.	e.	f.	g.	h.	i.	j.	k.	l.	m.	n.	o.	p.	q.	r.	s.	t.	u.	v.	w.	x.	y.	z.
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	

a. DATE OF ENL	b. ADSD	c. PERD	d. TERM	e. WALTER INFO	f. PAY GRADE	g. DATE OF GRADE	h. ENTRY STAFF
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	301	[REDACTED]	1

19. SERVICE RECORD DATA
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

III. VERIFICATION OF PERSONAL DATA

23. If Preferred Enrollment Name (name given in block 1) is not the same as stated on birth certificate and has not been changed by legal procedure prescribed by state law, complete the following:

a. NAME AS SHOWN ON BIRTH CERTIFICATE

I hereby state that I have not changed my name through any court procedure, and that I prefer to use the name by which I am known in the community as a matter of convenience and with no criminal or fraudulent intent. I further state that I am the same person as the one whose name is shown in block 1.

b. WITNESS (Name, grade, and signature)**c. SIGNATURE OF APPLICANT****24. EDUCATION**

YEAR & MONTH FROM		NAME AND LOCATION OF SCHOOL	GRADUATE YES	DEGREE RECEIVED
			A	BACHELOR

25. CITIZENSHIP VERIFICATION (To be completed in presence of your recruiter)**a. PLACE OF BIRTH (City, State and (if not in USA) Country)****b. BIRTH CERTIFICATE ISSUED BY (County and State)****c. PARENTS' CERTIFICATE NUMBER, DATE, PLACE AND COUNTRY****d. IF ALIEN, ALIEN REGISTRATION NUMBER****e. NATIVE COUNTRY****f. DATE AND PORT OF ENTRY****26. MILITARY SERVICE**

a. Are you now or have ever been in the Regular, Reserve or National Guard of the United States?

No Yes. If "yes", complete the following:

b. PAY GRADE AND SERVICE NUMBER	c. SERVICE AND COMPONENT	d. DATE OF ENTRY	e. DATE OF DISCH	f. TYPE DISCH REC	g. TIME LOST (NO. OF DAYS)

b. If you are now a member of a US Reserve or National Guard organization, fill in organization name and unit address:

27a. PREVIOUS MILITARY SERVICE

**DO NOT WRITE
IN THIS BLOCK**

Total Active Military Service	Year	Months	Days	g. PERIOD	e. ADDRESS
Total Inactive Military Service					

IV. OTHER BACKGROUND DATA

29. COMMERCIAL LIFE INSURANCE POLICY YOU OWN ON YOUR LIFE - Optional entry - used to assist your survivors in filing claims should you die while on active duty.

32. EMPLOYMENT - Show every employment you have had and all periods of unemployment
 a. YEAR & MONTH b. Company name and address (Street, City, State, and Zip Code) c. JOB TITLE d. SUPERVISOR NAME

No Yes. If "yes," give date(s) of employment, government you worked for, location and nature of your duties.

33. MEMBERSHIP IN YOUTH PROGRAMS - Optional entry - you may be eligible for a hip or paygrade based on membership and participation in the youth programs listed below.

No membership

ORGANIZATION	MEMBERSHIP HELD FROM	TO	CONDUCTED BY (SPONSOR)	LOCATION (CITY AND ADDRESS)	YEARS COMPLETED OR LEVEL REACHED
ROTC					YEARS
JROTC					YEARS
CAP			AIR FORCE		LEVEL
SEA CADET			NAVY		LEVEL
OTHER (Specify)					

34. FOREIGN TRAVEL - Other than as a direct result of military service

YEAR & MONTH FROM	COUNTRY VISITED	PURPOSE OF TRAVEL
TO		

35. DECLARATIONS - Explain "Yes" answers in item 41.

- a. HAVE YOU EVER BEEN REJECTED FOR ENLISTMENT, REENLISTMENT, OR INDUCTION INTO ANY BRANCH OF THE ARMED FORCES OF THE UNITED STATES? NO YES
- b. ARE YOU A CONSCIENTIOUS OBJECTOR? NO YES
- c. ARE YOU NOW OR HAVE YOU EVER BEEN A DESERTER FROM ANY BRANCH OF THE ARMED FORCES OF THE UNITED STATES? NO YES
- d. ARE YOU NOW DRAWING, OR DID YOU HAVE AN APPLICATION PENDING, OR APPROVAL FOR, RETIRED PAY, DISABILITY ALLOWANCE, OR SURVIVOR PAY, OR A PENSION FROM THE GOVERNMENT OF THE UNITED STATES? NO YES
- e. ARE YOU THE ONLY LIVING CHILD OF YOUR PARENTS? NO YES

36. UNDERSTANDINGS

37. CHARACTER AND SOCIAL ADJUSTMENT (6 of 6) Consider the following questions as fully as possible and answer them truthfully.

1. If your answer to every question is "truthfully - NO", please indicate in the appropriate space.
2. If your answer to any question in this section is "YES", or you have reservations about answering questions of this nature, you are not required to answer, or explain any of these questions on writing test, or you may request a personal interview, whereupon you may provide the required information for each question orally.
3. If you choose the personal interview, the information you supply may be transcribed, however, any statement made at the interview shall not be retained more than six months after entry upon active duty, and it will not become a part of your personnel military personnel service record.
4. If you ended this interview, this information may be requested from you again at some future date and may become a part of your security investigation at that time. This could occur as a result of your being considered for duties involving access to classified information or other types of duty requiring a personnel security investigation.
5. A "YES" answer will not necessarily disqualify you for enlistment. It will depend on the circumstances surrounding the situation involved.

INITIAL HERE IF YOU PREFER A PERSONAL INTERVIEW

APPLICANT HAS BEEN INTERVIEWED AND IS ELIGIBLE FOR ENLISTMENT INELIGIBLE FOR ENLISTMENT

DATE OF INTERVIEW

NAM, ORGANIZATION & TITLE

INITIALS OR INTERVIEWER

NA

NA

NA

EXPLAIN "YES" ANSWERS IN ITEM 37:

- a. HAVE YOU EVER TAKEN ANY NARCOTIC SUBSTANCE, SEDATIVE, STIMULANT, OR TRANQUILIZER DRUGS EXCEPT AS PRESCRIBED BY A LICENSED PHYSICIAN?
- b. HAVE YOU EVER INTENTIONALLY SNIFLED GLUE, PAINT, THINSPRUC, OR OTHER CHEMICAL FUMES?
- c. HAVE YOU EVER BEEN INVOLVED IN THE USE, PURCHASE, CONSUMPTION, OR SALE OF MARIJUANA, LSD, OR ANY HARMFUL OR HABIT FORMING DRUGS AND/OR CHEMICALS, EXCEPT AS PRESCRIBED BY A LICENSED PHYSICIAN?
- d. HAS YOUR USE OF ALCOHOLIC BEVERAGES CAUSED YOU OR BEEN INVOLVED IN THE LOSS OF A JOB, ARREST BY POLICE, OR TREATMENT FOR ALCOHOLISM?
- e. HAVE YOU EVER BEEN A PATIENT (WHETHER OR NOT VOLUNTARILY) COMMITTED TO ANY INSTITUTION, PRIMARILY DEVOTED TO THE TREATMENT OF MENTAL, NERVOUS, EMOTIONAL, PSYCHOLOGICAL, OR PERSONALITY DISORDERS?
- f. HAVE YOU EVER ENGAGED IN HOMOSEXUAL ACTIVITY (SEXUAL RELATIONS WITH ANOTHER MEMBER OF THE SAME SEX)?

38. MARITAL STATUS AND DEPENDENCY

- a. ARE YOU NOW, OR HAVE YOU EVER BEEN MARRIED?
- b. IF YOU HAVE BEEN MARRIED, ARE YOU NOW LIVING WITH YOUR SPOUSE?
- c. HAVE YOU EVER BEEN DIVORCED? (If yes, enter date, place and court which granted divorce or legal separation)

- d. IS ANY COURT ORDER OR JUDGEMENT BEING MAINTAINED FOR CHILDREN OF ANYONE? (If yes, enter date, place, and court which granted alimony, decree, or support as the result of a paternity suit)

- e. IS ANYONE OTHER THAN YOUR SPOUSE AND/OR CHILDREN SOLELY OR PARTIALLY DEPENDENT UPON YOU? (first name & address)

39. Do you, or have, or either the past ten years, taken you had, belong to, or belong with the specific object of furthering the army of, or adherence to, and active participation in any foreign or domestic organization, movement, group, or combination of persons, places, after referred to as "sabotage", who, usually, advocate or practice the use of acts of force or violence to prevent others from exercising their rights or in the Constitution or laws of the United States, or of any State, or which seeks to overthrow the Government of the United States, or any State, established by constitutional means?

If you answered "yes", give the names of the organizations and include, when known, and year of your membership. Describe the nature of your activities as a member of the organization in the Remarks section Item 41.

40. INVOLVEMENT WITH POLICE OR JUDICIAL AUTHORITIES

YOUR ANSWERS TO THE FOLLOWING QUESTIONS WILL BE PROVIDED TO THE FEDERAL BUREAU OF INVESTIGATION (FBI) & OTHER AGENCIES, TO DETERMINE ANY PREVIOUS RECORDS OF ARREST, CONVICTION, OR JUVENILE COURT ADMISSIONS IN YOUR CONCERNED RECORDS AT THE TIME YOU MAY, UPON ENLISTMENT, BE SUBJECT TO DETERMINATION AS TO WHETHER YOU ARE UNFIT FOR MILITARY SERVICE AND/OR DISCHARGE FROM THE MILITARY SERVICE WITH OTHER THAN AN HONORABLE DISCHARGE.

- a. Have you ever been arrested, charged, cited, or held by Federal, State, or other law enforcement agencies, regardless of whether the citation or charge was dropped or dismissed? If you were tried and not guilty?
- b. As a result of being arrested, charged, cited, or held by law enforcement or other public authorities, have you ever been convicted, held by or forfeited bond to a Federal, State, or other public authority adjudicated a youthful offender or juvenile delinquent regardless of whether the record in your case has been sealed or otherwise struck from the criminal record?
- c. Has you ever been detained, held for, or segregated from an educational institution, vocational school, or industrial school, or any other facility or institution under the jurisdiction of any city, County, State, Federal or foreign country?
- d. Have you ever been awarded, or are you now under suspended sentence, parole, or probation or awaiting any action on charges against you?

NO YES

✓ ✓

✓ ✓

✓ ✓



CERTIFICATION OF APPEAL

1A. NAME OF APPELLANT (<i>If other than veteran</i>). [REDACTED]	1B. RELATIONSHIP TO VETERAN [REDACTED]	2. FILE NUMBER [REDACTED]		
3. LAST NAME - F RST NAME - MIDDLE NAME OF VETERAN) [REDACTED]	4. INSURANCE FILE NO OR LOAN NO. (<i>If pertinent</i>) [REDACTED]			
THE APPEAL IS FOR (State the question(s) at issue clearly and concisely)				
5A. SERVICE CONNECTION FOR left shoulder disability	5B. DATE OF NOTIFICATION OF ACTION APPEALED 04-30-09			
6A. INCREASED RATING FOR DJD, lumbar spine in excess of 20% from 6-27-08 to 4-16-09; in excess of 10% from 5-14-10 to 9-4-11; in excess of 10% from 9-11-12 to 9-30-13 and in excess of 20% from 09-30-13	6B. DATE OF NOTIFICATION OF ACTION APPEALED 06-17-10			
7A. OTHER [REDACTED]	7B. DATE OF NOTIFICATION OF ACTION APPEALED [REDACTED]			
8A. APPELLANT REPRESENTED IN THIS APPEAL BY (Name of Organization, attorney, or agent) Disabled American Veterans				
8B. ONE OF THE FOLLOWING IS ON FILE AS AUTHORITY FOR RECOGNIZING SUCH REPRESENTATIVE IN THIS APPEAL <input checked="" type="checkbox"/> POWER OF ATTORNEY (VA Form 21-22 or VA Form 21-22a) <input type="checkbox"/> CERTIFICATION THAT VALID POWER OF ATTORNEY IS IN ANOTHER VA FILE (<i>If so, specify the file</i>)		8C. IF AGENT DESIGNATED, IS HE/SHE ON ACCREDITED LIST? <input type="checkbox"/> YES <input type="checkbox"/> NO		
9A. IF REPRESENTATIVE IS SERVICE ORGANIZATION IS VA FORM 646, OR EQUIVALENT, OF RECORD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	9B. IF VA FORM 646 IS NOT OF RECORD, EXPLAIN [REDACTED]			
10A. WAS HEARING REQUESTED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	10B. IF HELD, IS TRANSCRIPT IN FILE? <input type="checkbox"/> YES <input type="checkbox"/> NO			
10C. IF REQUESTED BUT NOT HELD, EXPLAIN BVA Travel Board hearing requested				
11A. ARE CONTESTED CLAIMS PROCEDURES APPLICABLE IN THIS CASE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (<i>If "YES", complete item 11B</i>).	11B. HAVE THE REQUIREMENTS OF 38 U.S.C. 7105A BEEN FOLLOWED? <input type="checkbox"/> YES <input type="checkbox"/> NO			
12A. DATE STATEMENT OF THE CASE FURNISHED. 02-06-12	12B. SUPPLEMENTAL STATEMENT OF THE CASE <input checked="" type="checkbox"/> REQUIRED AND FURNISHED <input type="checkbox"/> NOT REQUIRED			
13. RECORDS TO BE FORWARDED TO BOARD OF VETERANS APPEALS				
<input type="checkbox"/> CF OR XCF <input type="checkbox"/> INACTIVE CF	<input type="checkbox"/> R&E F <input type="checkbox"/> TRANSNG SUB-F <input type="checkbox"/> DEP. ED. F (Ch. 35)	<input type="checkbox"/> LOAN GUAR. F <input type="checkbox"/> INSURANCE F <input type="checkbox"/> DENTAL F	<input type="checkbox"/> OUTPATIENT F <input type="checkbox"/> HOSPITAL COR. <input type="checkbox"/> CLINICAL REC.	<input type="checkbox"/> X-RAYS <input type="checkbox"/> SLIDES <input type="checkbox"/> TISSUE BLOCKS
<input checked="" type="checkbox"/> OTHER (<i>Specify</i>) VBMS electronic file				
14. REMARKS (Continue on reverse) Ready for BVA Travel Board hearing Re-certification of remand, dated 11-26-14.				
CERTIFICATION: It is hereby certified that all material evidence is of record, that all contentions advanced by and on behalf of the appellant have been considered under all pertinent laws, and the issues determined.				
15. NAME AND LOCATION OF CERTIFYING OFFICE VA Regional Office St. Louis, MO	16. ORGANIZATIONAL ELEMENT CERTIFYING APPEAL Veterans Service Center			
17A. SIGNATURE OF CERTIFYING OFFICIAL [REDACTED]	17B. TITLE Decision Review Officer	17C. DATE 04-01-15		
18A. SIGNATURE OF MEDICAL MEMBER (<i>Insurance use only</i>)	18B. TITLE	18C. DATE		

64 APS PATIENT IDENTIFICATION

HEALTH RECORD OUTPATIENT	Specify Service & Grade for Military & Retired Military Member
	MILITARY USAF/SSG <input checked="" type="checkbox"/>
	RETIRED MILITARY <input type="checkbox"/>
	NONMILITARY <input type="checkbox"/>

RECEIVED

NOV 18 2002

RMC ST. LOUIS
MAIL CLERK #18

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RECORDS MAINTAINED AT
 459 AEROSPACE MEDICINE SQ
 3757 OREGON CIRCLE
 ANDREWS AFB MD 20762-4814

	SENSITIVE DUTIES PROGRAM (SDP)
	FOOD HANDLER

ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET

8. OCCUPATIONAL HISTORY/RISK

a. PRP		YES	NO
b. FLYING STATUS		YES	NO

9. IMMUNIZATIONS (Enter numeric class in sub block)

(1) IMMUNIZATION	(2) DATE (DDMMYYYY)	(1) IMMUNIZATION	(2) DATE (DDMMYYYY)	(1) IMMUNIZATION	(2) DATE (DDMMYYYY)	(1) IMMUNIZATION	(2) DATE (DDMMYYYY)						
a. HEP A #1		f. MMR #1		j. TD (q 10 yrs) (last)									
b. HEP A #2		g. MMR #2		k. TD (Due)									
c. HEP B #1		h. PNEUMOCOCCUS		i. YELLOW FEVER (last)									
d. HEP B #2		i. POLIO OPV = O IPV = I		m. YELLOW FEVER (Due)									
e. HEP B #3													
n. TYPHOID (Enter numeric class in sub block) ORAL = 0 TYPHUM VI = 1, TYPHOID USP = 2		(1) DATE		(2) DATE		(3) DATE		(4) DATE		(5) DATE		(6) DATE	
o. ANTHRAX	(1) INITIAL DATE	(2) 2 WEEK DATE	(3) 4 WEEK DATE	(4) 6 MONTH DATE	(5) 12 MONTH DATE	(6) 18 MONTH DATE							
p. PPD (Enter mm and date)	(1)(a) mm (b) DATE	(2)(a) mm (b) DATE	(3)(a) mm (b) DATE	(4)(a) mm (b) DATE	(5)(a) mm (b) DATE	(6)(a) mm (b) DATE							
q. INFLUENZA	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE (7) DATE							
r. VARICELLA	(1) DATE	(2) DATE	u. JAPANESE B ENCEPHALITIS	(1) DATE	(2) DATE	(3) DATE (4) DATE							
s. MENINGO	(1) DATE	(2) DATE	v. OTHER (Specify)	(1) DATE	(2) DATE	(3) DATE (4) DATE							
t. ADENO	(1) DATE	(2) DATE	w. OTHER (Specify)	(1) DATE	(2) DATE	(3) DATE							

10. READINESS

* (Glucose-6-phosphate dehydrogenase)

a. DNA	DATE: Nov 97	b. BLOOD TYPE	DATE:	RESULT: Apos	c. G6PD*	DATE:	RESULT: N/NL	d. SICKLE CELL	DATE: Jul 87	RESULT: Pos		
e. PERMANENT PROFILE CHANGE		(1) DATE Jan 97	(2) YR: /	(3) U: /	(4) L: /	(5) H: /	(6) E: /	(7) S: /				
f. GLASSES/GAS MASK Rx:		(1) DATE		(2) DATE		(3) DATE		(4) DATE		(5) DATE		(6) DATE
g. DENTAL EXAM (Enter numeric class in sub block)		(1) DATE		(2) DATE		(3) DATE		(4) DATE		(5) DATE		(6) DATE
h. HIV TESTING		(1) DATE May 96		(2) DATE		(3) DATE		(4) DATE		(5) DATE		(6) DATE
i. FITNESS (In sub block enter P=Pass, F=Fail, W=Waiver)		(1) DATE Physical Exam		(2) DATE May 96		(3) DATE		(4) DATE		(5) DATE		(6) DATE
		(1) DATE		(2) DATE		(3) DATE		(4) DATE		(5) DATE		(6) DATE

11. PRE/POST DEPLOYMENT HISTORY

a. LOCATION						
(1) PREDEPLOYMENT	(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE
(2) POSTDEPLOYMENT	(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE
b. LOCATION						
(1) PREDEPLOYMENT	(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE
(2) POSTDEPLOYMENT	(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE
c. CHART AUDIT	O	O	O	O	O	O

ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET

AMILY HISTORY (M = Mother, F = Father, S = Sibling, MGM = Maternal Grandmother, MGF = Maternal Grandfather, EM = Paternal Grandmother, PGF = Paternal Grandfather)

CANCER (Specify)	
ARTIOVASCULAR DISEASE (Specify)	
DIABETES (Specify)	
ENTAL ILLNESS/CHEMICAL DEPENDENCY (Specify)	

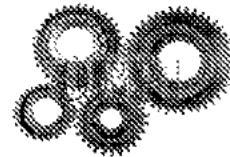
CREENING EXAMS (* = Actual Result, ** = Tricare Benefit, N = Normal, X = Abnormal, E = Done Elsewhere, R = Refused, N = Not Indicated) (● = Next Due)

a. TEST	b. FREQUENCY	c. YEAR	d. AGE	e. DATES					
CLINICAL DISEASE PREV EVAL/PHA (HEAR)	ANNUAL			○	○	○	○	○	○
WEIGHT	ANNUAL FOR ACTIVE DUTY			○	○	○	○	○	○
HEIGHT	ANNUAL FOR ACTIVE DUTY			○	○	○	○	○	○
BLOOD PRESSURE	ONCE q 2 YRS FOR BP < 130/85, ANNUAL IF GREATER			○	○	○	○	○	○
CHOLESTEROL**	q 5 YRS FOR AGE \geq 18 q YR IF PREV ABN			○	○	○	○	○	○
HEARING	CLINICIAN'S DISCRETION			○	○	○	○	○	○
SKIN EXAM (Cancer)	ANNUAL IF AT RISK			○	○	○	○	○	○
ORAL/DENTAL**	ANNUAL			○	○	○	○	○	○
EYE/VISION**	ROUTINE ACUITY WITH PERIODIC ASSESSMENT DIABETES ANNUALLY GLAUCOMA CHECK: Blacks q 3-5 yrs age 20-39 All q 2-4 yrs age 40-64			○	○	○	○	○	○
BREAST EXAM	ANNUAL: $>$ 40 YRS			○	○	○	○	○	○
MAMMOGRAM**	BASELINE @40, q 2 YRS 40-50, ANNUALLY $>$ 50			○	○	○	○	○	○
PAP ** (Digital Rectal Exam)	BASELINE: AGE 18 OR ONSET OF SEXUAL ACTIVITY AFTER 3 NL ANNUAL EXAMS, PERFORM q 1-3 YEARS			○	○	○	○	○	○
FECAL OCCULT BLOOD	ANNUAL: $>$ 50 YRS			○	○	○	○	○	○
SIGMOID	EVERY 3-5 YRS: $>$ 50 YRS			○	○	○	○	○	○
COLONOSCOPY**	HIGH RISK q 5 YRS: $>$ 40 YRS			○	○	○	○	○	○
TESTICULAR**	HIGH RISK ANNUAL 13-39 YRS			○	○	○	○	○	○
PROSTATE** ** (Digital Rectal Exam)	WITH P.E. \geq 40 YRS (Presently recommended annually)			○	○	○	○	○	○
ROSELLA SCREEN (Female)	ONCE BETWEEN AGES 12-18 YRS (Unless prev vaccinated)			○	○	○	○	○	○
OCCUPATIONAL SCREENING EXAMS	APPROPRIATE TO EXPOSURES			○	○	○	○	○	○
				○	○	○	○	○	○
				○	○	○	○	○	○
				○	○	○	○	○	○

USE THIS COVER SHEET TO FAX CLAIMS TO THE VA'S CLAIMS AND EVIDENCE INTAKE CENTERS



(Eastern and Southern Areas)



VBA's Office of Business Process
Integration

Fax Coversheet and Checklist

To: VBA Claims and Evidence Intake Center
Fax: 844-531-7818
Veterans Claims Intake Program

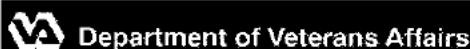
- Veteran First** _____
- Veteran C File** _____
- Claimant Zip** _____
- Fax Date:** 11/24/2015
- # of Pages to include Coversheet:** 5
- Forms Included:**

DOUBLE CHECK: Check Confirmation sheet and ensure fax is to

Disclaimer: Incorrect input of fax number, such as dialing the prefix "9" unnecessarily will result in failed submission to VA. Due to similarities in numbers, multiple parties have submitted to the wrong VA department. AVP Metro Petroleum is destroying any faxed Veterans records.

VA Directive 6609, NOVEMBER 9, 2007: NOTICE! Access to Veterans records is limited to Authorized Personnel Only. Information may not be disclosed unless permitted pursuant to 38 CFR 1.500-1.599. The Privacy Act contains provisions for criminal penalties for knowingly and willingly disclosing information from the file unless properly authorized to do so.

OMB Control No. 2900-0747
 Respondent Burden: 25 minutes
 Expiration Date: 11/30/2017



APPLICATION FOR DISABILITY COMPENSATION AND RELATED COMPENSATION BENEFITS

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 10 before completing the form.

SECTION I: IDENTIFICATION AND CLAIM INFORMATION

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

[REDACTED] YYYY)

4. SEX

MALE

FEMALE

5. HAVE YOU EVER FILED A CLAIM WITH VA?

YES NO (If "Yes," provide your file number in Item 6)

6. VA FILE NUMBER

7A. ARE YOU CURRENTLY HOMELESS OR AT RISK OF BECOMING HOMELESS?

YES NO (If "Yes," complete Items 7B & 7C)

7B. POINT OF CONTACT (Name of person that VA can contact in order to get in touch with you)

7C. POINT OF CONTACT TELEPHONE NUMBER (Include Area Code)

8A. SERVICE (Check all that apply)

ARMY NAVY MARINE CORPS

AIR FORCE COAST GUARD

8B. COMPONENT (Check all that apply)

ACTIVE RESERVES NATIONAL GUARD

9A. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

Number and Street
or Rural Route, P.O.
Box

City, State, ZIP Code

Country

Apt./Unit Number

9B. FORWARDING ADDRESS AND EFFECTIVE DATE

Number and Street
or Rural Route, P.O.
Box

City, State, ZIP Code

Country

Effective Date (MM/DD/YYYY):

9C. PREFERRED TELEPHONE NUMBER

10A. PREFERRED E-MAIL ADDRESS (If applicable)

10B. ALTERNATE E-MAIL ADDRESS (If applicable)

11. LIST THE DISABILITY(IES) YOU ARE CLAIMING (If applicable, identify whether a disability is due to a service-connected disability, is due to confinement as a Prisoner of War, is due to exposure to Agent Orange, Asbestos, Mustard Gas, Ionizing Radiation, or Gulf War Environmental Hazards, or is related to benefits under 38 U.S.C. 1151).

Please list your contentions below. See the following examples, for more information:

- Example 1: Hearing loss
- Example 2: Diabetes-Agent Orange (exposed 12/72, Da Nang)
- Example 3: Left knee - secondary to right knee

DISABILITIES

1.	RT knee pain /range of motion
2.	LT knee secondary to RT knee pain
3.	RT hip pain
4.	Lower Back
5.	depression
6.	anxiety
7.	adding to claim-Esophagitis
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
16.	
17.	
18.	
19.	
20.	

12. 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) AND PROVIDE TREATMENT DATES:

A. NAME AND LOCATION	B. DATE(S) OF TREATMENT
[REDACTED]	08/01/2015
[REDACTED]	08/26/2015
[REDACTED]	

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

For:	Required Form(s):
Dependents	VA Form 21-686c and, if claiming a child aged 18-23 years and in school, VA Form 21-674
Individual Unemployability	VA Form 21-8940 and 21-4192
Post-Traumatic Stress Disorder	VA Form 21-0781 and 21-0781a
Specially Adapted Housing or Special Home Adaptation	VA Form 28-4555
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 II: SERVICE INFORMATION

14A. DID YOU SERVE UNDER ANOTHER NAME? <input type="checkbox"/> YES (If "Yes," complete Item 14B) <input checked="" type="checkbox"/> NO (If "No," skip to Item 15A)		14B. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER: REDACTED	
15A. MOST RECENT ACTIVE SERVICE ENTRY (MM,DD,YYYY)		15B. SERVICE NUMBER (Fill out this item only if assigned a service number)	15C. RELEASE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE SERVICE REDACTED
15D. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001?		15E. PLACE OF LAST OR ANTICIPATED SEPARATION Offutt Air Force Base Omaha	
16A. ARE YOU CURRENTLY SERVING OR HAVE YOU EVER SERVED IN THE RESERVES OR NATIONAL GUARD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If "Yes," complete Items 16B thru 16F) (If "No," skip to Item 17A)		16B. COMPONENT <input type="checkbox"/> NATIONAL GUARD <input type="checkbox"/> RESERVES	16C. OBLIGATION TERM OF SERVICE From: To:
16D. CURRENT OR LAST ASSIGNED NAME AND ADDRESS OF UNIT:		16E. CURRENT OR ASSIGNED PHONE NUMBER OF UNIT (Include Area Code) ()	16F. ARE YOU CURRENTLY RECEIVING INACTIVE DUTY TRAINING PAY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
17A. ARE YOU CURRENTLY ACTIVATED ON FEDERAL ORDERS WITHIN THE NATIONAL GUARD OR RESERVES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If "Yes," complete Items 17B & 17C)		17B. DATE OF ACTIVATION: (MM,DD,YYYY)	17C. ANTICIPATED SEPARATION DATE: (MM,DD,YYYY)
18A. HAVE YOU EVER BEEN A PRISONER OF WAR? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If "Yes," complete Item 18B)		18B. DATES OF CONFINEMENT (MM,DD,YYYY) From: To: REDACTED	

SECTION III: SERVICE PAY

19A. DID/DO YOU RECEIVE ANY TYPE OF SEPARATION/SEVERANCE/RETIRED PAY? 19B. LIST AMOUNT (*If known*) 19C. LIST TYPE (*If known*)
 YES NO (*If "Yes," complete Items 19B and 19C*)

	\$ 701.00	Retired
--	-----------	---------

IMPORTANT: Submission of this application constitutes an election of VA compensation in lieu of military retired pay if it is determined you are entitled to both benefits. If you are entitled to receive military retired pay, your retired pay may be reduced by the amount of any VA compensation that you are awarded. VA will notify the Military Retired Pay Center of all benefit changes. Receipt of military retired pay or Voluntary Separation Incentive (VSI) and VA compensation at the same time may result in an overpayment, which may be subject to collection. However, if you do not want to receive VA compensation in lieu of military retired pay, you should check the box in **Item 20**. Please note that if you check the box in **Item 20**, you *will not* receive VA compensation, if granted.

20. I want military retired pay instead of VA compensation

IMPORTANT: You may elect to keep the training pay for inactive duty training days 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 21**, VA will adjust your VA award to withhold future benefits equal to the total number of inactive duty for training days waived and at the monthly rate in effect for the fiscal year period for which you received training pay. Your normal VA rate will be restored when the sufficient numbers of days' benefits have been withheld.

21. I elect to waive VA benefits for the days I accrued inactive duty training pay in order to retain my inactive duty training pay.

SECTION IV: DIRECT DEPOSIT INFORMATION

The Department of Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. Please attach a voided personal check or deposit slip or provide the information requested below in **Items 22, 23 and 24** to enroll in direct deposit. If you do not have a bank account, you must receive your payment through Direct Express Debit MasterCard. To request a Direct Express Debit MasterCard you must apply at www.usdirectexpress.com or by telephone at 1-800-333-1795. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

22. ACCOUNT NUMBER (*Check the appropriate box and provide the account number, or simply write "Established" if you have a direct deposit with VA*)

I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL CERTIFIED PAYMENT AGENT

23. ACH/ATM NUMBER (*The first nine numbers located at the bottom of your check*)

SECTION V: CLAIM CERTIFICATION AND SIGNATURE

I certify and authorize the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me, and I waive any privilege which makes the information confidential.

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

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility such as a VA medical center; OR, I have no information or evidence to give VA to support my claim; OR, I have checked the box in **Item 25**, indicating that I do not want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.

ALTERNATE SIGNER: By signing on behalf of the claimant, I certify 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 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.

25. The FDC Program is designed to rapidly process compensation or pension claims received with the evidence necessary to decide the claim. VA will automatically consider a claim submitted on this form for rapid processing under the FDC Program. Check the box below **ONLY IF YOU DO NOT WANT YOUR CLAIM CONSIDERED FOR RAPID PROCESSING** under the FDC Program because you plan on submitting further evidence in support of your claim.

evidence in support of my claim.

SECTION VI: WITNESSES TO SIGNATURE

27A. SIGNATURE OF WITNESS (*If veteran signed above using an "X"*)

27B. PRINTED NAME AND ADDRESS OF WITNESS

28A. SIGNATURE OF WITNESS (*If veteran signed above using an "X"*)

28B. PRINTED NAME AND ADDRESS OF WITNESS

SECTION VII: POWER OF ATTORNEY (POA) SIGNATURE

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

NOTE: A POA's signature *will not* be accepted unless at the time of submission of this claim a valid VA Form 21-22, *Appointment of Veterans Service Organization as Claim Agent*, is filed with VA. This form is available at www.vba.va.gov/forms/21-22.html. The claim agent listed on the form must be the appropriate POA is of record with VA.

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(e)(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.regulations.gov/OMB/PRAM/. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.



DEPARTMENT OF VETERANS AFFAIRS

January 20, 2016

In Reply Refer To: **314/MN**
File Number:
[REDACTED]

IMPORTANT – REPLY NEEDED WITHIN 10 DAYS

Dear [REDACTED]

We are continuing to work on your claim.

What Is The Current Status Of Your Claim?

We have requested your Service Treatment Records and determined that your Service Treatment Records cannot be located and therefore are unavailable for review. All efforts to obtain the needed information have been exhausted, and based on these facts, we have determined that further attempts to obtain the records would be unsuccessful.

We have taken the following actions in an effort to obtain these records:

- We contacted NRPC on November 13, 2015 to obtain your Service Treatment Records. However, they responded stating they 'can't identify record based on information received.'

What Do We Still Need From You?

Please submit any relevant documents in your possession including:

- Any available copies of Service Treatment Records as listed above.
- Any other relevant evidence or information that you think will support your claim, to include such things as buddy statements.

If you are unable to submit records, you may also advise us of possible locations(s) of these records.

How Soon Should You Send What We Need?

We strongly encourage you to send any information or evidence as soon as you can. However, if we do not hear from you within **10 days**, we will make a determination on the evidence of record.

How Should You Submit What We Need?

Please note that the quickest, easiest, and most secure way to submit any documents to us is via the eBenefits website. Just visit www.eBenefits.va.gov to register. Please also refer to the ‘What is eBenefits?’ section of this letter for more information.

You can also send what we need to the appropriate address listed on the attached “Where to Send Your Written Correspondence” chart.

What is eBenefits?

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

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

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

Do You Have Questions Or Need Assistance?

If you have any questions, you may contact us by telephone, e-mail, or letter.

If you	Here is what to do.
Telephone	Call us at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal number is 711.
Use the Internet	Send electronic inquiries through the Internet at https://iris.va.gov .
Write	VA now uses a centralized mail system. For all written communications, put your full name and VA file number on the letter. Please mail or fax all written correspondence to the appropriate address listed on the attached <i>Where to Send Your Written Correspondence</i> .

[REDACTED]

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

In all cases, be sure to refer to your VA file [REDACTED]

If you are looking for general information about benefits and eligibility, you should visit our website at <https://www.va.gov>, or search the Frequently Asked Questions (FAQs) at <https://iris.va.gov>.

We have no record of you appointing a service organization or representative to assist you. We have also enclosed information on how Veterans' Service Organizations can help you. You can contact us for a list of the VA recognized Veterans Service Organizations and/or representatives. Veterans Service Organizations which are recognized by VA to provide services to the Veteran community can also help you with questions.

Sincerely yours,

RO Director
VA Regional Office

Enclosures: VA Form 21-4138
VA Form 21-4142
Where to Send Your Written Correspondence



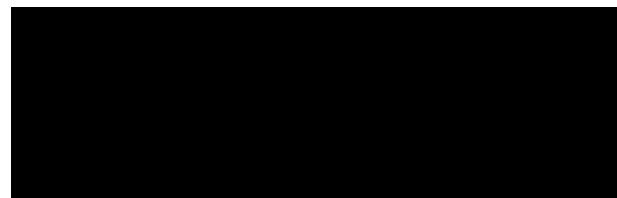
DEPARTMENT OF VETERANS AFFAIRS

Where to Send Your Written Correspondence

Location of Residence	Address to Send all Written Correspondence
Alabama	Ohio
Connecticut	Pennsylvania
Delaware	Rhode Island
District of Columbia	South Carolina
Florida	Tennessee
Georgia	Vermont
Indiana	Virginia
Kentucky	West Virginia
Maine	Puerto Rico
Maryland	
Massachusetts	Europe
Michigan	Asia
Mississippi	Australia
New Hampshire	Africa
New Jersey	Palau
New York	Marshall Islands
North Carolina	Federated States of Micronesia
Alaska	South Dakota
Arizona	Texas
Arkansas	Utah
California	Washington
Colorado	Wisconsin
Louisiana	Wyoming
Hawaii	
Idaho	Canada
Illinois	Mexico
Iowa	Central America
Kansas	South America
Oklahoma	The Caribbean
Oregon	The U.S. Virgin Islands
Minnesota	The Philippines
Missouri	American Samoa
Montana	Guam
Nebraska	Northern Mariana Islands
Nevada	U.S. Virgin Islands
New Mexico	
North Dakota	



**DEPARTMENT OF VETERANS AFFAIRS
Roanoke VA Regional Office
210 FRANKLIN ROAD SW
Roanoke VA
24011**



Represented By:

**Rating Decision
03/01/2016**

INTRODUCTION

[REDACTED] Peacetime. You served in the Air Force from [REDACTED] filed an original disability claim that was received on October 19, 2015. Based on a review of the evidence listed below, we have made the following decision(s) on your claim.

DECISION

1. Service connection for Esophagitis is denied.
2. Service connection for Left knee condition is denied.
3. Service connection for Right knee condition is denied.
4. Service connection for anxiety is denied.
5. Service connection for depression is denied.

[REDACTED]

6. Service connection for lower back is denied.

EVIDENCE

- Service treatment records (STRS) were not available. If records become available in the future we will review the records and this decision at that time.
- VA Form 21-526 received October 19, 2015.
- Washington DC VA Medical Center records dating from August of 2015.
- VA Form 21-4138 received November 19, 2015.
- Exam received November 19, 2015.
- VA letter dated January 19, 2016.
- VA Form 21-4138 received February 5, 2016.
- TRICARE immunization records.

REASONS FOR DECISION

1. Service connection for Esophagitis.

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

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

The evidence does not show an event, disease or injury in service.

We did not find a link between your medical condition and military service.

2. Service connection for Left knee condition.

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

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

The evidence does not show an event, disease or injury in service.



We did not find a link between your medical condition and military service.

3. Service connection for Right knee condition.

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

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

The evidence does not show an event, disease or injury in service.

We did not find a link between your medical condition and military service.

4. Service connection for anxiety.

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

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

The evidence does not show an event, disease or injury in service.

We did not find a link between your medical condition and military service.

5. Service connection for depression.

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

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

The evidence does not show an event, disease or injury in service.

We did not find a link between your medical condition and military service.



6. Service connection for lower back.

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

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

The evidence does not show an event, disease or injury in service.

We did not find a link between your medical condition and military service.

REFERENCES:

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

Rating Decision	<i>Department of Veterans Affairs Roanoke VA Regional Office</i>	Page 1 of 1 03/01/2016
		POA
		COPY TO

ACTIVE DUTY		
	BRANCH	CHARACTER OF DISCHARGE
	Air Force	Honorable

LEGACY CODES			
ADD'L SVC CODE	COMBAT CODE	SPECIAL PROV CDE	FUTURE EXAM DATE
	1		None

JURISDICTION: Original Disability Claim Received 10/19/2015

ASSOCIATED CLAIM(s): 110; Initial Live Comp < 8 issues; 10/19/2015

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

- 5237 LOWER BACK
Not Service Connected, Not Incurred/Caused by Service
- 5257 LEFT KNEE CONDITION
Not Service Connected, Not Incurred/Caused by Service
- 5257 RIGHT KNEE CONDITION
Not Service Connected, Not Incurred/Caused by Service
- 7203 ESOPHAGITIS
Not Service Connected, Not Incurred/Caused by Service
- 9400 ANXIETY
Not Service Connected, Not Incurred/Caused by Service
- 9434 DEPRESSION
Not Service Connected, Not Incurred/Caused by Service

I certify that I have reviewed and electronically signed
this decision."

FAX

To: varo

Company:

Fax:

Phone:

From:

Fax:

Phone:

E-mail:

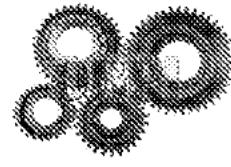
NOTES:

[REDACTED]

USE THIS COVER SHEET TO FAX CLAIMS TO THE VA'S CLAIMS AND EVIDENCE INTAKE CENTERS



(Eastern and Southern Areas)



VBA's Office of Business Process
Integration

Fax Coversheet and Checklist

To: VBA Claims and Evidence Intake Center
Fax: [REDACTED]
Veterans Claims Intake Program

- Veteran First and Last Name: [REDACTED]
- Veteran C File #: C [REDACTED]
- Claimant Zip Code: [REDACTED]
- Fax Date: 04/04/2016
- # of Pages to include Coversheet: 7
- Forms Included:
[REDACTED]

DOUBLE CHECK: Check Confirmation sheet and ensure fax is to

[REDACTED] co [REDACTED] q [REDACTED] o [REDACTED] x [REDACTED] [REDACTED] q [REDACTED] [REDACTED] prefix "9" unnecessarily will result in failed submission to VA. Due to similarities in numbers, multiple parties have submitted to the wrong VA department. AVP Metro Petroleum is destroying any faxed Veterans records.

VA Directive 6609, NOVEMBER 9, 2007: NOTICE! Access to Veterans records is limited to Authorized Personnel Only. Information may not be disclosed unless permitted pursuant to 38 CFR 1.500-1.599. The Privacy Act contains provisions for criminal penalties for knowingly and willingly disclosing information from the file unless properly authorized to do so.

 Department of Veterans Affairs		NOTICE OF DISAGREEMENT
<p>A CLAIMANT OR HIS OR HER DULY APPOINTED REPRESENTATIVE MAY FILE NOTICE EXPRESSING THEIR DISSATISFACTION OR DISAGREEMENT WITH AN ADJUDICATIVE DETERMINATION BY THE VA REGIONAL OFFICE. A DESIRE TO CONTEST THE RESULT WILL CONSTITUTE A NOTICE OF DISAGREEMENT (NOD). WHILE SPECIAL WORDING IS NOT REQUIRED, THE NOD MUST BE IN TERMS WHICH CAN BE REASONABLY CONSTRUED AS DISAGREEMENT WITH THAT DETERMINATION AND A DESIRE FOR APPELLATE REVIEW. (AUTHORITY: 38 U.S.C. 7105)</p> <p>TO FILE A VALID NOD, THERE IS A TIME LIMIT OF ONE YEAR FROM THE DATE VA MAILED THE NOTIFICATION OF THE DECISION TO THE CLAIMANT. FOR CONTESTED CLAIMS INCLUDING CLAIMS OF APPORTIONMENT, THIS TIME LIMIT IS 60 DAYS FROM THE DATE VA MAILED THE NOTIFICATION OF THE DECISION TO THE CLAIMANT.</p> <p>NOTE: You can <i>either</i> complete the form online or by hand. Please print information using blue or black ink, neatly, and legibly to help process the form.</p>		
PART I - PERSONAL INFORMATION		
<p>1. VETERAN'S NAME (<i>First, middle initial, last</i>) [REDACTED]</p> <p>2. VETERAN'S SOCIAL SECURITY NUMBER 3. VA FILE NUMBER [REDACTED]</p>		
CLAIMANT'S PERSONAL INFORMATION		
<p>4. CLAIMANT'S NAME (<i>First, middle initial, last</i>) [REDACTED]</p> <p>5. CURRENT MAILING ADDRESS (<i>Number and street or rural route, P.O. Box, City, State, ZIP Code and Country</i>) [REDACTED]</p>		
<p>6. PREFERRED TELEPHONE NUMBER (<i>Include Area Code</i>) 7. PREFERRED E-MAIL ADDRESS [REDACTED] [REDACTED]</p>		
PART II - TELEPHONE CONTACT		
<p>8. WOULD YOU LIKE TO RECEIVE A TELEPHONE CALL OR E-MAIL FROM A REPRESENTATIVE AT YOUR LOCAL REGIONAL OFFICE REGARDING YOUR NOD?</p> <p><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><i>(If you answered "Yes," VA will make up to two attempts to call you between 8:00 a.m. and 4:30 p.m. local time at the telephone number and time period you select below. Please select up to two time periods you are available to receive a phone call.)</i></p> <p><input type="checkbox"/> 8:00 a.m. - 10:00 a.m. <input type="checkbox"/> 10:00 a.m. - 12:30 p.m. <input checked="" type="checkbox"/> 12:30 p.m. - 2:00 p.m. <input type="checkbox"/> 2:00 p.m. - 4:30 p.m.</p> <p>Phone number I can be reached at the above checked time [REDACTED]</p>		
PART III - APPEAL PROCESS ELECTION		
<p>9. SELECT ONE OF THE APPEALS PROCESSING METHODS BELOW (See <i>Specific Instructions, Page 2, Part III</i> for additional information)</p> <p><input checked="" type="checkbox"/> Decision Review Officer (DRO) Review Process</p> <p><input type="checkbox"/> Traditional Appellate Review Process</p>		

VETERAN'S SSN

PART IV - SPECIFIC ISSUES OF DISAGREEMENT**10. NOTIFICATION/DECISION LETTER DATE**

03/03/2016

11. PLEASE LIST EACH SPECIFIC ISSUE OF DISAGREEMENT AND NOTE THE AREA OF DISAGREEMENT. IF YOU DISAGREE ON THE EVALUATION OF A DISABILITY, SPECIFY PERCENTAGE EVALUATION SOUGHT, IF KNOWN. PLEASE LIST ONLY ONE DISABILITY IN EACH BOX. YOU MAY ATTACH ADDITIONAL SHEETS IF NECESSARY.

A. Specific Issue of Disagreement	B. Area of Disagreement	C. Percentage (%) Evaluation Sought (If known)
Depression	<input checked="" type="checkbox"/> Service Connection <input type="checkbox"/> Effective Date of Award <input type="checkbox"/> Evaluation of Disability <input type="checkbox"/> Other (Please specify below) <hr/>	
LT & RT knee condition	<input checked="" type="checkbox"/> Service Connection <input type="checkbox"/> Effective Date of Award <input type="checkbox"/> Evaluation of Disability <input type="checkbox"/> Other (Please specify below) <hr/>	
Lower back condition	<input checked="" type="checkbox"/> Service Connection <input type="checkbox"/> Effective Date of Award <input type="checkbox"/> Evaluation of Disability <input type="checkbox"/> Other (Please specify below) <hr/>	
Anxiety	<input checked="" type="checkbox"/> Service Connection <input type="checkbox"/> Effective Date of Award <input type="checkbox"/> Evaluation of Disability <input type="checkbox"/> Other (Please specify below) <hr/>	
Esophagitis	<input checked="" type="checkbox"/> Service Connection <input type="checkbox"/> Effective Date of Award <input type="checkbox"/> Evaluation of Disability <input type="checkbox"/> Other (Please specify below) <hr/>	

12A. IN THE SPACE BELOW, OR ON A SEPARATE PAGE, PLEASE EXPLAIN WHY YOU FEEL WE INCORRECTLY DECIDED YOUR CLAIM, AND LIST ANY DISAGREEMENT(S) NOT COVERED ABOVE:

Please reference attached 21-4138

12B. DID YOU ATTACH ADDITIONAL PAGES TO THIS NOD?

YES NO (If so, how many?) 2

PART V - CERTIFICATION AND SIGNATURE

I CERTIFY THAT THE STATEMENTS ON THIS FORM ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

PENALTY. THE LAW PROVIDES SEVERE PENALTIES WHICH INCLUDE A FINE, IMPRISONMENT, OR BOTH, FOR THE WILLFUL SUBMISSION OF ANY STATEMENT OR EVIDENCE OF A MATERIAL FACT, KNOWING IT TO BE FALSE.

** PROGRESS NOTES *****

LOCAL TITLE: PRIMARY CARE SECURE MESSAGING
STANDARD TITLE: PRIMARY CARE SECURE MESSAGING

DATE OF NOTE:

AUTHOR:

INSTITUTION:

DIVISION:

URGENCY:

-----Original Message-----

Sent: 03/03/2016 03:30 PM

From:

To: *

Subjec

Dr. [REDACTED]

[REDACTED] a prescription renewal of Omeprazole (20mg) should have noted that I did increase the dosage from 1 per day to 2 per day as you recommended during our last discussion (if 1 per day did not improve my swallowing difficulties). So, the new prescription should reflect this increase.

-----Original Message-----

Sent: 03/04/2016 04:06 PM

RN STAFF

Signed: 03/04/2016 16:06

Receipt Acknowledged By:

03/05/2016 18:05 /es/

LOCAL TITLE: PRIMARY CARE SECURE MESSAGING
STANDARD TITLE: PRIMARY CARE SECURE MESSAGING
DATE OF NOTE: MAR 03, 2016@15:01:29 ENTRY DATE: MAR 03, 2016@15:01:31

AUTHOR: [REDACTED] EXP COSIGNER:
INSTITUTION: FORT BELVOIR VA CLINIC
DIVISION: ALEXANDRIA CBOC
URGENCY: STATUS: COMPLETED

-----Original Message-----

Sent: 03/02/2016 04:14 PM

[REDACTED]
Subject: Medication Refills

I have requested me last refills of Omeprazole (20mg), Hydrochlorothiazide (12.5mg), and Metoprolol Tartrate (100mg). Please provide additional refills for these medications, or advise if I need an appointment to do this.

-----Original Message-----

Sent: 03/03/2016 03:01 PM

[REDACTED]
Subject: Medication Refills

Forwarding your request for medication renewal to [REDACTED]

Please make a convenience. D [REDACTED] at your earliest 15.

[REDACTED]
RN STAFF
Signed: 03/03/2016 15:01

Receipt Acknowledged By:
03/03/2016 16:39 /es/ [REDACTED]
MD

LOCAL TITLE: PRIMARY CARE SECURE MESSAGING
STANDARD TITLE: PRIMARY CARE SECURE MESSAGING
DATE OF NOT [REDACTED] MAR 03, 2016@14:57:37
AUTHO [REDACTED]
INSTITUTIO [REDACTED]
DIVISION: ALEXANDRIA CBOC
URGENCY: STATUS: COMPLETED

-----Original Message-----
Sent: 03/02/2016 04:30 PM
[REDACTED]

[REDACTED]
[REDACTED] rding my depression in September 2015, and she provided [REDACTED] for Duloxetine (60mg/1 per day). This is a medication I [REDACTED] g VA health services. I have an appointment with Dr. [REDACTED] but I will be out of the prescription before then. I didn't know that I wouldn't have the option to communicate my needs, or renew prescriptions except with an appointment with her until now. Are you able to help at all with this circumstance? Please advise how you think I should proceed.
[REDACTED]

-----Original Message-----
Sent: 03/03/2016 02:57 PM
From: [REDACTED]
To: [REDACTED]
Subject: [REDACTED]

Forwarding your concerns [REDACTED]
[REDACTED]
[REDACTED]

Signed: 03/03/2016 14:57

Receipt Acknowledged By:
03/03/2016 16:41 /es/ [REDACTED]
MD
03/07/2016 06:06 /es/ [REDACTED]
NURSE PRACTITIONER

LOCAL TITLE: PCC - TELEPHONE NOTE
STANDARD TITLE: PRIMARY CARE TELEPHONE ENCOUNTER NOTE
DATE OF NOTE: NOV 25, 2015@16:51 ENTRY DATE: NOV 25, 2015@16:51:53
AUTHOR: [REDACTED] EXP COSIGNER:
INSTITUTION: FORT BELVOIR VA CLINIC
DIVISION: ALEXANDRIA CBOC
URGENCY:
STATUS: COMPLETED

Reason for call/Assessment/Plan:

Renewed BP meds.

Discussed in detail endoscopy findings, bx report and GI recommendations for further f/u. He will contact me in 4 weeks with progress of sx of dysphagia on QDaily PPI.

Signed: 11/25/2015 16:53

LOCAL TITLE: GASTROENTEROLOGY BIOPSY RESULTS LETTER

STANDARD TITLE: GASTROENTEROLOGY LETTERS

DATE OF NOTE: NOV 02, 2015@11:33 ENTRY DATE: NOV 02, 2015@11:33:37

AUTHOR: [REDACTED] EXP COSIGNER:

INSTITUTION: WASHINGTON

DIVISION: WASHINGTON VAMC

URGENCY:

STATUS: COMPLETED

The biopsy obtained during your endoscopic exam on Oct 29, 2015:
Did not reveal any sign of cancer., Showed:

DIAGNOSIS

1. ESOPHAGUS, 40 CM, BIOPSY:

GASTRIC MUCOSA WITH CHRONIC INFLAMMATION AND REACTIVE
CHANGES.

NO EVIDENCE OF INTESTINAL METAPLASIA OR DYSPLASIA.

2. PROXIMAL ESOPHAGUS, BIOPSY:

SQUAMOUS MUCOSA, NO SIGNIFICANT HISTOPATHOLOGIC
ABNORMALITY.

3. DISTAL ESOPHAGUS, BIOPSY:

CHRONIC ESOPHAGITIS CONSISTENT WITH REFLUX.

MINUTE SUPERFICIAL STRIPS OF BENIGN GASTRIC GLANDULAR
EPITHELIUM.

These findings are consistent with acid reflux.

Take the medication we prescribed and follow up with primary care.

[REDACTED]
ATTENDING

Signed: 11/02/2015 11:36

Receipt Acknowledged By:

11/02/2015 12:12 /es/ [REDACTED]

ssistant

Page: 4

Printed on: Apr 05, 2016 10:05:15 am

Division: 688



U.S. Department
of Veterans Affairs

Memorandum

Date: May 16, 2016

From: VA Records Management Center

RMC/cja

Subj: Memorandum for Record
Response to Records Request for
[REDACTED]

On 05/26/2016, the VA Records Management Center (RMC) received a request for the following records for the above-named Veteran:

- Clinical Records
- Official Military Personnel File (OMPF)
- Service Treatment Records
- VA Claims File
- Other:

The requested records are:

A search was conducted at the RMC for all records which may be associated with this Veteran, to include claims folder and Service Treatment Records.

All available records (for all periods of service) were pulled by our files activity on 05/16/2016, and delivered to RMC's mailroom to be shipped to the scan vendor (or routed for local scanning). Please allow up to 14 days for upload to VBMS; shipping information will be available in VBMS Intake. No further records are located at the RMC.

Sincerely,

Director
VA Records Management Center

FAX

To:

Company:

Fax:

Phone:

From: BENEVETS (DVS)

Fax:

Phone:

E-mail:

NOTES:

[REDACTED]

USE THIS COVER SHEET TO FAX CLAIMS TO THE VA'S CLAIMS AND EVIDENCE INTAKE CENTERS



(Eastern and Southern Areas)



VBA's Office of Business Process
Integration

Fax Coversheet and Checklist

To: VBA Claims and Evidence Intake Center
Fax: 844-531-7818
Veterans Claims Intake Program

Veteran First and Last Name _____

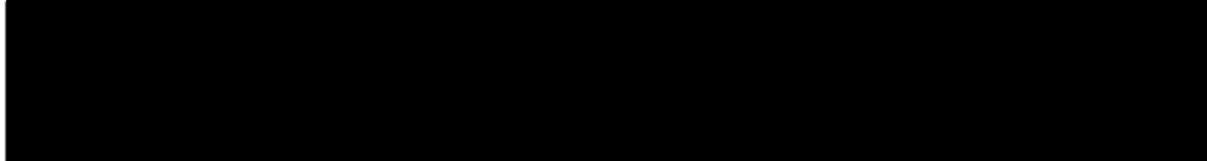
Veteran C File # _____

Claimant Zip Code _____

Fax Date: 05/20/2016

of Pages to include Coversheet: 5

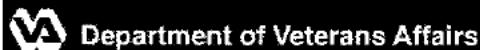
Forms Included:

A large rectangular area of the page has been completely blacked out, obscuring several lines of text that were likely intended to be filled in or listed.

DOUBLE CHECK: Check Confirmation sheet and ensure fax is to

Disclaimer: Incorrect input of fax number, such as dialing the prefix "9" unnecessarily will result in failed submission to VA. Due to similarities in numbers, multiple parties have submitted to the wrong VA department. AVP Metro Petroleum is destroying any faxed Veterans records.

VA Directive 6609, NOVEMBER 9, 2007: NOTICE! Access to Veterans records is limited to Authorized Personnel Only. Information may not be disclosed unless permitted pursuant to 38 CFR 1.500-1.599. The Privacy Act contains provisions for criminal penalties for knowingly and willingly disclosing information from the file unless properly authorized to do so.



STATEMENT IN SUPPORT OF CLAIM

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

RESPONDENT BURDEN: We need this information to obtain evidence in support of your claim for benefits (38 U.S.C. 501(a) and (b)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 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.

FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN (*Type or print*)

SOCIAL SECURITY NO.

VA FILE NO.

The following statement is made in connection with a claim for benefits in the case of the above-named veteran:

Reference VA letter dated 4/27/2016 for additional information records to support my pending NOD. Please see the attached 21-4142.

I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the wilful submission of any statement of evidence of a material fact, knowing it to be false.

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



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

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

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

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

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

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

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

SECTION II - VETERAN IDENTIFICATION

SECTION III - PATIENT IDENTIFICATION FOR RECORDS VA IS REQUESTING

SECTION IV - INFORMATION REGARDING SOURCE OF RECORD(S)

SOURCE OF RECORD(S):

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

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

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

TO WHOM: The Department of Veterans Affairs (VA)

PURPOSE: Determining my eligibility for benefits and whether I can manage such benefits

EXPIRES: This authorization is good for 12 months from the date shown in Item 12

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

[Redacted], YYYY) (Required)

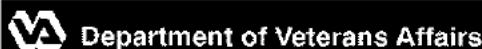
3 PRINTED NAME OF PERSON SIGNING (First, Middle Initial, Last)

4 TELEPHONE NUMBER (Include Area Code)

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

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

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



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

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

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

SECTION I - PATIENT IDENTIFICATION FOR RECORDS VA IS REQUESTING

SECTION II - MEDICAL PROVIDER INFORMATION

4A PROVIDER OR FACILITY NAME

4B DATE(S) OF TREATMENT
(Include the time period (month/day/year) for the treatment by the provider listed in Item 4A)

From 01 01 1995 To 12 31 2000

From To

5C PROVIDER/FACILITY STREET ADDRESS (Number and street, P.O. or rural route)

TELEPHONE NUMBER (Include Area Code)

5A PROVIDER OR FACILITY NAME

5B DATE(S) OF TREATMENT
(Include the time period (month/day/year) for the treatment by the provider listed in Item 5A)

From To

From To

5C PROVIDER/FACILITY STREET ADDRESS (Number and street, P.O. or rural route)

5D CITY

5E STATE AND ZIP CODE

5F PROVIDER OR FACILITY TELEPHONE NUMBER (Include Area Code)

6A PROVIDER OR FACILITY NAME

6B DATE(S) OF TREATMENT
(Include the time period (month/day/year) for the treatment by the provider listed in Item 6A)

From To

From To

6C PROVIDER/FACILITY STREET ADDRESS (Number and street, P.O. or rural route)

6D CITY

6E STATE AND ZIP CODE

6F PROVIDER OR FACILITY TELEPHONE NUMBER (Include Area Code)

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

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

User Name	Entry Time	Message
[REDACTED]	05/24/2016	RO: Request is illegible, unable to process.



Department of Veterans Affairs

APPEAL TO BOARD OF VETERANS' APPEALS

IMPORTANT: Read the attached instructions before you fill out this form. VA also encourages you to get assistance from your representative in filling out this form.

1. NAME OF VETERAN (Last Name, First Name, Middle Initial) [REDACTED]

2. CLAIM FILE NO. (Include prefix) [REDACTED]

3. INSURANCE FILE NO., OR LOAN NO. [REDACTED]

4. I AM THE:

- VETERAN VETERAN'S WIDOW/ER VETERAN'S CHILD VETERAN'S PARENT
 OTHER (Specify) [REDACTED]

5. TELEPHONE NUMBERS

A. HOME (Include Area Code) [REDACTED]

B. WORK (Include Area Code) [REDACTED]

7. IF I AM NOT THE VETERAN, MY NAME IS:

(Last Name, First Name, Middle Initial) [REDACTED]

6. MY ADDRESS IS:
(Number & Street or Post Office Box, City, State & ZIP Code)
[REDACTED]

8. HEARING

IMPORTANT: Read the information about this block in paragraph 6 of the attached instructions. This block is used to request a Board of Veterans' Appeals hearing. DO NOT USE THIS FORM TO REQUEST A HEARING BEFORE VA REGIONAL OFFICE PERSONNEL.
Check one (and only one) of the following boxes:

- A. I DO NOT WANT A BVA HEARING.
B. I WANT A BVA HEARING IN WASHINGTON, DC.
C. I WANT A BVA HEARING AT A LOCAL VA OFFICE BEFORE A MEMBER, OR MEMBERS, OF THE BVA.
(Not available at Washington, DC, or Baltimore, MD, Regional Offices.)

9. THESE ARE THE ISSUES I WANT TO APPEAL TO THE BVA: (Be sure to read the information about this block in paragraph 6 of the attached instructions.)

- A. I WANT TO APPEAL ALL OF THE ISSUES LISTED ON THE STATEMENT OF THE CASE AND ANY SUPPLEMENTAL STATEMENTS OF THE CASE THAT MY LOCAL VA OFFICE SENT TO ME.
B. I HAVE READ THE STATEMENT OF THE CASE AND ANY SUPPLEMENTAL STATEMENT OF THE CASE I RECEIVED. I AM ONLY APPEALING THESE ISSUES:
(List below.)

RECD. MAIL 04/02/2012
MAIL #751515/2012
P-5:58

10. HERE IS WHY I THINK THAT VA DECIDED MY CASE INCORRECTLY: (Be sure to read the information about this block in paragraph 6 of the attached instructions.)
[REDACTED]

recommend surgery, however, was deployed to OCONUS to serve this outstanding nation.

Thank you for your time in this matter.

(Continue on the back, or attach sheets of paper, if you need more space.)

11. SIGNATURE OF PERSON MAKING THIS APPEAL	12. DATE (MM/DD/YYYY)	13. SIGNATURE OF APPOINTED REPRESENTATIVE, IF ANY (Not required if signed by appellant. See paragraph 6 of the attached instructions.)	14. DATE (MM/DD/YYYY)
[REDACTED]			

04/02/2012

AdobeFormsDesigner

VACAS UPDATE 10/4/2012

DEPARTMENT OF VETERANS AFFAIRS

July 28, 2016

[REDACTED]

In reply, refer to:

[REDACTED]

IMPORTANT -- reply needed

To Whom It May Concern:

The Veteran [REDACTED] as applied for disability benefits and states he or she received [REDACTED] facility.

We would appreciate your sending us all treatment records, hospital summaries, findings and/or diagnoses during the following period(s):

Starting: January 1, 1995, Ending: December 31, 2000

VA has transitioned to a paperless claim processing system. We will no longer send original documents. The enclosed VA Form 21-4142, or its equivalent, is an official VA copy of the document received from the claimant. This letter is being sent in duplicate so that you may retain a copy. Attach the other copy of our letter to your reply to ensure proper identification.

Where To Send Records

Please mail or fax all responses to the appropriate address listed on the attached *Where to Send Your Written Correspondence* chart.

Please send a copy of the available records as soon as possible.

Please provide a negative response if you do not have any information concerning this Veteran.

Please note: We can't pay any fees for this information.



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

Thank you for your assistance.

Sincerely yours,

RO Director
VA Regional Office

Enclosures: Where to Send Your Written Correspondence Chart
 Signed Release
 Duplicate copy of this letter

DEPARTMENT OF VETERANS AFFAIRS

July 28, 2016

Dear Mr. [REDACTED]

We are working on your appeal.

How Should You Submit What We Need?

Please note that the quickest, easiest, and most secure way to submit any documents to us is via the eBenefits website. Just visit www.eBenefits.va.gov to register. Please also refer to the ‘What is eBenefits?’ section of this letter for more information.

You can also send what we need to the appropriate address listed on the attached Where to Send Your Written Correspondence chart.

How Soon Should You Send What We Need?

We strongly encourage you to send any information or evidence as soon as you can. **If we do not hear from you, we may make a decision on your claim after 30 days.**

What Have We Done?

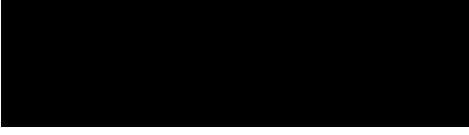
- We have requested copies of treatment records or other evidence from:

[REDACTED] ote: This is our first request for this information.)

Even though we have asked for this information, it is your responsibility to see that VA receives it (except for any evidence kept by the VA, military or any other federal government agency).

What is eBenefits?

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

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

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

How Can You Contact Us?

If you are looking for general information about benefits and eligibility, you should visit our web site at <http://www.va.gov>. Otherwise, you can contact us in several ways. Please give us your VA file number, **227 86 0971**, when you do contact us.

- Call us at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal number is 711 (international number is 1-800-829-4833).
- Send us an inquiry using the Internet at <https://iris.va.gov>.
- Please mail or fax all responses to the appropriate address listed on the attached *Where to Send Your Written Correspondence* chart.

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

Sincerely yours,

RO Director
VA Regional Office

Enclosures: Where to Send Your Written Correspondence





Arthritis [REDACTED]

**FAX COVER SHEET**

Please note the following confidential disclosures:

If medical record information has been faxed to you, be aware that HIPAA regulations and Virginia State Law prohibit you from making any further disclosures of this information without the written consent of the patient or as otherwise permitted under the HIPAA regulations or state law. A general authorization for release of medical information is not sufficient for this purpose.

If you receive this communication in error, please notify us immediately by phone so we can arrange for return of the transmitted documents. Thank you.

Number of Pages: Cover + 19. Date: Aug 02 2016

If you do not receive the correct number of pages, please call us and let us know.



To: Dept. of Veterans Affairs

Phone: [REDACTED]

Fax: [REDACTED]

Medical Notes



Thank You!

CC

Patient is here for Rheumatology follow-up due to Chronic pain, Osteoarthritis, and elevated CPK levels

HPI

for further evaluation (appointment pending). NSAIDS don't help (meloxicam). Pte C/O pain "all over", with persistent stiffness "all day". He C/O recurrent right hip pain on-and-off for about 10 years with mild degenerative joint disease changes in 11-2011. EMG, MRI head and Lumbar spine were done recently, results not available. No new symptoms lately. No joint swelling or skin lesions.

Lumbar spine were normal and he also had negative HLA-B27. Because of his chronic pain and persistent elevation of with +ANA (SSA) he had a new rheumatology consult after 5 years in 11/2011. He C/O "overall body aches involving muscle and joints with stiffness but no focal muscle weakness. He C/O fatigue, chronic low back pain with occasional radiation into the right posterior thigh, right groin pain and muscle twitching. He has no sicca symptoms, skin lesions, joint swelling or Raynaud's. No major joint or muscle abnormalities have been found at exam. He C/O chronic low back pain that worsened over the years with occasional radiation the right buttocks area and down to the right leg with no distal motor or sensory loss. MRI L-spine in 5/2002 showed degenerative disc changes at L4-L5 and L5-S1, with normal MRI of the Thoracic spine. He received treatment with several antidepressants and opiates. He also had several spinal injections in the past. He has chronic elevation of the CPK. It was up to 1220 in 04/2004 with Aldolase 8.2, serum myoglobin 140, and Creat 1.5. CPK was 789 on 8/29/05 with similar creatinine value. On 1/4/2006 CPK was 1000, Creat 1.5, Myoglobin 226, Aldolase 8.4, and normal CRP & ESR.

metabolic myopathy.

ROS

Denies prolonged morning stiffness or gel phenomenon. No focal weakness, numbness, or tingling. No acute episodes of joint swelling or sausage digits. Denies weight loss, fever, chills, night sweating, anorexia, or abnormal lymph nodes. No snoring or sleep disturbances. No history of tick exposure, skin rash, photosensitivity, psoriasis or Raynaud's. Denies red or dry eyes, no oral or nasal ulcers. No chronic sinusitis or chronic cough. Denies shortness of breath, wheezing or chest pain. No urinary symptoms. Denies chronic diarrhea or constipation. No abdominal pain, nausea or vomiting. No memory loss, LOC or seizures. No easy bruising. Denies weakness, numbness, or tingling. No episodes of joint swelling or sausage digits.

PMH

Sickle cell trait, Depression, HTN, chronic pain syndrome, DJD, genital herpes. No clear H/O statins intake

SH

[Tobacco: Never smoker]
Patient denies any tobacco use. Occasional alcohol consumption.
Work: former sales manager (Engineering)

**Supplemental
Statement of the Case**

*Department of Veterans Affairs
Saint Louis Regional Office*

Page 1

POA
MVC

ISSUE:

1. Evaluation of lumbar spine degenerative joint disease with sclerosis and osteophyte formation currently evaluated as 10 percent disabling.
2. Service connection for left shoulder condition.

EVIDENCE:

- Statement of the Case dated February 6, 2012 and the evidence on which it was based.
- VA Form 9, Appeal to Board of Veteran's Appeals received April 5, 2012.
- VA Medical Center Columbia examination conducted on September 30, 2013.
- Treatment reports from VA Medical Center Columbia for the period June 1, 2010 to April 22, 2013.

ADJUDICATIVE ACTIONS:

- 02-06-2012 The veteran was furnished a Statement of the Case outlining actions taken on the claim.
- 04-03-2012 Substantive Appeal Received.
- 04-05-2012 Substantive Appeal Received.
- 11-07-2013 The veteran was furnished a Supplemental Statement of the Case outlining actions taken on the claim.

PERTINENT LAWS; REGULATIONS; RATING SCHEDULE PROVISIONS:

Unless otherwise indicated, the symbol “§” denotes a section from title 38 of the Code of Federal Regulations, Pensions, Bonuses and Veterans’ Relief. Title 38 contains the regulations of the Department of Veterans Affairs which govern entitlement to all veteran benefits.

38 USC Section 5107 (03/02) Claimant responsibility; benefit of the doubt

(a) CLAIMANT RESPONSIBILITY- Except as otherwise provided by law, a claimant has the responsibility to present and support a claim for benefits under laws administered by the Secretary.

(b) BENEFIT OF THE DOUBT- The Secretary shall consider all information and lay and medical evidence of record in a case before the Secretary with respect to benefits under laws administered by the Secretary. When there is an approximate balance of positive and negative

evidence regarding any issue material to the determination of a matter, the Secretary shall give the benefit of the doubt to the claimant.

DECISION:

1. Evaluation of lumbar spine degenerative joint disease with sclerosis and osteophyte formation, which is currently 10 percent disabling, is increased to 20 percent effective September 30, 2013.
2. Service connection for left shoulder condition remains denied.

REASONS AND BASES:

1. Evaluation of lumbar spine degenerative joint disease with sclerosis and osteophyte formation currently evaluated as 10 percent disabling.

The evaluation of lumbar spine degenerative joint disease with sclerosis and osteophyte formation is increased to 20 percent disabling effective September 30, 2013, date of the VA examination showing an increase in symptoms.

In the VA examination of September 30, 2013, you are noted to report that your back condition has worsened. You state that you currently have persistent pain in the lower back that is worse in the mornings. You report that you have shooting pain in the left thigh that is very brief. Range of the motion of your spine shows forward flexion of 45 degrees, extension of 15 degrees, right lateral flexion of 20 degrees, left lateral flexion of 25 degrees, right lateral rotation of 25 degrees and left lateral rotation of 25 degrees.

We have assigned a 20 percent evaluation for your thoracolumbar spine based on:

- o Forward flexion of the thoracolumbar spine greater than 30 degrees but not greater than 60 degrees

Additional symptom(s) include:

- o Painful motion upon examination
- o Combined range of motion of the thoracolumbar spine greater than 120 degrees but not greater than 235 degrees

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

A higher evaluation of 40 percent is not warranted for thoracolumbar spine unless there is:

- o Forward flexion of the thoracolumbar spine 30 degrees or less; or,
- o Favorable ankylosis of the entire thoracolumbar spine.

2. Service connection for left shoulder condition.

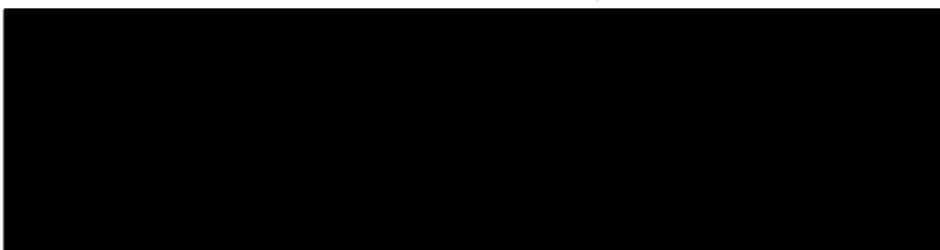
Service connection may be granted for a disability which began in military service or was caused by some event or experience in service. Service connection for left shoulder condition is denied since this condition neither occurred in nor was caused by service.

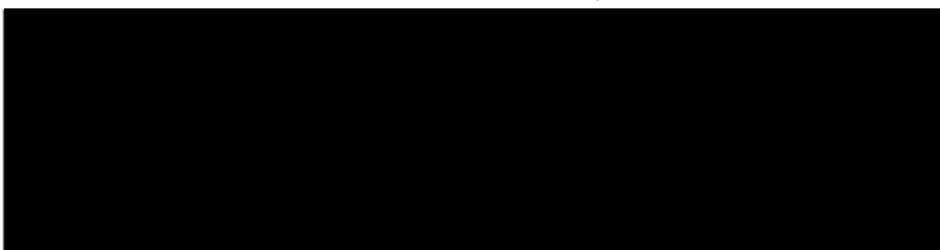
In the VA examination, the examiner opined that your left shoulder condition is less likely than not (less than 50 percent probability) incurred in or caused by the claimed in-service injury, event, or illness. The examiner noted that your service treatment records are negative for a left shoulder condition during service. The medical records indicate that you injured the left shoulder in January 2004 while not on active duty and that you required surgery shortly after that injury.

Absent evidence showing that this condition is related to military service or it is related to a service connected disability, service connection is denied.

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.





APPLICATION FOR ENLISTMENT - ARMED FORCES OF THE UNITED STATES

OMB 29 R 0331

INSTRUCTIONS

1. The information in this document is to determine your eligibility for enlistment in the Armed Forces of the United States. Some of the information required by law is mandatory. You must answer all questions to provide the information necessary to determine your eligibility in the Armed Forces of the United States.

2. The authority to request the information contained in this document is Title 10, U.S.C., § 501 of title 10, United States Code, which provides qualifications for enlistment in the Armed Forces of the United States. You are requested to read on this application, without answers to all questions except those in items 12, 29, 33 and 37.

3. Your answers to questions in items 27 may be given orally in a personal interview as provided in the instructions for that item. Failure to answer completely any of the required questions on this application may result in your being refused enlistment in the Armed Forces.

4. If your application is accepted, it is your responsibility to furnish information to the Armed Forces of the United States. The information

provided by you on this application becomes a part of your military personnel records which are used to process your request to enlist. You are subject to personnel management actions if you fail to meet OMB STANDARDS OF QUALITY and will be subject to the laws of the Armed Forces and Federal law and regulation.

5. Mail inquiries concerning OMB standards of quality to the application control city by letter or telegram or to the address section 10004 of the 10, United States Code.

6. Your statement(s) appended by you when enlisting automatically consent and permit the use of your name and other personal information in any manner in situations such as consideration for special assignment, security clearances and court-martial and administrative proceedings.

7. If you print, type or orally answer all the above questions, and if not applicable, use state.

8. If additional space is needed for any answer, continue on item 11, Remarks.

I PERSONAL DATA

6. RACE <input checked="" type="checkbox"/> CAUC. <input checked="" type="checkbox"/> NEGRO <input type="checkbox"/> OTHER	7. ETHNIC GROUP C	8. PRESENT ADDRESS (Street, City, State, County, Zip Code) [REDACTED]		
9. MARITAL STATUS Widowed	10. NUMBER OF DEPENDENTS 0	11. DATE OF BIRTH 1 Aug 1942	12. RELIGIOUS PREFERENCE Protestant	13. HIGHEST GRADE COMPLETED 4
14. SELECTIVE SERVICE SYSTEM DATA		15. FOREIGN LANGUAGE PROFICIENCY	16. DIVERSITY INFORMATION	

II EXAMINATION AND ENLISTMENT DATA PROCESSING CODES - FOR OFFICE USE ONLY

17. MENTAL AND APTITUDE RESULTS

a. HEET ID	b. PERCENT SCORED	c. GROUP	d. APTITUDE SCORES
42	63	3	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

18. MEDICAL RESULTS

a.	b.	c.	d.	e.	f.	g.	h.	i.	j.	k.	l.	m.	n.	o.	p.	q.	r.	s.	t.	u.	v.	w.	x.	y.	z.
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1

a. DATE OF ENL	b. ADSD	c. PERD	d. TERM	e. WALTER INFO	f. PAY GRADE	g. DATE OF GRADE	h. ENTRY STAFF
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	301	[REDACTED]	1

19. SERVICE RECORD DATA
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

III. VERIFICATION OF PERSONAL DATA

23. If Preferred Enrollment Name (name given in block 1) is not the same as stated on birth certificate and has not been changed by legal procedure prescribed by state law, complete the following:

a. NAME AS SHOWN ON BIRTH CERTIFICATE

I hereby state that I have not changed my name through any court procedure, and that I prefer to use the name by which I am known in the community as a matter of convenience and with no criminal or fraudulent intent. I further state that I am the same person as the one whose name is shown in block 1.

b. WITNESS (Name, grade, and signature)**c. SIGNATURE OF APPLICANT****24. EDUCATION**

YEAR & MONTH FROM		NAME AND LOCATION OF SCHOOL	GRADUATE YES	DEGREE RECEIVED
			A	BACHELOR

25. CITIZENSHIP VERIFICATION (To be completed in presence of your recruiter)**a. PLACE OF BIRTH (City, State and (if not in USA) Country)****b. BIRTH CERTIFICATE ISSUED BY (County and State)****c. PARENTS' CERTIFICATE NUMBER, DATE, PLACE AND COUNTRY****d. IF ALIEN, ALIEN REGISTRATION NUMBER****e. NATIVE COUNTRY****f. DATE AND PORT OF ENTRY****26. MILITARY SERVICE**

a. Are you now or have ever been in the Regular, Reserve or National Guard of the United States?

No Yes. If "yes", complete the following:

b. PAY GRADE AND SERVICE NUMBER	c. SERVICE AND COMPONENT	d. DATE OF ENTRY	e. DATE OF DISCH	f. TYPE DISCH REC	g. TIME LOST (NO. OF DAYS)

b. If you are now a member of a US Reserve or National Guard organization, fill in organization name and unit address:

27a. PREVIOUS MILITARY SERVICE

**DO NOT WRITE
IN THIS BLOCK**

Total Active Military Service	Year	Months	Days	g. PERIOD	c. ADDRESS
Total Inactive Military Service					

IV. OTHER BACKGROUND DATA

29. COMMERCIAL LIFE INSURANCE POLICY YOU OWN ON YOUR LIFE - Optional entry - used to assist your survivors in filing claims should you die while on active duty.

32. EMPLOYMENT - Show every employment you have had and all periods of unemployment
 a. YEAR & MONTH b. Company name and address (Street, City, State, and Zip Code) c. JOB TITLE d. SUPERVISOR NAME

No Yes. If "yes," give date(s) of employment, government you worked for, location and nature of your duties.

33. MEMBERSHIP IN YOUTH PROGRAMS - Optional entry - you may be eligible for a hip or paygrade based on membership and participation in the youth programs listed below.

No membership

ORGANIZATION	MEMBERSHIP HELD FROM	TO	CONDUCTED BY (SPONSOR)	LOCATION (CITY AND ADDRESS)	YEARS COMPLETED OR LEVEL REACHED
ROTC					YEARS
JROTC					YEARS
CAP			AIR FORCE		LEVEL
SEA CADET			NAVY		LEVEL
OTHER (Specify)					

34. FOREIGN TRAVEL - Other than as a direct result of military service

YEAR & MONTH FROM	COUNTRY VISITED	PURPOSE OF TRAVEL
TO		

35. DECLARATIONS - Explain "Yes" answers in item 41.

- a. HAVE YOU EVER BEEN REJECTED FOR ENLISTMENT, REENLISTMENT, OR INDUCTION INTO ANY BRANCH OF THE ARMED FORCES OF THE UNITED STATES? NO YES
- b. ARE YOU A CONSCIENTIOUS OBJECTOR? NO YES
- c. ARE YOU NOW OR HAVE YOU EVER BEEN A DESERTER FROM ANY BRANCH OF THE ARMED FORCES OF THE UNITED STATES? NO YES
- d. ARE YOU NOW DRAWING, OR DID YOU HAVE AN APPLICATION PENDING, OR APPROVAL FOR, RETIRED PAY, DISABILITY ALLOWANCE, OR SURVIVOR PAY, OR A PENSION FROM THE GOVERNMENT OF THE UNITED STATES? NO YES
- e. ARE YOU THE ONLY LIVING CHILD OF YOUR PARENTS? NO YES

36. UNDERSTANDINGS

37. CHARACTER AND SOCIAL ADJUSTMENT (6 of 6) Consider the following questions as fully as you can, giving your answers in the space provided.

1. If your answer to every question is "truthfully - NO", please indicate in the appropriate space.
2. If your answer to any question in this section is "YES", or you have reservations about answering questions of this nature, you are not required to answer, or explain any of these questions on writing test, as you may request a personal interview, whereupon you may provide the required information for each question orally.
3. If you choose the personal interview, the information you supply may be transcribed, however, any statement made at the interview shall not be retained more than six months after entry upon active duty, and it will not become a part of your personnel military personnel service record.
4. If you ended this interview, the information may be requested from you again at some future date and may become a part of your security investigation at that time. This could occur as a result of your being considered for duties involving access to classified information or other types of duty requiring a personnel security investigation.
5. A "YES" answer will not necessarily disqualify you for enlistment. It will depend on the circumstances surrounding the situation involved.

INITIAL HERE IF YOU PREFER A PERSONAL INTERVIEW

APPLICANT HAS BEEN INTERVIEWED AND IS ELIGIBLE FOR ENLISTMENT INELIGIBLE FOR ENLISTMENT

DATE OF INTERVIEW

NAM, ORGANIZATION & TITLE

INITIALS OR INTERVIEWER

NA

NA

NA

EXPLAIN "YES" ANSWERS IN ITEM 37:

- a. HAVE YOU EVER TAKEN ANY NARCOTIC SUBSTANCE, SEDATIVE, STIMULANT, OR TRANQUILIZER DRUGS EXCEPT AS PRESCRIBED BY A LICENSED PHYSICIAN?
- b. HAVE YOU EVER INTENTIONALLY SNIFLED GLUE, PAINT, THINSPRUC, OR OTHER CHEMICAL FUMES?
- c. HAVE YOU EVER BEEN INVOLVED IN THE USE, PURCHASE, CONSUMPTION, OR SALE OF MARIJUANA, LSD, OR ANY HARMFUL OR HABIT FORMING DRUGS AND/OR CHEMICALS, EXCEPT AS PRESCRIBED BY A LICENSED PHYSICIAN?
- d. HAS YOUR USE OF ALCOHOLIC BEVERAGES CAUSED YOU OR BEEN INVOLVED IN THE LOSS OF A JOB, ARREST BY POLICE, OR TREATMENT FOR ALCOHOLISM?
- e. HAVE YOU EVER BEEN A PATIENT (WHETHER OR NOT VOLUNTARILY) COMMITTED TO ANY INSTITUTION, PRIMARILY DEVOTED TO THE TREATMENT OF MENTAL, NERVOUS, EMOTIONAL, PSYCHOLOGICAL, OR PERSONALITY DISORDERS?
- f. HAVE YOU EVER ENGAGED IN HOMOSEXUAL ACTIVITY (SEXUAL RELATIONS WITH ANOTHER MEMBER OF THE SAME SEX)?

38. MARITAL STATUS AND DEPENDENCY

- a. ARE YOU NOW, OR HAVE YOU EVER BEEN MARRIED?
- b. IF YOU HAVE BEEN MARRIED, ARE YOU NOW LIVING WITH YOUR SPOUSE?
- c. HAVE YOU EVER BEEN DIVORCED? (If yes, enter date, place and court which granted divorce or legal separation)

- d. IS ANY COURT ORDER OR JUDGEMENT BEING MAINTAINED FOR CHILDREN OF ANYONE? (Enter date, place, and court which granted alimony, decree, or support as the result of a paternity suit)

- e. IS ANYONE OTHER THAN YOUR SPOUSE AND/OR CHILDREN SOLELY OR PARTIALLY DEPENDENT UPON YOU? (first name & address)

39. Do you, or have, or either the past ten years, taken you had, belong to, or belong with the specific object of furthering the army of, or adherence to, and active participation in any foreign or domestic organization, movement, group, or combination of persons, places, after referred to as "sabotage", who, usually, advocate or practice the use of acts of force or violence to prevent others from exercising their rights or in the Constitution or laws of the United States, or any State, or which seeks to overthrow the Government of the United States, or any State, established by constitutional means?

If you answered "yes", give the names of the organizations and include, when known, and year of your membership. Describe the nature of your activities as a member of the organization in the Remarks section Item 41.

40. INVOLVEMENT WITH POLICE OR JUDICIAL AUTHORITIES

YOUR ANSWERS TO THE FOLLOWING QUESTIONS WILL BE PROVIDED TO THE FEDERAL BUREAU OF INVESTIGATION (FBI) & OTHER AGENCIES, TO DETERMINE ANY PREVIOUS RECORDS OF ARREST, CONVICTION, OR JUVENILE COURT ADMISSIONS IN YOUR CONCERNED RECORDS AT THE TIME YOU MAY, UPON ENLISTMENT, BE SUBJECT TO DETERMINATION AS TO WHETHER YOU ARE UNFIT FOR MILITARY SERVICE AND/OR DISCHARGE FROM THE MILITARY SERVICE WITH OTHER THAN AN HONORABLE DISCHARGE.

- a. Have you ever been arrested, charged, cited, or held by Federal, State, or other law enforcement agencies, regardless of whether the citation or charge was dropped or dismissed? If you were tried and not guilty?
- b. As a result of being arrested, charged, cited, or held by law enforcement or other public authorities, have you ever been convicted, held by or forfeited bond to a Federal, State, or other public authority adjudicated a youthful offender or juvenile delinquent regardless of whether the record in your case has been sealed or otherwise struck from the criminal record?
- c. Has you ever been detained, held for, or segregated from an educational institution, vocational school, or industrial school, or any other facility or institution under the jurisdiction of any city, County, State, Federal or foreign country?
- d. Have you ever been awarded, or are you now under suspended sentence, parole, or probation or awaiting any action on charges against you?

NO YES

✓ ✓

✓ ✓

✓ ✓



CERTIFICATION OF APPEAL

1A. NAME OF APPELLANT (<i>If other than veteran</i>). [REDACTED]	1B. RELATIONSHIP TO VETERAN [REDACTED]	2. FILE NUMBER [REDACTED]															
3. LAST NAME - F RST NAME - MIDDLE NAME OF VETERAN) [REDACTED]	4. INSURANCE FILE NO OR LOAN NO. (<i>If pertinent</i>) [REDACTED]																
THE APPEAL IS FOR (State the question(s) at issue clearly and concisely)																	
5A. SERVICE CONNECTION FOR left shoulder disability	5B. DATE OF NOTIFICATION OF ACTION APPEALED 04-30-09																
6A. INCREASED RATING FOR DJD, lumbar spine in excess of 20% from 6-27-08 to 4-16-09; in excess of 10% from 5-14-10 to 9-4-11; in excess of 10% from 9-11-12 to 9-30-13 and in excess of 20% from 09-30-13	6B. DATE OF NOTIFICATION OF ACTION APPEALED 06-17-10																
7A. OTHER [REDACTED]	7B. DATE OF NOTIFICATION OF ACTION APPEALED [REDACTED]																
8A. APPELLANT REPRESENTED IN THIS APPEAL BY (Name of Organization, attorney, or agent) Disabled American Veterans																	
8B. ONE OF THE FOLLOWING IS ON FILE AS AUTHORITY FOR RECOGNIZING SUCH REPRESENTATIVE IN THIS APPEAL <input checked="" type="checkbox"/> POWER OF ATTORNEY (VA Form 21-22 or VA Form 21-22a) <input type="checkbox"/> CERTIFICATION THAT VALID POWER OF ATTORNEY IS IN ANOTHER VA FILE (<i>If so, specify the file</i>)		8C. IF AGENT DESIGNATED, IS HE/SHE ON ACCREDITED LIST? <input type="checkbox"/> YES <input type="checkbox"/> NO															
9A. IF REPRESENTATIVE IS SERVICE ORGANIZATION IS VA FORM 646, OR EQUIVALENT, OF RECORD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	9B. IF VA FORM 646 IS NOT OF RECORD, EXPLAIN [REDACTED]																
10A. WAS HEARING REQUESTED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	10B. IF HELD, IS TRANSCRIPT IN FILE? <input type="checkbox"/> YES <input type="checkbox"/> NO																
10C. IF REQUESTED BUT NOT HELD, EXPLAIN BVA Travel Board hearing requested																	
11A. ARE CONTESTED CLAIMS PROCEDURES APPLICABLE IN THIS CASE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (<i>If "YES", complete item 11B</i>).	11B. HAVE THE REQUIREMENTS OF 38 U.S.C. 7105A BEEN FOLLOWED? <input type="checkbox"/> YES <input type="checkbox"/> NO																
12A. DATE STATEMENT OF THE CASE FURNISHED. 02-06-12	12B. SUPPLEMENTAL STATEMENT OF THE CASE <input checked="" type="checkbox"/> REQUIRED AND FURNISHED <input type="checkbox"/> NOT REQUIRED																
13. RECORDS TO BE FORWARDED TO BOARD OF VETERANS APPEALS <table border="1"> <tr> <td><input type="checkbox"/> CF OR XCF</td> <td><input type="checkbox"/> R&E F</td> <td><input type="checkbox"/> LOAN GUAR. F</td> <td><input type="checkbox"/> OUTPATIENT F</td> <td><input type="checkbox"/> X-RAYS</td> </tr> <tr> <td><input type="checkbox"/> INACTIVE CF</td> <td><input type="checkbox"/> TRA N NG SUB-F</td> <td><input type="checkbox"/> INSURANCE F</td> <td><input type="checkbox"/> HOSPITAL COR.</td> <td><input type="checkbox"/> SLIDES</td> </tr> <tr> <td></td> <td><input type="checkbox"/> DEP. ED. F (Ch. 35)</td> <td><input type="checkbox"/> DENTAL F</td> <td><input type="checkbox"/> CLINICAL REC.</td> <td><input type="checkbox"/> TISSUE BLOCKS</td> </tr> </table> <input checked="" type="checkbox"/> OTHER (<i>Specify</i>) VBMS electronic file			<input type="checkbox"/> CF OR XCF	<input type="checkbox"/> R&E F	<input type="checkbox"/> LOAN GUAR. F	<input type="checkbox"/> OUTPATIENT F	<input type="checkbox"/> X-RAYS	<input type="checkbox"/> INACTIVE CF	<input type="checkbox"/> TRA N NG SUB-F	<input type="checkbox"/> INSURANCE F	<input type="checkbox"/> HOSPITAL COR.	<input type="checkbox"/> SLIDES		<input type="checkbox"/> DEP. ED. F (Ch. 35)	<input type="checkbox"/> DENTAL F	<input type="checkbox"/> CLINICAL REC.	<input type="checkbox"/> TISSUE BLOCKS
<input type="checkbox"/> CF OR XCF	<input type="checkbox"/> R&E F	<input type="checkbox"/> LOAN GUAR. F	<input type="checkbox"/> OUTPATIENT F	<input type="checkbox"/> X-RAYS													
<input type="checkbox"/> INACTIVE CF	<input type="checkbox"/> TRA N NG SUB-F	<input type="checkbox"/> INSURANCE F	<input type="checkbox"/> HOSPITAL COR.	<input type="checkbox"/> SLIDES													
	<input type="checkbox"/> DEP. ED. F (Ch. 35)	<input type="checkbox"/> DENTAL F	<input type="checkbox"/> CLINICAL REC.	<input type="checkbox"/> TISSUE BLOCKS													
14. REMARKS (Continue on reverse) Ready for BVA Travel Board hearing Re-certification of remand, dated 11-26-14.																	
CERTIFICATION: It is hereby certified that all material evidence is of record, that all contentions advanced by and on behalf of the appellant have been considered under all pertinent laws, and the issues determined.																	
15. NAME AND LOCATION OF CERTIFYING OFFICE VA Regional Office St. Louis, MO	16. ORGANIZATIONAL ELEMENT CERTIFYING APPEAL Veterans Service Center																
17A. SIGNATURE OF CERTIFYING OFFICIAL [REDACTED]	17B. TITLE Decision Review Officer	17C. DATE 04-01-15															
18A. SIGNATURE OF MEDICAL MEMBER (<i>Insurance use only</i>) [REDACTED]	18B. TITLE [REDACTED]	18C. DATE [REDACTED]															

64 APS PATIENT IDENTIFICATION

HEALTH RECORD OUTPATIENT	Specify Service & Grade for Military & Retired Military Member
	MILITARY USAF/SSG <input checked="" type="checkbox"/>
	RETIRED MILITARY <input type="checkbox"/>
	NONMILITARY <input type="checkbox"/>

RECEIVED

NOV 18 2002

RMC ST. LOUIS
MAIL CLERK #18

1984
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1998

RECORDS MAINTAINED AT
 459 AEROSPACE MEDICINE SQ
 3757 OREGON CIRCLE
 ANDREWS AFB MD 20762-4814

	SENSITIVE DUTIES PROGRAM (SDP)
	FOOD HANDLER

ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET

8. OCCUPATIONAL HISTORY/RISK

a. PRP		YES	NO
b. FLYING STATUS		YES	NO

9. IMMUNIZATIONS (Enter numeric class in sub block)

(1) IMMUNIZATION	(2) DATE (DDMMYYYY)	(1) IMMUNIZATION	(2) DATE (DDMMYYYY)	(1) IMMUNIZATION	(2) DATE (DDMMYYYY)	(1) IMMUNIZATION	(2) DATE (DDMMYYYY)						
a. HEP A #1		f. MMR #1		j. TD (q 10 yrs) (last)									
b. HEP A #2		g. MMR #2		k. TD (Due)									
c. HEP B #1		h. PNEUMOCOCCUS		i. YELLOW FEVER (last)									
d. HEP B #2		i. POLIO OPV = O IPV = I		m. YELLOW FEVER (Due)									
e. HEP B #3													
n. TYPHOID (Enter numeric class in sub block) ORAL = 0 TYPHUM VI = 1, TYPHOID USP = 2		(1) DATE		(2) DATE		(3) DATE		(4) DATE		(5) DATE		(6) DATE	
o. ANTHRAX	(1) INITIAL DATE	(2) 2 WEEK DATE	(3) 4 WEEK DATE	(4) 6 MONTH DATE	(5) 12 MONTH DATE	(6) 18 MONTH DATE							
p. PPD (Enter mm and date)	(1)(a) mm (b) DATE	(2)(a) mm (b) DATE	(3)(a) mm (b) DATE	(4)(a) mm (b) DATE	(5)(a) mm (b) DATE	(6)(a) mm (b) DATE							
q. INFLUENZA	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE (7) DATE							
r. VARICELLA	(1) DATE	(2) DATE	u. JAPANESE B ENCEPHALITIS	(1) DATE	(2) DATE	(3) DATE (4) DATE							
s. MENINGO	(1) DATE	(2) DATE	v. OTHER (Specify)	(1) DATE	(2) DATE	(3) DATE							
t. ADENO	(1) DATE	(2) DATE	w. OTHER (Specify)	(1) DATE	(2) DATE	(3) DATE							

10. READINESS

* (Glucose-6-phosphate dehydrogenase)

a. DNA	DATE: Nov 97	b. BLOOD TYPE	DATE:	RESULT: Apos	c. G6PD*	DATE:	RESULT: N/NL	d. SICKLE CELL	DATE: Jul 87	RESULT: Pos
e. PERMANENT PROFILE CHANGE		(1) DATE Jan 97	(2) YR: /	(3) U: /	(4) L: /	(5) H: /	(6) E: /	(7) S: /		
f. GLASSES/GAS MASK Rx:		(1) DATE		(2) DATE		(3) DATE		(4) DATE		(5) DATE
g. DENTAL EXAM (Enter numeric class in sub block)		(1) DATE		(2) DATE		(3) DATE		(4) DATE		(5) DATE
h. HIV TESTING		(1) DATE May 96		(2) DATE		(3) DATE		(4) DATE		(5) DATE
i. FITNESS (In sub block enter P=Pass, F=Fail, W=Waiver)		(1) DATE		(2) DATE		(3) DATE		(4) DATE		(5) DATE
Physical Exam		(1) DATE May 96		(2) DATE		(3) DATE		(4) DATE		(5) DATE
		(1) DATE		(2) DATE		(3) DATE		(4) DATE		(6) DATE

11. PRE/POST DEPLOYMENT HISTORY

a. LOCATION						
(1) PREDEPLOYMENT	(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE
(2) POSTDEPLOYMENT	(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE
b. LOCATION						
(1) PREDEPLOYMENT	(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE
(2) POSTDEPLOYMENT	(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE
c. CHART AUDIT	O	O	O	O	O	O

ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET

AMILY HISTORY (M = Mother, F = Father, S = Sibling, MGM = Maternal Grandmother, MGF = Maternal Grandfather, EM = Paternal Grandmother, PGF = Paternal Grandfather)

CANCER (Specify)	
ARTIOVASCULAR DISEASE (Specify)	
DIABETES (Specify)	
ENTAL ILLNESS/CHEMICAL DEPENDENCY (Specify)	

CREENING EXAMS (* = Actual Result, ** = Tricare Benefit, N = Normal, X = Abnormal, E = Done Elsewhere, R = Refused, N = Not Indicated) (D = Next Due)

a. TEST	b. FREQUENCY	c. YEAR	d. AGE	e. DATES					
CLINICAL DISEASE PREV EVAL/PHA (HEAR)	ANNUAL			O	O	O	O	O	O
WEIGHT	ANNUAL FOR ACTIVE DUTY			O	O	O	O	O	O
HEIGHT	ANNUAL FOR ACTIVE DUTY			O	O	O	O	O	O
BLOOD PRESSURE	ONCE q 2 YRS FOR BP < 130/85, ANNUAL IF GREATER			O	O	O	O	O	O
CHOLESTEROL**	q 5 YRS FOR AGE \geq 18 q YR IF PREV ABN			O	O	O	O	O	O
HEARING	CLINICIAN'S DISCRETION			O	O	O	O	O	O
SKIN EXAM (Cancer)	ANNUAL IF AT RISK			O	O	O	O	O	O
ORAL/DENTAL**	ANNUAL			O	O	O	O	O	O
EYE/VISION**	ROUTINE ACUITY WITH PERIODIC ASSESSMENT DIABETES ANNUALLY GLAUCOMA CHECK: Blacks q 3-5 yrs age 20-39 All q 2-4 yrs age 40-64			O	O	O	O	O	O
BREAST EXAM	ANNUAL: >40 YRS			O	O	O	O	O	O
MAMMOGRAM**	BASELINE @40, q 2 YRS 40-50, ANNUALLY >50			O	O	O	O	O	O
PAP ** (Digital Rectal Exam)	BASELINE: AGE 18 OR ONSET OF SEXUAL ACTIVITY AFTER 3 NL ANNUAL EXAMS, PERFORM q 1-3 YEARS			O	O	O	O	O	O
FECAL OCCULT BLOOD	ANNUAL: >50 YRS			O	O	O	O	O	O
SIGMOID	EVERY 3-5 YRS: >50 YRS			O	O	O	O	O	O
COLONOSCOPY**	HIGH RISK q 5 YRS: >40 YRS			O	O	O	O	O	O
TESTICULAR**	HIGH RISK ANNUAL 13-39 YRS			O	O	O	O	O	O
PROSTATE** ** (Digital Rectal Exam)	WITH P.E. \geq 40 YRS (Presently recommended annually)			O	O	O	O	O	O
ROSELLA SCREEN (Female)	ONCE BETWEEN AGES 12-18 YRS (Unless prev vaccinated)			O	O	O	O	O	O
OCCUPATIONAL SCREENING EXAMS	APPROPRIATE TO EXPOSURES			O	O	O	O	O	O
				O	O	O	O	O	O
				O	O	O	O	O	O
				O	O	O	O	O	O

USE THIS COVER SHEET TO FAX CLAIMS TO THE VA'S CLAIMS AND EVIDENCE INTAKE CENTERS



(Eastern and Southern Areas)



VBA's Office of Business Process
Integration

Fax Coversheet and Checklist

To: VBA Claims and Evidence Intake Center
Fax: 844-531-7818
Veterans Claims Intake Program

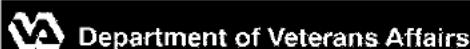
- Veteran First** _____
- Veteran C File** _____
- Claimant Zip** _____
- Fax Date:** 11/24/2015
- # of Pages to include Coversheet:** 5
- Forms Included:**

DOUBLE CHECK: Check Confirmation sheet and ensure fax is to

Disclaimer: Incorrect input of fax number, such as dialing the prefix "9" unnecessarily will result in failed submission to VA. Due to similarities in numbers, multiple parties have submitted to the wrong VA department. AVP Metro Petroleum is destroying any faxed Veterans records.

VA Directive 6609, NOVEMBER 9, 2007: NOTICE! Access to Veterans records is limited to Authorized Personnel Only. Information may not be disclosed unless permitted pursuant to 38 CFR 1.500-1.599. The Privacy Act contains provisions for criminal penalties for knowingly and willingly disclosing information from the file unless properly authorized to do so.

OMB Control No. 2900-0747
 Respondent Burden: 25 minutes
 Expiration Date: 11/30/2017



APPLICATION FOR DISABILITY COMPENSATION AND RELATED COMPENSATION BENEFITS

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 10 before completing the form.

SECTION I: IDENTIFICATION AND CLAIM INFORMATION

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

[REDACTED] YYYY)

4. SEX

MALE

FEMALE

5. HAVE YOU EVER FILED A CLAIM WITH VA?

YES NO (If "Yes," provide your file number in Item 6)

6. VA FILE NUMBER

7A. ARE YOU CURRENTLY HOMELESS OR AT RISK OF BECOMING HOMELESS?

YES NO (If "Yes," complete Items 7B & 7C)

7B. POINT OF CONTACT (Name of person that VA can contact in order to get in touch with you)

7C. POINT OF CONTACT TELEPHONE NUMBER (Include Area Code)

8A. SERVICE (Check all that apply)

ARMY NAVY MARINE CORPS

AIR FORCE COAST GUARD

8B. COMPONENT (Check all that apply)

ACTIVE RESERVES NATIONAL GUARD

9A. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

Number and Street
or Rural Route, P.O.
Box

City, State, ZIP Code

Country

Apt./Unit Number

9B. FORWARDING ADDRESS AND EFFECTIVE DATE

Number and Street
or Rural Route, P.O.
Box

City, State, ZIP Code

Country

Effective Date (MM/DD/YYYY):

9C. PREFERRED TELEPHONE NUMBER

10A. PREFERRED E-MAIL ADDRESS (If applicable)

10B. ALTERNATE E-MAIL ADDRESS (If applicable)

11. LIST THE DISABILITY(IES) YOU ARE CLAIMING (If applicable, identify whether a disability is due to a service-connected disability, is due to confinement as a Prisoner of War, is due to exposure to Agent Orange, Asbestos, Mustard Gas, Ionizing Radiation, or Gulf War Environmental Hazards, or is related to benefits under 38 U.S.C. 1151).

Please list your contentions below. See the following examples, for more information:

- Example 1: Hearing loss
- Example 2: Diabetes-Agent Orange (exposed 12/72, Da Nang)
- Example 3: Left knee - secondary to right knee

DISABILITIES

1.	RT knee pain /range of motion
2.	LT knee secondary to RT knee pain
3.	RT hip pain
4.	Lower Back
5.	depression
6.	anxiety
7.	adding to claim-Esophagitis
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
16.	
17.	
18.	
19.	
20.	

12. 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) AND PROVIDE TREATMENT DATES:

A. NAME AND LOCATION	B. DATE(S) OF TREATMENT
[REDACTED]	08/01/2015
[REDACTED]	08/26/2015
[REDACTED]	

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

For:	Required Form(s):
Dependents	VA Form 21-686c and, if claiming a child aged 18-23 years and in school, VA Form 21-674
Individual Unemployability	VA Form 21-8940 and 21-4192
Post-Traumatic Stress Disorder	VA Form 21-0781 and 21-0781a
Specially Adapted Housing or Special Home Adaptation	VA Form 28-4555
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 II: SERVICE INFORMATION

14A. DID YOU SERVE UNDER ANOTHER NAME? <input type="checkbox"/> YES (If "Yes," complete Item 14B) <input checked="" type="checkbox"/> NO (If "No," skip to Item 15A)	14B. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER: [Redacted]	
15A. MOST RECENT ACTIVE SERVICE ENTRY (MM,DD,YYYY)	15B. SERVICE NUMBER (Fill out this item only if assigned a service number)	15C. RELEASE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE SERVICE [Redacted]
15D. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	15E. PLACE OF LAST OR ANTICIPATED SEPARATION Offutt Air Force Base Omaha	
16A. ARE YOU CURRENTLY SERVING OR HAVE YOU EVER SERVED IN THE RESERVES OR NATIONAL GUARD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If "Yes," complete Items 16B thru 16F) (If "No," skip to Item 17A)	16B. COMPONENT <input type="checkbox"/> NATIONAL GUARD <input type="checkbox"/> RESERVES	16C. OBLIGATION TERM OF SERVICE From: To:
16D. CURRENT OR LAST ASSIGNED NAME AND ADDRESS OF UNIT:	16E. CURRENT OR ASSIGNED PHONE NUMBER OF UNIT (Include Area Code) ()	16F. ARE YOU CURRENTLY RECEIVING INACTIVE DUTY TRAINING PAY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
17A. ARE YOU CURRENTLY ACTIVATED ON FEDERAL ORDERS WITHIN THE NATIONAL GUARD OR RESERVES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If "Yes," complete Items 17B & 17C)	17B. DATE OF ACTIVATION: (MM,DD,YYYY)	17C. ANTICIPATED SEPARATION DATE: (MM,DD,YYYY)
18A. HAVE YOU EVER BEEN A PRISONER OF WAR? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If "Yes," complete Item 18B)	18B. DATES OF CONFINEMENT (MM,DD,YYYY) From: _____ To: _____	

SECTION III: SERVICE PAY

19A. DID/DO YOU RECEIVE ANY TYPE OF SEPARATION/SEVERANCE/RETIRIED PAY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes," complete Items 19B and 19C)	19B. LIST AMOUNT (If known) \$ 701.00	19C. LIST TYPE (If known) Retired
---	--	--------------------------------------

IMPORTANT: Submission of this application constitutes an election of VA compensation in lieu of military retired pay if it is determined you are entitled to both benefits. If you are entitled to receive military retired pay, your retired pay may be reduced by the amount of any VA compensation that you are awarded. VA will notify the Military Retired Pay Center of all benefit changes. Receipt of military retired pay or Voluntary Separation Incentive (VSI) and VA compensation at the same time may result in an overpayment, which may be subject to collection. However, if you do not want to receive VA compensation in lieu of military retired pay, you should check the box in **Item 20**. Please note that if you check the box in **Item 20**, you *will not* receive VA compensation, if granted.

20. I want military retired pay instead of VA compensation

IMPORTANT: You may elect to keep the training pay for inactive duty training days 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 21**, VA will adjust your VA award to withhold future benefits equal to the total number of inactive duty for training days waived and at the monthly rate in effect for the fiscal year period for which you received training pay. Your normal VA rate will be restored when the sufficient numbers of days' benefits have been withheld.

21. I elect to waive VA benefits for the days I accrued inactive duty training pay in order to retain my inactive duty training pay.

SECTION IV: DIRECT DEPOSIT INFORMATION

The Department of Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. Please attach a voided personal check or deposit slip or provide the information requested below in **Items 22, 23 and 24** to enroll in direct deposit. If you do not have a bank account, you must receive your payment through Direct Express Debit MasterCard. To request a Direct Express Debit MasterCard you must apply at www.usdirectexpress.com or by telephone at 1-800-333-1795. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

22. ACCOUNT NUMBER (*Check the appropriate box and provide the account number, or simply write "Established" if you have a direct deposit with VA*)

I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL CERTIFIED PAYMENT AGENT

23. ACH/ATM NUMBER (*The first nine numbers located at the bottom of your check*)

SECTION V: CLAIM CERTIFICATION AND SIGNATURE

I certify and authorize the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me, and I waive any privilege which makes the information confidential.

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

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility such as a VA medical center; OR, I have no information or evidence to give VA to support my claim; OR, I have checked the box in **Item 25**, indicating that I do not want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.

ALTERNATE SIGNER: By signing on behalf of the claimant, I certify 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 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.

25. The FDC Program is designed to rapidly process compensation or pension claims received with the evidence necessary to decide the claim. VA will automatically consider a claim submitted on this form for rapid processing under the FDC Program. Check the box below **ONLY IF YOU DO NOT WANT YOUR CLAIM CONSIDERED FOR RAPID PROCESSING** under the FDC Program because you plan on submitting further evidence in support of your claim.

evidence in support of my claim.

SECTION VI: WITNESSES TO SIGNATURE

27A. SIGNATURE OF WITNESS (*If veteran signed above using an "X"*)

27B. PRINTED NAME AND ADDRESS OF WITNESS

28A. SIGNATURE OF WITNESS (*If veteran signed above using an "X"*)

28B. PRINTED NAME AND ADDRESS OF WITNESS

SECTION VII: POWER OF ATTORNEY (POA) SIGNATURE

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

NOTE: A POA's signature *will not* be accepted unless at the time of submission of this claim a valid VA Form 21-22, *Appointment of Veterans Service Organization as Claim Agent*, is filed with VA. This form is available at www.vba.va.gov/forms/21-22.html. The claim agent listed on the form must be the appropriate POA is of record with VA.

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(e)(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.regulations.gov/OMB/PRAM/. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.



DEPARTMENT OF VETERANS AFFAIRS

January 20, 2016

In Reply Refer To: **314/MN**
File Number:
[REDACTED]

IMPORTANT – REPLY NEEDED WITHIN 10 DAYS

Dear [REDACTED]

We are continuing to work on your claim.

What Is The Current Status Of Your Claim?

We have requested your Service Treatment Records and determined that your Service Treatment Records cannot be located and therefore are unavailable for review. All efforts to obtain the needed information have been exhausted, and based on these facts, we have determined that further attempts to obtain the records would be unsuccessful.

We have taken the following actions in an effort to obtain these records:

- We contacted NRPC on November 13, 2015 to obtain your Service Treatment Records. However, they responded stating they 'can't identify record based on information received.'

What Do We Still Need From You?

Please submit any relevant documents in your possession including:

- Any available copies of Service Treatment Records as listed above.
- Any other relevant evidence or information that you think will support your claim, to include such things as buddy statements.

If you are unable to submit records, you may also advise us of possible locations(s) of these records.

How Soon Should You Send What We Need?

We strongly encourage you to send any information or evidence as soon as you can. However, if we do not hear from you within **10 days**, we will make a determination on the evidence of record.

How Should You Submit What We Need?

Please note that the quickest, easiest, and most secure way to submit any documents to us is via the eBenefits website. Just visit www.eBenefits.va.gov to register. Please also refer to the ‘What is eBenefits?’ section of this letter for more information.

You can also send what we need to the appropriate address listed on the attached “Where to Send Your Written Correspondence” chart.

What is eBenefits?

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

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

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

Do You Have Questions Or Need Assistance?

If you have any questions, you may contact us by telephone, e-mail, or letter.

If you	Here is what to do.
Telephone	Call us at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal number is 711.
Use the Internet	Send electronic inquiries through the Internet at https://iris.va.gov .
Write	VA now uses a centralized mail system. For all written communications, put your full name and VA file number on the letter. Please mail or fax all written correspondence to the appropriate address listed on the attached <i>Where to Send Your Written Correspondence</i> .

[REDACTED]

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

In all cases, be sure to refer to your VA file [REDACTED]

If you are looking for general information about benefits and eligibility, you should visit our website at <https://www.va.gov>, or search the Frequently Asked Questions (FAQs) at <https://iris.va.gov>.

We have no record of you appointing a service organization or representative to assist you. We have also enclosed information on how Veterans' Service Organizations can help you. You can contact us for a list of the VA recognized Veterans Service Organizations and/or representatives. Veterans Service Organizations which are recognized by VA to provide services to the Veteran community can also help you with questions.

Sincerely yours,

RO Director
VA Regional Office

Enclosures: VA Form 21-4138
VA Form 21-4142
Where to Send Your Written Correspondence



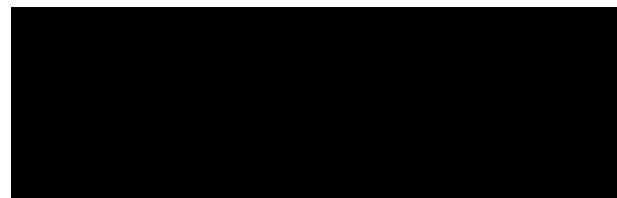
DEPARTMENT OF VETERANS AFFAIRS

Where to Send Your Written Correspondence

Location of Residence	Address to Send all Written Correspondence
Alabama	Ohio
Connecticut	Pennsylvania
Delaware	Rhode Island
District of Columbia	South Carolina
Florida	Tennessee
Georgia	Vermont
Indiana	Virginia
Kentucky	West Virginia
Maine	Puerto Rico
Maryland	
Massachusetts	Europe
Michigan	Asia
Mississippi	Australia
New Hampshire	Africa
New Jersey	Palau
New York	Marshall Islands
North Carolina	Federated States of Micronesia
Alaska	South Dakota
Arizona	Texas
Arkansas	Utah
California	Washington
Colorado	Wisconsin
Louisiana	Wyoming
Hawaii	
Idaho	Canada
Illinois	Mexico
Iowa	Central America
Kansas	South America
Oklahoma	The Caribbean
Oregon	The U.S. Virgin Islands
Minnesota	The Philippines
Missouri	American Samoa
Montana	Guam
Nebraska	Northern Mariana Islands
Nevada	U.S. Virgin Islands
New Mexico	
North Dakota	



**DEPARTMENT OF VETERANS AFFAIRS
Roanoke VA Regional Office
210 FRANKLIN ROAD SW
Roanoke VA
24011**



Represented By:

**Rating Decision
03/01/2016**

INTRODUCTION

[REDACTED] Peacetime. You served in the Air Force from [REDACTED] filed an original disability claim that was received on October 19, 2015. Based on a review of the evidence listed below, we have made the following decision(s) on your claim.

DECISION

1. Service connection for Esophagitis is denied.
2. Service connection for Left knee condition is denied.
3. Service connection for Right knee condition is denied.
4. Service connection for anxiety is denied.
5. Service connection for depression is denied.

[REDACTED]

6. Service connection for lower back is denied.

EVIDENCE

- Service treatment records (STRS) were not available. If records become available in the future we will review the records and this decision at that time.
- VA Form 21-526 received October 19, 2015.
- Washington DC VA Medical Center records dating from August of 2015.
- VA Form 21-4138 received November 19, 2015.
- Exam received November 19, 2015.
- VA letter dated January 19, 2016.
- VA Form 21-4138 received February 5, 2016.
- TRICARE immunization records.

REASONS FOR DECISION

1. Service connection for Esophagitis.

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

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

The evidence does not show an event, disease or injury in service.

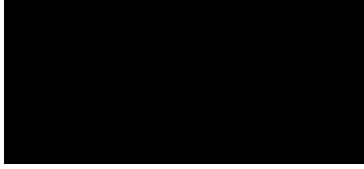
We did not find a link between your medical condition and military service.

2. Service connection for Left knee condition.

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

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

The evidence does not show an event, disease or injury in service.



We did not find a link between your medical condition and military service.

3. Service connection for Right knee condition.

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

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

The evidence does not show an event, disease or injury in service.

We did not find a link between your medical condition and military service.

4. Service connection for anxiety.

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

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

The evidence does not show an event, disease or injury in service.

We did not find a link between your medical condition and military service.

5. Service connection for depression.

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

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

The evidence does not show an event, disease or injury in service.

We did not find a link between your medical condition and military service.



6. Service connection for lower back.

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

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

The evidence does not show an event, disease or injury in service.

We did not find a link between your medical condition and military service.

REFERENCES:

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

Rating Decision	<i>Department of Veterans Affairs Roanoke VA Regional Office</i>	Page 1 of 1 03/01/2016
		POA
		COPY TO

ACTIVE DUTY		
	BRANCH	CHARACTER OF DISCHARGE
	Air Force	Honorable

LEGACY CODES			
ADD'L SVC CODE	COMBAT CODE	SPECIAL PROV CDE	FUTURE EXAM DATE
	1		None

JURISDICTION: Original Disability Claim Received 10/19/2015

ASSOCIATED CLAIM(s): 110; Initial Live Comp < 8 issues; 10/19/2015

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

- 5237 LOWER BACK
Not Service Connected, Not Incurred/Caused by Service
- 5257 LEFT KNEE CONDITION
Not Service Connected, Not Incurred/Caused by Service
- 5257 RIGHT KNEE CONDITION
Not Service Connected, Not Incurred/Caused by Service
- 7203 ESOPHAGITIS
Not Service Connected, Not Incurred/Caused by Service
- 9400 ANXIETY
Not Service Connected, Not Incurred/Caused by Service
- 9434 DEPRESSION
Not Service Connected, Not Incurred/Caused by Service

I certify that I have reviewed and electronically signed
this decision."

FAX

To: varo

Company:

Fax:

Phone:

From:

Fax:

Phone:

E-mail:

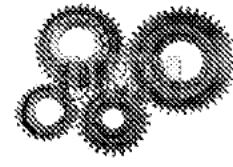
NOTES:

[REDACTED]

USE THIS COVER SHEET TO FAX CLAIMS TO THE VA'S CLAIMS AND EVIDENCE INTAKE CENTERS



(Eastern and Southern Areas)



VBA's Office of Business Process
Integration

Fax Coversheet and Checklist

To: VBA Claims and Evidence Intake Center
Fax: [REDACTED]
Veterans Claims Intake Program

- Veteran First and Last Name: [REDACTED]
- Veteran C File #: C [REDACTED]
- Claimant Zip Code: [REDACTED]
- Fax Date: 04/04/2016
- # of Pages to include Coversheet: 7
- Forms Included:
[REDACTED]

DOUBLE CHECK: Check Confirmation sheet and ensure fax is to

[REDACTED] co [REDACTED] q [REDACTED] o [REDACTED] x [REDACTED] q [REDACTED] q [REDACTED] prefix "9" unnecessarily will result in failed submission to VA. Due to similarities in numbers, multiple parties have submitted to the wrong VA department. AVP Metro Petroleum is destroying any faxed Veterans records.

VA Directive 6609, NOVEMBER 9, 2007: NOTICE! Access to Veterans records is limited to Authorized Personnel Only. Information may not be disclosed unless permitted pursuant to 38 CFR 1.500-1.599. The Privacy Act contains provisions for criminal penalties for knowingly and willingly disclosing information from the file unless properly authorized to do so.

 Department of Veterans Affairs		NOTICE OF DISAGREEMENT	
<p>A CLAIMANT OR HIS OR HER DULY APPOINTED REPRESENTATIVE MAY FILE NOTICE EXPRESSING THEIR DISSATISFACTION OR DISAGREEMENT WITH AN ADJUDICATIVE DETERMINATION BY THE VA REGIONAL OFFICE. A DESIRE TO CONTEST THE RESULT WILL CONSTITUTE A NOTICE OF DISAGREEMENT (NOD). WHILE SPECIAL WORDING IS NOT REQUIRED, THE NOD MUST BE IN TERMS WHICH CAN BE REASONABLY CONSTRUED AS DISAGREEMENT WITH THAT DETERMINATION AND A DESIRE FOR APPELLATE REVIEW. (AUTHORITY: 38 U.S.C. 7105)</p> <p>TO FILE A VALID NOD, THERE IS A TIME LIMIT OF ONE YEAR FROM THE DATE VA MAILED THE NOTIFICATION OF THE DECISION TO THE CLAIMANT. FOR CONTESTED CLAIMS INCLUDING CLAIMS OF APPORTIONMENT, THIS TIME LIMIT IS 60 DAYS FROM THE DATE VA MAILED THE NOTIFICATION OF THE DECISION TO THE CLAIMANT.</p>		<p>(DO NOT WRITE IN THIS SPACE) (VA DATE STAMP)</p>	
<p>NOTE: You can <i>either</i> complete the form online or by hand. Please print information using blue or black ink, neatly, and legibly to help process the form.</p>			
PART I - PERSONAL INFORMATION			
<p>1. VETERAN'S NAME (<i>First, middle initial, last</i>) [REDACTED]</p>			
<p>2. VETERAN'S SOCIAL SECURITY NUMBER [REDACTED]</p>		<p>3. VA FILE NUMBER [REDACTED]</p>	
CLAIMANT'S PERSONAL INFORMATION			
<p>4. CLAIMANT'S NAME (<i>First, middle initial, last</i>) [REDACTED]</p>			
<p>5. CURRENT MAILING ADDRESS (<i>Number and street or rural route, P.O. Box, City, State, ZIP Code and Country</i>) [REDACTED]</p>			
<p>6. PREFERRED TELEPHONE NUMBER (<i>Include Area Code</i>) [REDACTED]</p>		<p>7. PREFERRED E-MAIL ADDRESS [REDACTED]</p>	
PART II - TELEPHONE CONTACT			
<p>8. WOULD YOU LIKE TO RECEIVE A TELEPHONE CALL OR E-MAIL FROM A REPRESENTATIVE AT YOUR LOCAL REGIONAL OFFICE REGARDING YOUR NOD?</p>			
<p><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><i>(If you answered "Yes," VA will make up to two attempts to call you between 8:00 a.m. and 4:30 p.m. local time at the telephone number and time period you select below. Please select up to two time periods you are available to receive a phone call.)</i></p>			
<p><input type="checkbox"/> 8:00 a.m. - 10:00 a.m. <input type="checkbox"/> 10:00 a.m. - 12:30 p.m. <input checked="" type="checkbox"/> 12:30 p.m. - 2:00 p.m. <input type="checkbox"/> 2:00 p.m. - 4:30 p.m.</p>			
<p>Phone number I can be reached at the above checked time [REDACTED]</p>			
PART III - APPEAL PROCESS ELECTION			
<p>9. SELECT ONE OF THE APPEALS PROCESSING METHODS BELOW (See <i>Specific Instructions, Page 2, Part III</i> for additional information)</p>			
<p><input checked="" type="checkbox"/> Decision Review Officer (DRO) Review Process</p>			
<p><input type="checkbox"/> Traditional Appellate Review Process</p>			

VETERAN'S SSN

PART IV - SPECIFIC ISSUES OF DISAGREEMENT**10. NOTIFICATION/DECISION LETTER DATE**

03/03/2016

11. PLEASE LIST EACH SPECIFIC ISSUE OF DISAGREEMENT AND NOTE THE AREA OF DISAGREEMENT. IF YOU DISAGREE ON THE EVALUATION OF A DISABILITY, SPECIFY PERCENTAGE EVALUATION SOUGHT, IF KNOWN. PLEASE LIST ONLY ONE DISABILITY IN EACH BOX. YOU MAY ATTACH ADDITIONAL SHEETS IF NECESSARY.

A. Specific Issue of Disagreement	B. Area of Disagreement	C. Percentage (%) Evaluation Sought (If known)
Depression	<input checked="" type="checkbox"/> Service Connection <input type="checkbox"/> Effective Date of Award <input type="checkbox"/> Evaluation of Disability <input type="checkbox"/> Other (Please specify below) <hr/>	
LT & RT knee condition	<input checked="" type="checkbox"/> Service Connection <input type="checkbox"/> Effective Date of Award <input type="checkbox"/> Evaluation of Disability <input type="checkbox"/> Other (Please specify below) <hr/>	
Lower back condition	<input checked="" type="checkbox"/> Service Connection <input type="checkbox"/> Effective Date of Award <input type="checkbox"/> Evaluation of Disability <input type="checkbox"/> Other (Please specify below) <hr/>	
Anxiety	<input checked="" type="checkbox"/> Service Connection <input type="checkbox"/> Effective Date of Award <input type="checkbox"/> Evaluation of Disability <input type="checkbox"/> Other (Please specify below) <hr/>	
Esophagitis	<input checked="" type="checkbox"/> Service Connection <input type="checkbox"/> Effective Date of Award <input type="checkbox"/> Evaluation of Disability <input type="checkbox"/> Other (Please specify below) <hr/>	

12A. IN THE SPACE BELOW, OR ON A SEPARATE PAGE, PLEASE EXPLAIN WHY YOU FEEL WE INCORRECTLY DECIDED YOUR CLAIM, AND LIST ANY DISAGREEMENT(S) NOT COVERED ABOVE:

Please reference attached 21-4138

12B. DID YOU ATTACH ADDITIONAL PAGES TO THIS NOD?

YES NO (If so, how many?) 2

PART V - CERTIFICATION AND SIGNATURE

I CERTIFY THAT THE STATEMENTS ON THIS FORM ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

PENALTY. THE LAW PROVIDES SEVERE PENALTIES WHICH INCLUDE A FINE, IMPRISONMENT, OR BOTH, FOR THE WILLFUL SUBMISSION OF ANY STATEMENT OR EVIDENCE OF A MATERIAL FACT, KNOWING IT TO BE FALSE.

** PROGRESS NOTES *****

LOCAL TITLE: PRIMARY CARE SECURE MESSAGING
STANDARD TITLE: PRIMARY CARE SECURE MESSAGING

DATE OF NOTE:

AUTHOR:

INSTITUTION:

DIVISION:

URGENCY:

-----Original Message-----

Sent: 03/03/2016 03:30 PM

From:

To: *

Subjec

Dr. [REDACTED]

[REDACTED] a prescription renewal of Omeprazole (20mg) should have noted that I did increase the dosage from 1 per day to 2 per day as you recommended during our last discussion (if 1 per day did not improve my swallowing difficulties). So, the new prescription should reflect this increase.

-----Original Message-----

Sent: 03/04/2016 04:06 PM

RN STAFF

Signed: 03/04/2016 16:06

Receipt Acknowledged By:

03/05/2016 18:05 /es/

LOCAL TITLE: PRIMARY CARE SECURE MESSAGING
STANDARD TITLE: PRIMARY CARE SECURE MESSAGING
DATE OF NOTE: MAR 03, 2016@15:01:29 ENTRY DATE: MAR 03, 2016@15:01:31

AUTHOR: [REDACTED] EXP COSIGNER:
INSTITUTION: FORT BELVOIR VA CLINIC
DIVISION: ALEXANDRIA CBOC
URGENCY: STATUS: COMPLETED

-----Original Message-----

Sent: 03/02/2016 04:14 PM

[REDACTED]
Subject: Medication Refills

I have requested me last refills of Omeprazole (20mg), Hydrochlorothiazide (12.5mg), and Metoprolol Tartrate (100mg). Please provide additional refills for these medications, or advise if I need an appointment to do this.

-----Original Message-----

Sent: 03/03/2016 03:01 PM

[REDACTED]
Subject: Medication Refills

Forwarding your request for medication renewal to [REDACTED]

Please make a convenience. D [REDACTED] at your earliest 15.

[REDACTED]
RN STAFF
Signed: 03/03/2016 15:01

Receipt Acknowledged By:
03/03/2016 16:39 /es/ [REDACTED]
MD

LOCAL TITLE: PRIMARY CARE SECURE MESSAGING
STANDARD TITLE: PRIMARY CARE SECURE MESSAGING
DATE OF NOT [REDACTED] MAR 03, 2016@14:57:37
AUTHO [REDACTED]
INSTITUTIO [REDACTED]
DIVISION: ALEXANDRIA CBOC
URGENCY: STATUS: COMPLETED

-----Original Message-----
Sent: 03/02/2016 04:30 PM
[REDACTED]

[REDACTED]
[REDACTED] rding my depression in September 2015, and she provided [REDACTED] for Duloxetine (60mg/1 per day). This is a medication I [REDACTED] g VA health services. I have an appointment with Dr. [REDACTED] but I will be out of the prescription before then. I didn't know that I wouldn't have the option to communicate my needs, or renew prescriptions except with an appointment with her until now. Are you able to help at all with this circumstance? Please advise how you think I should proceed.
[REDACTED]

-----Original Message-----
Sent: 03/03/2016 02:57 PM
From: [REDACTED]
To: [REDACTED]
Subject: [REDACTED]

Forwarding your concerns [REDACTED]
[REDACTED]
[REDACTED]

Signed: 03/03/2016 14:57

Receipt Acknowledged By:

03/03/2016 16:41 /es/ [REDACTED]

MD

03/07/2016 06:06 /es/ [REDACTED]
NURSE PRACTITIONER

LOCAL TITLE: PCC - TELEPHONE NOTE

STANDARD TITLE: PRIMARY CARE TELEPHONE ENCOUNTER NOTE

DATE OF NOTE: NOV 25, 2015@16:51 ENTRY DATE: NOV 25, 2015@16:51:53

AUTHOR: [REDACTED] EXP COSIGNER: [REDACTED]

INSTITUTION: FORT BELVOIR VA CLINIC

DIVISION: ALEXANDRIA CBOC

URGENCY:

STATUS: COMPLETED

Reason for call/Assessment/Plan:

Renewed BP meds.

Discussed in detail endoscopy findings, bx report and GI recommendations for further f/u. He will contact me in 4 weeks with progress of sx of dysphagia on QDaily PPI.

Signed: 11/25/2015 16:53

LOCAL TITLE: GASTROENTEROLOGY BIOPSY RESULTS LETTER

STANDARD TITLE: GASTROENTEROLOGY LETTERS

DATE OF NOTE: NOV 02, 2015@11:33 ENTRY DATE: NOV 02, 2015@11:33:37

AUTHOR: [REDACTED] EXP COSIGNER:

INSTITUTION: WASHINGTON

DIVISION: WASHINGTON VAMC

URGENCY:

STATUS: COMPLETED

The biopsy obtained during your endoscopic exam on Oct 29, 2015:
Did not reveal any sign of cancer., Showed:

DIAGNOSIS

1. ESOPHAGUS, 40 CM, BIOPSY:

GASTRIC MUCOSA WITH CHRONIC INFLAMMATION AND REACTIVE
CHANGES.

NO EVIDENCE OF INTESTINAL METAPLASIA OR DYSPLASIA.

2. PROXIMAL ESOPHAGUS, BIOPSY:

SQUAMOUS MUCOSA, NO SIGNIFICANT HISTOPATHOLOGIC
ABNORMALITY.

3. DISTAL ESOPHAGUS, BIOPSY:

CHRONIC ESOPHAGITIS CONSISTENT WITH REFLUX.

MINUTE SUPERFICIAL STRIPS OF BENIGN GASTRIC GLANDULAR
EPITHELIUM.

These findings are consistent with acid reflux.

Take the medication we prescribed and follow up with primary care.

[REDACTED]
ATTENDING

Signed: 11/02/2015 11:36

Receipt Acknowledged By:

11/02/2015 12:12 /es/ [REDACTED]

ssistant

Page: 4

Printed on: Apr 05, 2016 10:05:15 am

Division: 688



U.S. Department
of Veterans Affairs

Memorandum

Date: May 16, 2016

From: VA Records Management Center

RMC/cja

Subj: Memorandum for Record
Response to Records Request for
[REDACTED]

On 05/26/2016, the VA Records Management Center (RMC) received a request for the following records for the above-named Veteran:

- Clinical Records
- Official Military Personnel File (OMPF)
- Service Treatment Records
- VA Claims File
- Other:

The requested records are:

A search was conducted at the RMC for all records which may be associated with this Veteran, to include claims folder and Service Treatment Records.

All available records (for all periods of service) were pulled by our files activity on 05/16/2016, and delivered to RMC's mailroom to be shipped to the scan vendor (or routed for local scanning). Please allow up to 14 days for upload to VBMS; shipping information will be available in VBMS Intake. No further records are located at the RMC.

Sincerely,

Director
VA Records Management Center

FAX

To:

Company:

Fax:

Phone:

From: BENEVETS (DVS)

Fax:

Phone:

E-mail:

NOTES:

[REDACTED]

USE THIS COVER SHEET TO FAX CLAIMS TO THE VA'S CLAIMS AND EVIDENCE INTAKE CENTERS



(Eastern and Southern Areas)



VBA's Office of Business Process
Integration

Fax Coversheet and Checklist

To: VBA Claims and Evidence Intake Center
Fax: 844-531-7818
Veterans Claims Intake Program

Veteran First and Last Name _____

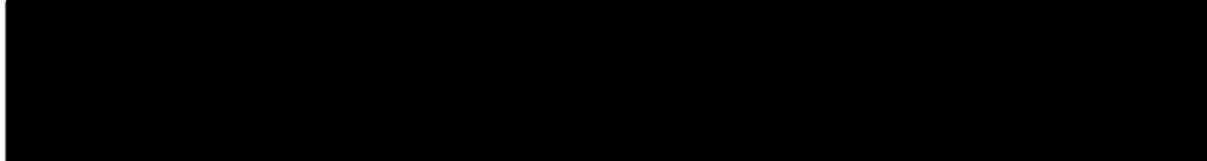
Veteran C File # _____

Claimant Zip Code _____

Fax Date: 05/20/2016

of Pages to include Coversheet: 5

Forms Included:

A large rectangular area of the page has been completely blacked out, obscuring several lines of text that were likely intended to be filled in or listed.

DOUBLE CHECK: Check Confirmation sheet and ensure fax is to

Disclaimer: Incorrect input of fax number, such as dialing the prefix "9" unnecessarily will result in failed submission to VA. Due to similarities in numbers, multiple parties have submitted to the wrong VA department. AVP Metro Petroleum is destroying any faxed Veterans records.

VA Directive 6609, NOVEMBER 9, 2007: NOTICE! Access to Veterans records is limited to Authorized Personnel Only. Information may not be disclosed unless permitted pursuant to 38 CFR 1.500-1.599. The Privacy Act contains provisions for criminal penalties for knowingly and willingly disclosing information from the file unless properly authorized to do so.



STATEMENT IN SUPPORT OF CLAIM

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

RESPONDENT BURDEN: We need this information to obtain evidence in support of your claim for benefits (38 U.S.C. 501(a) and (b)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 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.

FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN (*Type or print*)

SOCIAL SECURITY NO.

VA FILE NO.

The following statement is made in connection with a claim for benefits in the case of the above-named veteran:

Reference VA letter dated 4/27/2016 for additional information records to support my pending NOD. Please see the attached 21-4142.

I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the wilful submission of any statement of evidence of a material fact, knowing it to be false.

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



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

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

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

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

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

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

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

SECTION II - VETERAN IDENTIFICATION

SECTION III - PATIENT IDENTIFICATION FOR RECORDS VA IS REQUESTING

SECTION IV - INFORMATION REGARDING SOURCE OF RECORD(S)

SOURCE OF RECORD(S):

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

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

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

TO WHOM: The Department of Veterans Affairs (VA)

PURPOSE: Determining my eligibility for benefits and whether I can manage such benefits

EXPIRES: This authorization is good for 12 months from the date shown in Item 12

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

[Redacted], YYYY) (Required)

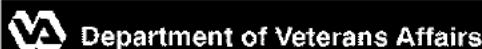
3 PRINTED NAME OF PERSON SIGNING (First, Middle Initial, Last)

4 TELEPHONE NUMBER (Include Area Code)

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

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

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



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

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

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

SECTION I - PATIENT IDENTIFICATION FOR RECORDS VA IS REQUESTING

SECTION II - MEDICAL PROVIDER INFORMATION

4A PROVIDER OR FACILITY NAME

4B DATE(S) OF TREATMENT
(Include the time period (month/day/year) for the treatment by the provider listed in Item 4A)

From 01 01 1995 To 12 31 2000

From To

5C PROVIDER/FACILITY STREET ADDRESS (Number and street, P.O. or rural route)

TELEPHONE NUMBER (Include Area Code)

5A PROVIDER OR FACILITY NAME

5B DATE(S) OF TREATMENT
(Include the time period (month/day/year) for the treatment by the provider listed in Item 5A)

From To

From To

5C PROVIDER/FACILITY STREET ADDRESS (Number and street, P.O. or rural route)

5D CITY

5E STATE AND ZIP CODE

5F PROVIDER OR FACILITY TELEPHONE NUMBER (Include Area Code)

6A PROVIDER OR FACILITY NAME

6B DATE(S) OF TREATMENT
(Include the time period (month/day/year) for the treatment by the provider listed in Item 6A)

From To

From To

6C PROVIDER/FACILITY STREET ADDRESS (Number and street, P.O. or rural route)

6D CITY

6E STATE AND ZIP CODE

6F PROVIDER OR FACILITY TELEPHONE NUMBER (Include Area Code)

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

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

User Name	Entry Time	Message
[REDACTED]	05/24/2016	RO: Request is illegible, unable to process.



Department of Veterans Affairs

APPEAL TO BOARD OF VETERANS' APPEALS

IMPORTANT: Read the attached instructions before you fill out this form. VA also encourages you to get assistance from your representative in filling out this form.

1. NAME OF VETERAN (Last Name, First Name, Middle Initial) [REDACTED]

2. CLAIM FILE NO. (Include prefix) [REDACTED]

3. INSURANCE FILE NO., OR LOAN NO. [REDACTED]

4. I AM THE:

- VETERAN VETERAN'S WIDOW/ER VETERAN'S CHILD VETERAN'S PARENT
 OTHER (Specify) [REDACTED]

5. TELEPHONE NUMBERS

A. HOME (Include Area Code) [REDACTED]

B. WORK (Include Area Code) [REDACTED]

7. IF I AM NOT THE VETERAN, MY NAME IS:

(Last Name, First Name, Middle Initial) [REDACTED]

6. MY ADDRESS IS:

(Number & Street or Post Office Box, City, State & ZIP Code) [REDACTED]

8. HEARING

IMPORTANT: Read the information about this block in paragraph 6 of the attached instructions. This block is used to request a Board of Veterans' Appeals hearing. DO NOT USE THIS FORM TO REQUEST A HEARING BEFORE VA REGIONAL OFFICE PERSONNEL. Check one (and only one) of the following boxes:

- A. I DO NOT WANT A BVA HEARING.
B. I WANT A BVA HEARING IN WASHINGTON, DC.
C. I WANT A BVA HEARING AT A LOCAL VA OFFICE BEFORE A MEMBER, OR MEMBERS, OF THE BVA.
(Not available at Washington, DC, or Baltimore, MD, Regional Offices.)

9. THESE ARE THE ISSUES I WANT TO APPEAL TO THE BVA: (Be sure to read the information about this block in paragraph 6 of the attached instructions.)

- A. I WANT TO APPEAL ALL OF THE ISSUES LISTED ON THE STATEMENT OF THE CASE AND ANY SUPPLEMENTAL STATEMENTS OF THE CASE THAT MY LOCAL VA OFFICE SENT TO ME.
B. I HAVE READ THE STATEMENT OF THE CASE AND ANY SUPPLEMENTAL STATEMENT OF THE CASE I RECEIVED. I AM ONLY APPEALING THESE ISSUES:
(List below.)

RECD. MAIL 04/02/2012
MAIL #751515/2012
5:58

10. HERE IS WHY I THINK THAT VA DECIDED MY CASE INCORRECTLY: (Be sure to read the information about this block in paragraph 6 of the attached instructions.)

recommend surgery, however, was deployed to OCONUS to serve this outstanding nation.

Thank you for your time in this matter.

(Continue on the back, or attach sheets of paper, if you need more space.)

11. SIGNATURE OF PERSON MAKING THIS APPEAL	12. DATE (MM/DD/YYYY)	13. SIGNATURE OF APPOINTED REPRESENTATIVE, IF ANY (Not required if signed by appellant. See paragraph 6 of the instructions.)	14. DATE (MM/DD/YYYY)
[REDACTED]			

04/02/2012

AdobeFormsDesigner

VACAS UPDATE 10/4/2012

DEPARTMENT OF VETERANS AFFAIRS

July 28, 2016

[REDACTED]

In reply, refer to:

[REDACTED]

IMPORTANT -- reply needed

To Whom It May Concern:

The Veteran [REDACTED] as applied for disability benefits and states he or she received [REDACTED] facility.

We would appreciate your sending us all treatment records, hospital summaries, findings and/or diagnoses during the following period(s):

Starting: January 1, 1995, Ending: December 31, 2000

VA has transitioned to a paperless claim processing system. We will no longer send original documents. The enclosed VA Form 21-4142, or its equivalent, is an official VA copy of the document received from the claimant. This letter is being sent in duplicate so that you may retain a copy. Attach the other copy of our letter to your reply to ensure proper identification.

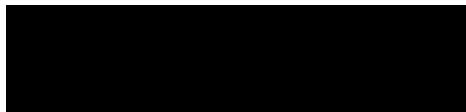
Where To Send Records

Please mail or fax all responses to the appropriate address listed on the attached *Where to Send Your Written Correspondence* chart.

Please send a copy of the available records as soon as possible.

Please provide a negative response if you do not have any information concerning this Veteran.

Please note: We can't pay any fees for this information.



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

Thank you for your assistance.

Sincerely yours,

RO Director
VA Regional Office

Enclosures: Where to Send Your Written Correspondence Chart
 Signed Release
 Duplicate copy of this letter

DEPARTMENT OF VETERANS AFFAIRS

July 28, 2016

Dear Mr. [REDACTED]

We are working on your appeal.

How Should You Submit What We Need?

Please note that the quickest, easiest, and most secure way to submit any documents to us is via the eBenefits website. Just visit www.eBenefits.va.gov to register. Please also refer to the ‘What is eBenefits?’ section of this letter for more information.

You can also send what we need to the appropriate address listed on the attached Where to Send Your Written Correspondence chart.

How Soon Should You Send What We Need?

We strongly encourage you to send any information or evidence as soon as you can. **If we do not hear from you, we may make a decision on your claim after 30 days.**

What Have We Done?

- We have requested copies of treatment records or other evidence from:

[REDACTED] ote: This is our first request for this information.)

Even though we have asked for this information, it is your responsibility to see that VA receives it (except for any evidence kept by the VA, military or any other federal government agency).

What is eBenefits?

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

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

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

How Can You Contact Us?

If you are looking for general information about benefits and eligibility, you should visit our web site at <http://www.va.gov>. Otherwise, you can contact us in several ways. Please give us your VA file number, **227 86 0971**, when you do contact us.

- Call us at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal number is 711 (international number is 1-800-829-4833).
- Send us an inquiry using the Internet at <https://iris.va.gov>.
- Please mail or fax all responses to the appropriate address listed on the attached *Where to Send Your Written Correspondence* chart.

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

Sincerely yours,

RO Director
VA Regional Office

Enclosures: Where to Send Your Written Correspondence





Arthritis [REDACTED]

**FAX COVER SHEET**

Please note the following confidential disclosures:

If medical record information has been faxed to you, be aware that HIPAA regulations and Virginia State Law prohibit you from making any further disclosures of this information without the written consent of the patient or as otherwise permitted under the HIPAA regulations or state law. A general authorization for release of medical information is not sufficient for this purpose.

If you receive this communication in error, please notify us immediately by phone so we can arrange for return of the transmitted documents. Thank you.

Number of Pages: Cover + 19. Date: Aug 02 2016

If you do not receive the correct number of pages, please call us and let us know.



To: Dept. of Veterans Affairs

Phone: [REDACTED]

Fax: [REDACTED]

Medical Notes



Thank You!

CC

Patient is here for Rheumatology follow-up due to Chronic pain, Osteoarthritis, and elevated CPK levels

HPI

for further evaluation (appointment pending). NSAIDS don't help (meloxicam). Pte C/O pain "all over", with persistent stiffness "all day". He C/O recurrent right hip pain on-and-off for about 10 years with mild degenerative joint disease changes in 11-2011. EMG, MRI head and Lumbar spine were done recently, results not available. No new symptoms lately. No joint swelling or skin lesions.

Lumbar spine were normal and he also had negative HLA-B27. Because of his chronic pain and persistent elevation of with +ANA (SSA) he had a new rheumatology consult after 5 years in 11/2011. He C/O "overall body aches involving muscle and joints with stiffness but no focal muscle weakness. He C/O fatigue, chronic low back pain with occasional radiation into the right posterior thigh, right groin pain and muscle twitching. He has no sicca symptoms, skin lesions, joint swelling or Raynaud's. No major joint or muscle abnormalities have been found at exam. He C/O chronic low back pain that worsened over the years with occasional radiation the right buttocks area and down to the right leg with no distal motor or sensory loss. MRI L-spine in 5/2002 showed degenerative disc changes at L4-L5 and L5-S1, with normal MRI of the Thoracic spine. He received treatment with several antidepressants and opiates. He also had several spinal injections in the past. He has chronic elevation of the CPK. It was up to 1220 in 04/2004 with Aldolase 8.2, serum myoglobin 140, and Creat 1.5. CPK was 789 on 8/29/05 with similar creatinine value. On 1/4/2006 CPK was 1000, Creat 1.5, Myoglobin 226, Aldolase 8.4, and normal CRP & ESR.

metabolic myopathy.

ROS

Denies prolonged morning stiffness or gel phenomenon. No focal weakness, numbness, or tingling. No acute episodes of joint swelling or sausage digits. Denies weight loss, fever, chills, night sweating, anorexia, or abnormal lymph nodes. No snoring or sleep disturbances. No history of tick exposure, skin rash, photosensitivity, psoriasis or Raynaud's. Denies red or dry eyes, no oral or nasal ulcers. No chronic sinusitis or chronic cough. Denies shortness of breath, wheezing or chest pain. No urinary symptoms. Denies chronic diarrhea or constipation. No abdominal pain, nausea or vomiting. No memory loss, LOC or seizures. No easy bruising. Denies weakness, numbness, or tingling. No episodes of joint swelling or sausage digits.

PMH

Sickle cell trait, Depression, HTN, chronic pain syndrome, DJD, genital herpes. No clear H/O statins intake

SH

[Tobacco: Never smoker]
Patient denies any tobacco use. Occasional alcohol consumption.
Work: former sales manager (Engineering)

**Supplemental
Statement of the Case**

*Department of Veterans Affairs
Saint Louis Regional Office*

Page 1

POA
MVC

ISSUE:

1. Evaluation of lumbar spine degenerative joint disease with sclerosis and osteophyte formation currently evaluated as 10 percent disabling.
2. Service connection for left shoulder condition.

EVIDENCE:

- Statement of the Case dated February 6, 2012 and the evidence on which it was based.
- VA Form 9, Appeal to Board of Veteran's Appeals received April 5, 2012.
- VA Medical Center Columbia examination conducted on September 30, 2013.
- Treatment reports from VA Medical Center Columbia for the period June 1, 2010 to April 22, 2013.

ADJUDICATIVE ACTIONS:

- 02-06-2012 The veteran was furnished a Statement of the Case outlining actions taken on the claim.
- 04-03-2012 Substantive Appeal Received.
- 04-05-2012 Substantive Appeal Received.
- 11-07-2013 The veteran was furnished a Supplemental Statement of the Case outlining actions taken on the claim.

PERTINENT LAWS; REGULATIONS; RATING SCHEDULE PROVISIONS:

Unless otherwise indicated, the symbol “§” denotes a section from title 38 of the Code of Federal Regulations, Pensions, Bonuses and Veterans’ Relief. Title 38 contains the regulations of the Department of Veterans Affairs which govern entitlement to all veteran benefits.

38 USC Section 5107 (03/02) Claimant responsibility; benefit of the doubt

(a) CLAIMANT RESPONSIBILITY- Except as otherwise provided by law, a claimant has the responsibility to present and support a claim for benefits under laws administered by the Secretary.

(b) BENEFIT OF THE DOUBT- The Secretary shall consider all information and lay and medical evidence of record in a case before the Secretary with respect to benefits under laws administered by the Secretary. When there is an approximate balance of positive and negative

evidence regarding any issue material to the determination of a matter, the Secretary shall give the benefit of the doubt to the claimant.

DECISION:

1. Evaluation of lumbar spine degenerative joint disease with sclerosis and osteophyte formation, which is currently 10 percent disabling, is increased to 20 percent effective September 30, 2013.
2. Service connection for left shoulder condition remains denied.

REASONS AND BASES:

1. Evaluation of lumbar spine degenerative joint disease with sclerosis and osteophyte formation currently evaluated as 10 percent disabling.

The evaluation of lumbar spine degenerative joint disease with sclerosis and osteophyte formation is increased to 20 percent disabling effective September 30, 2013, date of the VA examination showing an increase in symptoms.

In the VA examination of September 30, 2013, you are noted to report that your back condition has worsened. You state that you currently have persistent pain in the lower back that is worse in the mornings. You report that you have shooting pain in the left thigh that is very brief. Range of the motion of your spine shows forward flexion of 45 degrees, extension of 15 degrees, right lateral flexion of 20 degrees, left lateral flexion of 25 degrees, right lateral rotation of 25 degrees and left lateral rotation of 25 degrees.

We have assigned a 20 percent evaluation for your thoracolumbar spine based on:

- o Forward flexion of the thoracolumbar spine greater than 30 degrees but not greater than 60 degrees

Additional symptom(s) include:

- o Painful motion upon examination
- o Combined range of motion of the thoracolumbar spine greater than 120 degrees but not greater than 235 degrees

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

A higher evaluation of 40 percent is not warranted for thoracolumbar spine unless there is:

- o Forward flexion of the thoracolumbar spine 30 degrees or less; or,
- o Favorable ankylosis of the entire thoracolumbar spine.

2. Service connection for left shoulder condition.

Service connection may be granted for a disability which began in military service or was caused by some event or experience in service. Service connection for left shoulder condition is denied since this condition neither occurred in nor was caused by service.

In the VA examination, the examiner opined that your left shoulder condition is less likely than not (less than 50 percent probability) incurred in or caused by the claimed in-service injury, event, or illness. The examiner noted that your service treatment records are negative for a left shoulder condition during service. The medical records indicate that you injured the left shoulder in January 2004 while not on active duty and that you required surgery shortly after that injury.

Absent evidence showing that this condition is related to military service or it is related to a service connected disability, service connection is denied.

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.

