[LETTERHEAD OF MEDICAL PRACTICE/FACILITY]

[Date]

SUBJECT: Medical Nexus Letter for [Veteran's Name]

Veteran's SSN: [XXX-XX-XXXX]

Veteran's VA File #: [XXXXXXXXXX]

To Whom It May Concern:

I am writing this medical nexus letter in support of [Veteran's Name]'s VA disability claim. I am a board-certified [specialty] with [X] years of experience. I have been treating [Veteran's Name] since [date].

RECORDS REVIEWED:

• Service Treatment Records

• Military Personnel Records

• Post-service Medical Records

• VA Medical Records

• [List any other relevant records reviewed]

CURRENT DIAGNOSIS:

[Veteran's Name] has been diagnosed with [specific condition(s)]. The diagnosis was confirmed through [list specific tests, examinations, or procedures performed].

MILITARY SERVICE HISTORY:

During military service from [dates], the veteran experienced [describe relevant in-service event, injury, or exposure]. Documentation shows [describe specific evidence from service records].

MEDICAL OPINION:

After thorough review of the aforementioned records and based on my examination and treatment of the veteran, it is my professional medical opinion that the veteran's current [condition] is **at least as likely as not** related to [specific in-service event/injury/exposure] during military service.

RATIONALE:

This opinion is based on the following:

1. [Specific medical evidence supporting the connection]

2. [Relevant medical research or studies]

3. [Clinical observations]

4. [Timeline of symptom progression]

5. [Any other supporting evidence]

SUPPORTING MEDICAL LITERATURE (if applicable):

• [Cite relevant medical journals/studies]

• [List any applicable medical references]

CONCLUSION:

The evidence supports a direct causal relationship between the veteran's current condition and their military service. The onset and progression of symptoms are consistent with [explain medical reasoning].

Sincerely,

[Physician's Signature]

_____

[Physician's Name], [Credentials]

[Medical License Number]

[Board Certifications]

[Practice Name/Address]

[Contact Information]

[Official Stamp/Seal if applicable]