TODAY'S DATE: [redacted]
RANK/NAME: [redacted]
SSN: [redacted]
PCM: [redacted]

ADDENDUM:

I have reviewed the C&P exam results and the Claimed Conditions and find the information within the NARSUM to be current and complete.

[redacted]

VM

OMB Approved No. 2900-0704
Respondent Burden: 30 minutes
Expiration Date: 7/31/2019

Department of Veterans Affairs

VA DATE STAMP (DO NOT WRITE IN THIS SPACE)
RECEIVED
2017 NOV 29 AM 10: 20

VA/DOD JOINT DISABILITY EVALUATION BOARD CLAIM

IMPORTANT - Please read the Privacy Act and Respondent Burden on the back before completing the form.

Section I: To be completed by Military Treatment Facility referring Service member to Disability Evaluation System *(DES)*

SERVICE MEMBER NAME *(First, middle, last)*	GRADE
[redacted]	[redacted]

COMPONENT	UNIT ADDRESS
USAF/AD	[redacted]

SOCIAL SECURITY NUMBER	DATE OF BIRTH *(MM,DD,YYYY)*	SEX
[redacted]	[redacted]	☒ MALE ☐ FEMALE

NAME AND PHONE NUMBER OF ASSIGNED PHYSICAL EVALUATION BOARD LIAISON OFFICER *(PEBLO)*		NAME OF REFERRING MILITARY TREATMENT FACILITY *(MTF)*	DATE OF REFERRAL TO MEDICAL EVALUATION BOARD *(MEB) (MM.DD.YYYY)*
(First, MI, Last)	*(Include Area Code)*		
[redacted]	[redacted]	[redacted]	[redacted]

MEDICAL CONDITIONS TO BE CONSIDERED AS THE BASIS OF FITNESS FOR DUTY DETERMINATION *(List only conditions referred by physician)*:
HIV

PREPARED BY	DATE PREPARED
[redacted]	[redacted]

Section II: Tell us about yourself. Please provide a contact name and address. If you are on Temporary Duty, please indicate that on the VA Form 21-4138, Statement In Support of Claim available on the internet at www.va.gov/vaforms

1. WHAT IS YOUR ADDRESS?
[redacted]
Street address, rural route, or P.O. Box — Apt. number
[redacted]
City — State — ZIP Code — Country

2. WHAT ARE YOUR TELEPHONE NUMBERS? *(Include Area Code)*
Daytime [redacted]
Evening
Cell phone [redacted]

3. WHAT IS YOUR E-MAIL ADDRESS *(If applicable)*
[redacted]

4. HAVE YOU EVER FILED A CLAIM WITH VA?
☐ YES ☒ NO
(If "Yes," provide file number) _____ *(VA File Number)*

5. POINT OF CONTACT NAME AND ADDRESS
[redacted]

6A. DID YOU SERVE UNDER ANOTHER NAME?
☐ YES *(If "Yes," go to Item 6b)* ☒ NO *(If "No," go to Item 7)*

6B. PLEASE LIST OTHER NAME(S) YOU SERVED UNDER

7. I ENTERED THIS CURRENT PERIOD OF ACTIVE SERVICE ON
[redacted]

8. PLACE OF ENTRY
[redacted]

Section III: Tell us about your military service. Enter complete information for your service. Tell us about your reserve duty or National Guard Duty

9. ARE YOU CURRENTLY ASSIGNED TO AN ACTIVE RESERVE UNIT OR NATIONAL GUARD UNIT?	10A. WHAT IS THE NAME AND MAILING ADDRESS OF YOUR CURRENT UNIT?	10B. WHAT IS THE TELEPHONE NUMBER OF YOUR CURRENT UNIT? *(Include Area Code)*
☐ YES *(If "Yes," provide date of activation below)* ☒ NO _____		

VA FORM JUL 2016 **21-0819** SUPERSEDES VA FORM 21-0819, OCT 2009, WHICH WILL NOT BE USED.

CRS Ltr EP 689 dtd 11/24/2017

EP 689 12/5/2017 MD

11. ADDITIONAL CONDITIONS - *(Do you have any disabling conditions, other than those referred for the fitness for duty determination, that you feel were incurred in or aggravated by, your active military service? Please list those disabilities below.) (If you need additional space, please use VA Form 21-4138, Statement in Support of Claim available at www.va.gov/vaforms)*

[redacted]

12. DO YOU HAVE DEPENDENTS?

[redacted] *(If "Yes," please complete VA Form 21-686c, Declaration of Status of Dependents, available at www.va.gov/vaforms)*

Section IV: MILITARY RETIRED PAY

IMPORTANT - Unless you check the box in Item 13 below, you are telling us that you are choosing to receive VA compensation instead of military retired pay, if it is determined you are entitled to both benefits. If you are awarded military retired pay prior to compensation, we will reduce your retired pay by the amount of any compensation that you are awarded. VA will notify the Military Retired Pay Center of all benefit changes. If you receive both military retired pay and VA compensation, some of the amount you get may be recouped by VA, or in the case of Voluntary Separation Incentive (VSI), by the Department of Defense.

13. ☐ No I do not want VA compensation in lieu of military retired pay.

Section V: DIRECT DEPOSIT INFORMATION

Generally, all Federal payments are required to 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 14, 15 and 16 to enroll in Direct Deposit. If you do not have a bank account we will give you a waiver from Direct Deposit, just check the box below in Item 14. The Treasury Department is working to make bank accounts available to you. Once these accounts are available, you will be able to decide whether you wish to sign-up for one of the accounts or continue to receive a paper check. You can also request a waiver if you have other circumstances that you feel would cause you a hardship to be enrolled in Direct Deposit. You can write to: Department of Veterans Affairs, 125 S. Main Street Suite B, Muskogee, OK 74401-7004, and give us a brief description of why you do not wish to participate in Direct Deposit.

14. ACCOUNT NUMBER *(Please check the appropriate box and provide the account number, if applicable)*

☐ Checking _____ ☐ Savings _____ ☐ I certify that I do not have an account with a financial institution or certified payment agent

15. NAME OF FINANCIAL INSTITUTION *(Please provide the name of the bank where you want your direct deposit)*	16. ROUTING OR TRANSIT NUMBER *(The first nine numbers located at the bottom left of your check)*

Section VI: CERTIFICATIONS 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.

17. YOUR SIGNATURE *(Do NOT print)*	18. DATE SIGNED

Section VII: WITNESSES TO SIGNATURE

19A. SIGNATURE OF WITNESS *(If claimant signed above using an "X")*	19B. PRINTED NAME AND ADDRESS OF WITNESS
20A. SIGNATURE OF WITNESS *(If claimant signed above using an "X")*	**20B. PRINTED NAME AND ADDRESS OF WITNESS**

PRIVACY ACT NOTICE: The form will be used to determine allowance to compensation benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28 Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration. Your obligation to respond is required in order to obtain or retain benefits. Information that you furnish may be utilized in computer matching programs with other Federal or state agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.

RESPONDENT BURDEN: We need this information to determine your eligibility for compensation. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 30 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.

VA FORM 21-0819, JUL 2016

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

Department of Veterans Affairs

APPLICATION FOR DISABILITY COMPENSATION AND RELATED COMPENSATION BENEFITS

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

RECEIVED
2017 DEC -5 PM 1:15
VA REGIONAL OFFICE
PHILADELPHIA, PA

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)*

2. VETERAN'S SOCIAL SECURITY NUMBER

3. HAVE YOU EVER FILED A CLAIM WITH VA?
☐ YES ☒ NO *(If "Yes," provide your file number in Item 4)*

4. VA FILE NUMBER

5. DATE OF BIRTH (MM,DD,YYYY)
Month Day Year

6. SEX
☒ MALE ☐ FEMALE

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

8A. ARE YOU CURRENTLY HOMELESS OR AT RISK OF BECOMING HOMELESS?
☐ YES ☒ NO *(If "Yes," complete items 8B & 8C)*

8B. POINT OF CONTACT *(Name of person that VA can contact in order to get in touch with you)*
SELF

8C. POINT OF CONTACT TELEPHONE NUMBER *(Include Area Code)*

9A. SERVICE *(Check all that apply)*
☐ ARMY ☐ NAVY ☐ MARINE CORPS ☒ AIR FORCE ☐ COAST GUARD

9B. COMPONENT *(Check all that apply)*
☒ ACTIVE ☐ RESERVES ☐ NATIONAL GUARD

10A. CURRENT MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code

10B. FORWARDING ADDRESS AND EFFECTIVE DATE *(Provide the date you will be living at this address)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code

EFFECTIVE DATE:
Month Day Year

EP 689 12/5/17

11. PREFERRED TELEPHONE NUMBER

12A. PREFERRED E-MAIL ADDRESS *(If applicable)*

12B. ALTERNATE E-MAIL ADDRESS *(If applicable)*

VETERANS SOCIAL SECURITY NO [redacted]

13. 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.	H I V
	[redacted]
11.	
12.	
13.	
14.	
15.	
16.	
17.	
18.	
19.	
20.	

14. 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
Service treatment record	**Ongoing**

VETERANS SOCIAL SECURITY NO [redacted]

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 26-4555
Auto Allowance	VA Form 21-4502
Veteran/Spouse Aid and Attendance benefits	VA Form 21-2680 or, if based on nursing home attendance, VA Form 21-0779

SECTION II: SERVICE INFORMATION

15A. DID YOU SERVE UNDER ANOTHER NAME?
☐ YES *(If "Yes," complete Item 15B)* ☒ NO *(If "No," skip to Item 16A)*

15B. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER:

16A. MOST RECENT ACTIVE SERVICE ENTRY DATE (MM,DD,YYYY) [redacted]

16B. RELEASE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE SERVICE (MM,DD,YYYY) [redacted]

16C. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001?
☐ YES ☒ NO

16D. PLACE OF LAST OR ANTICIPATED SEPARATION [redacted]

17A. ARE YOU CURRENTLY SERVING OR HAVE YOU EVER SERVED IN THE RESERVES OR NATIONAL GUARD?
☐ YES ☒ NO *(If "Yes," complete Items 17B thru 17F)* *(If "No," skip to Item 18A)*

17B. COMPONENT
☐ NATIONAL GUARD
☐ RESERVES

17C. OBLIGATION TERM OF SERVICE
From: Month ___ Day ___ Year ____
To: Month ___ Day ___ Year ____

17D. CURRENT OR LAST ASSIGNED NAME AND ADDRESS OF UNIT:

17E. CURRENT OR ASSIGNED PHONE NUMBER OF UNIT *(Include Area Code)*
( )

17F. ARE YOU CURRENTLY RECEIVING INACTIVE DUTY TRAINING PAY?
☐ YES ☐ NO

18A. ARE YOU CURRENTLY ACTIVATED ON FEDERAL ORDERS WITHIN THE NATIONAL GUARD OR RESERVES?
☐ YES ☒ NO
(If "Yes," complete Items 18B & 18C)

18B. DATE OF ACTIVATION: (MM,DD,YYYY)
Month ___ Day ___ Year ____

18C. ANTICIPATED SEPARATION DATE: (MM,DD,YYYY)
Month ___ Day ___ Year ____

19A. HAVE YOU EVER BEEN A PRISONER OF WAR?
☐ YES ☒ NO
(If "Yes," complete Item 19B)

19B. DATES OF CONFINEMENT (MM,DD,YYYY)

From: Month	Day	Year	To: Month	Day	Year

SECTION III: SERVICE PAY

20A. DID/DO YOU RECEIVE ANY TYPE OF SEPARATION/SEVERANCE/RETIRED PAY?
☐ YES ☒ NO *(If "Yes," complete Items 20B and 20C)*

20B. LIST AMOUNT *(If known)*
$

20C. LIST TYPE *(If known)*

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 21**. Please note that if you check the box in **Item 21**, you ***will not*** receive VA compensation, if granted.

☐ **21. 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 22**, 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.

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

VETERANS SOCIAL SECURITY NO. [redacted]

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 23, 24 and 25** 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.

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

☒ CHECKING ☐ SAVINGS ☐ I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

Account No.: [redacted] Account No.: _____

24. NAME OF FINANCIAL INSTITUTION *(Please provide the name of the bank where you want your direct deposit)*	25. ROUTING OR TRANSIT NUMBER *(The first nine numbers located at the bottom left of your check)*
[redacted]	[redacted]

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 26**, 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.

26. 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.

☐ **I DO NOT want my claim considered for rapid processing** under the FDC Program because I plan to submit further evidence in support of my claim.

27A. CLAIMANT/SERVICE MEMBER/ALTERNATE SIGNER SIGNATURE (REQUIRED)	27B. DATE SIGNED
[redacted]	5 Dec 17

SECTION VI: WITNESSES TO SIGNATURE

28A. SIGNATURE OF WITNESS *(If veteran signed above using an "X")*	28B. PRINTED NAME AND ADDRESS OF WITNESS
29A. SIGNATURE OF WITNESS *(If veteran signed above using an "X")*	**29B. PRINTED NAME AND ADDRESS OF WITNESS**

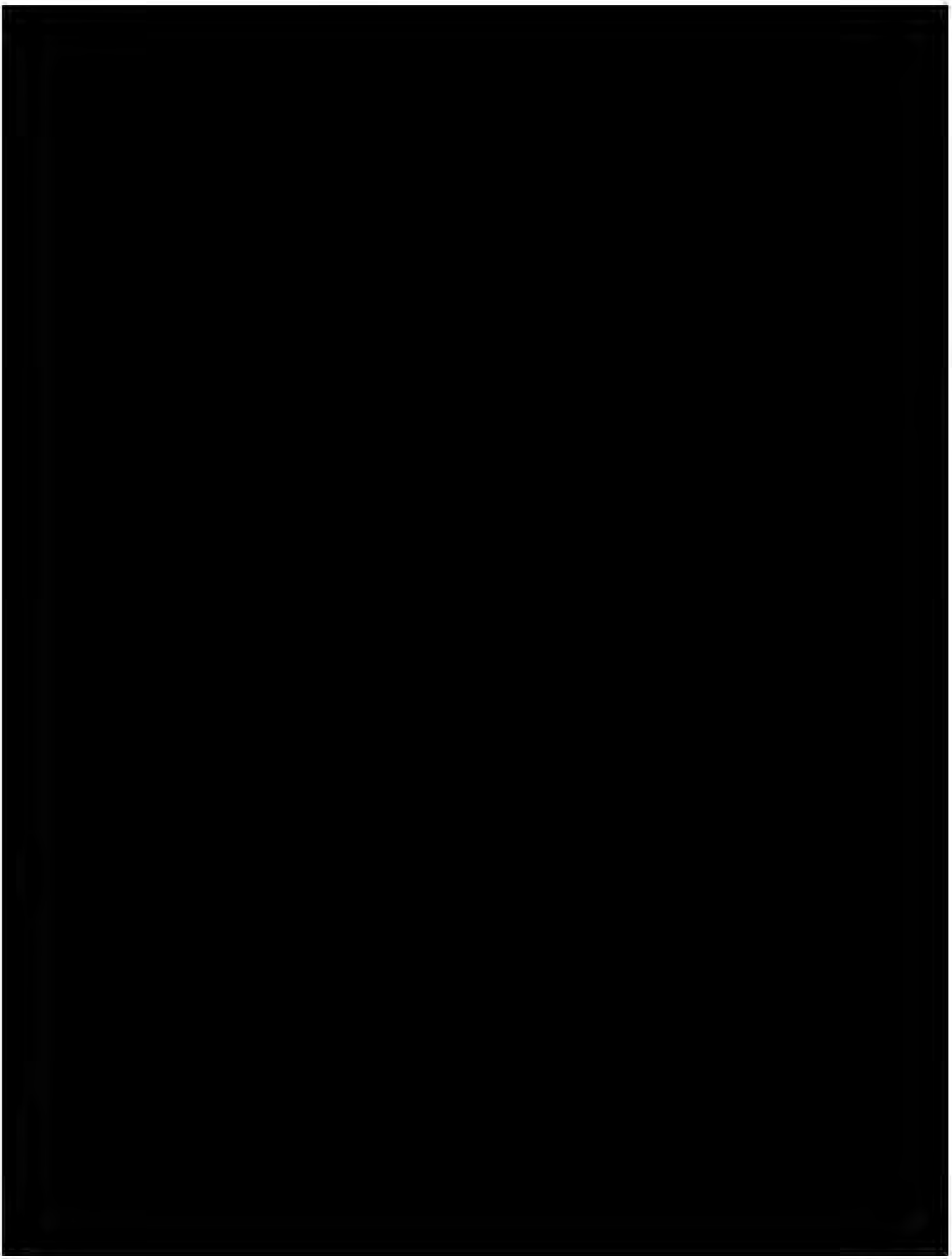
SECTION VII: POWER OF ATTORNEY (POA) SIGNATURE

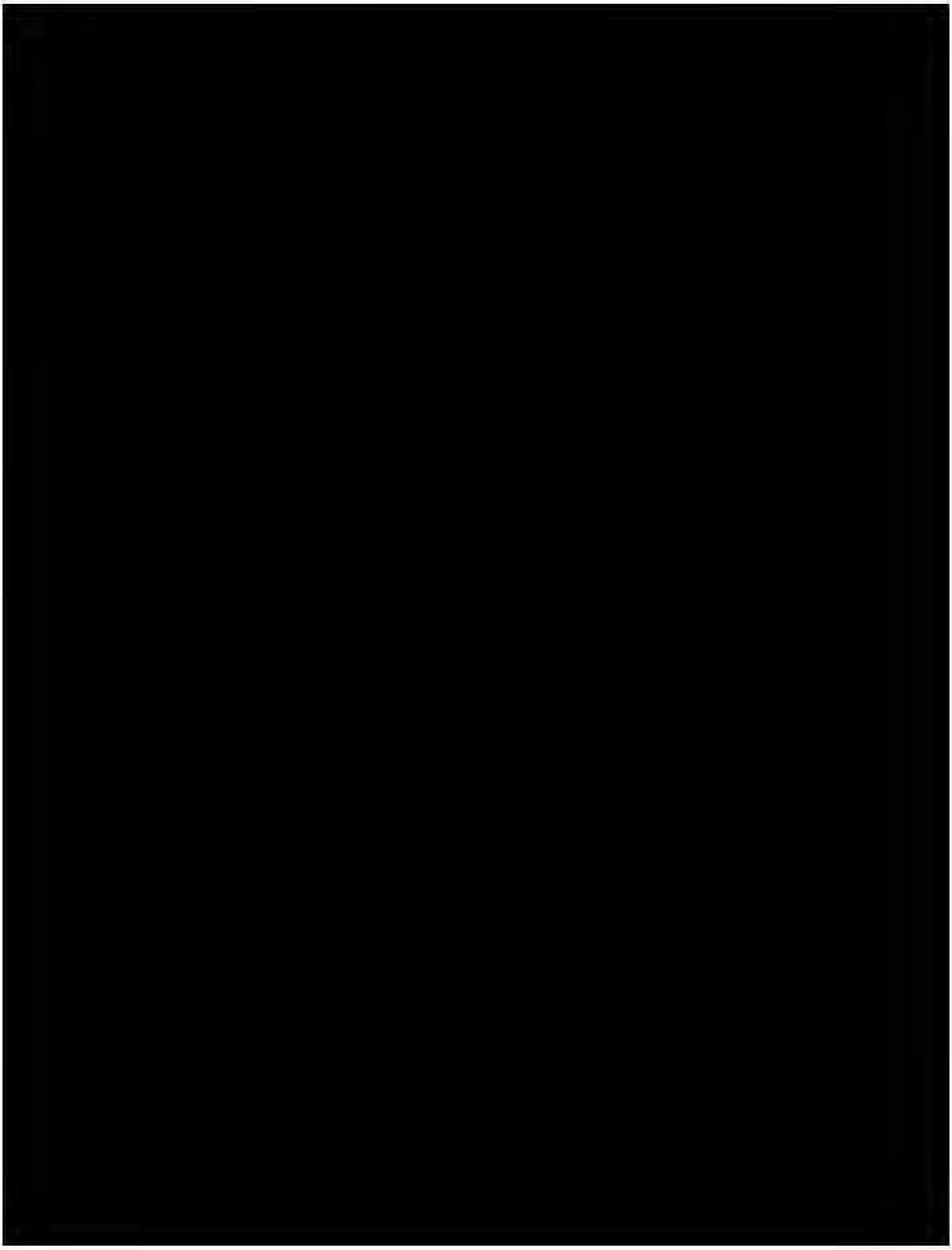
I certify that the claimant has authorized the undersigned representative to file this supplemental claim on behalf of the claimant and that the claimant is aware and accepts the information provided in this document. I certify that the claimant has authorized the undersigned representative to state 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 Claimant's Representative*, or VA Form 21-22a, *Appointment of Individual As Claimant's Representative*, indicating the appropriate POA is of record with VA.

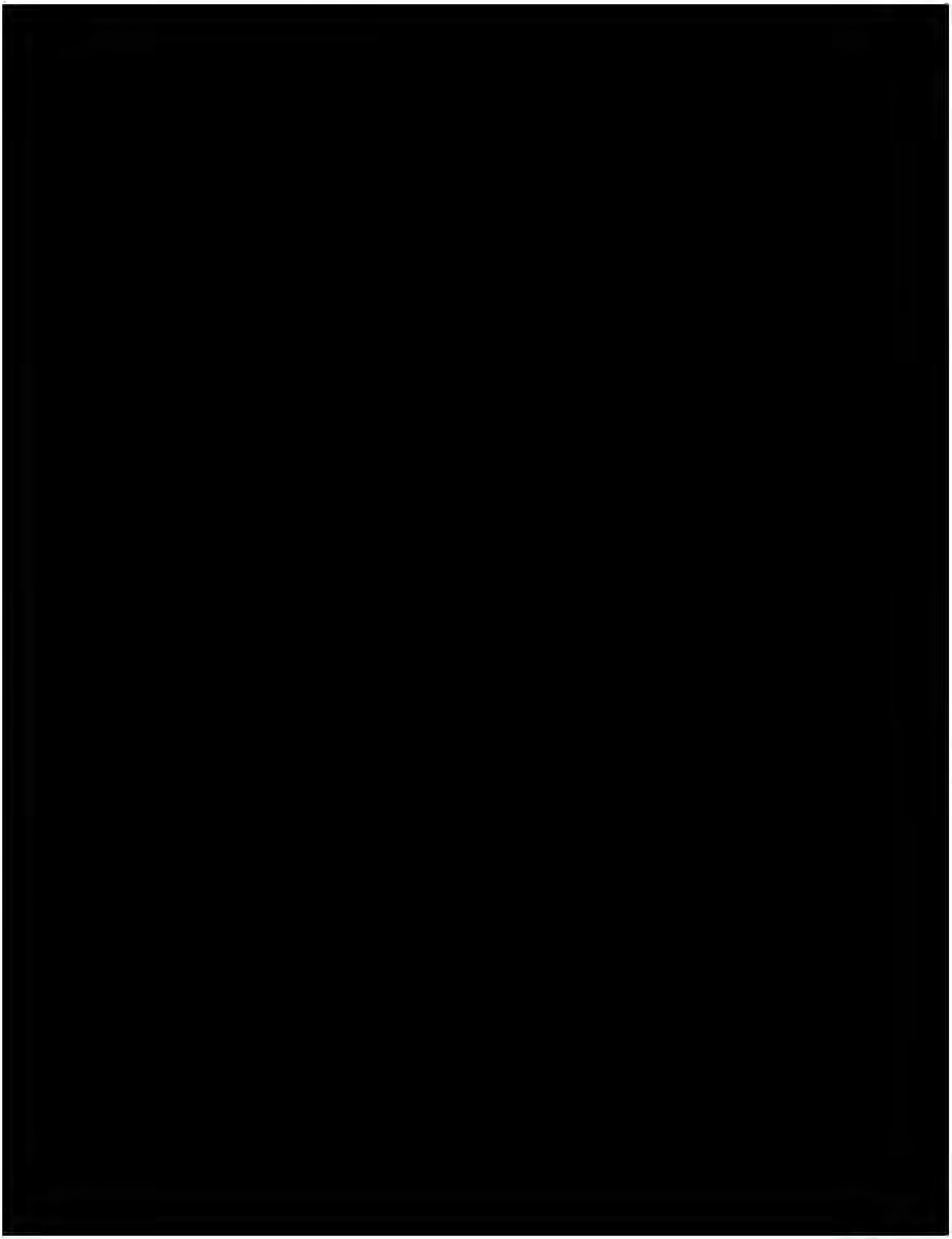
30A. POA/AUTHORIZED REPRESENTATIVE SIGNATURE	30B. DATE SIGNED

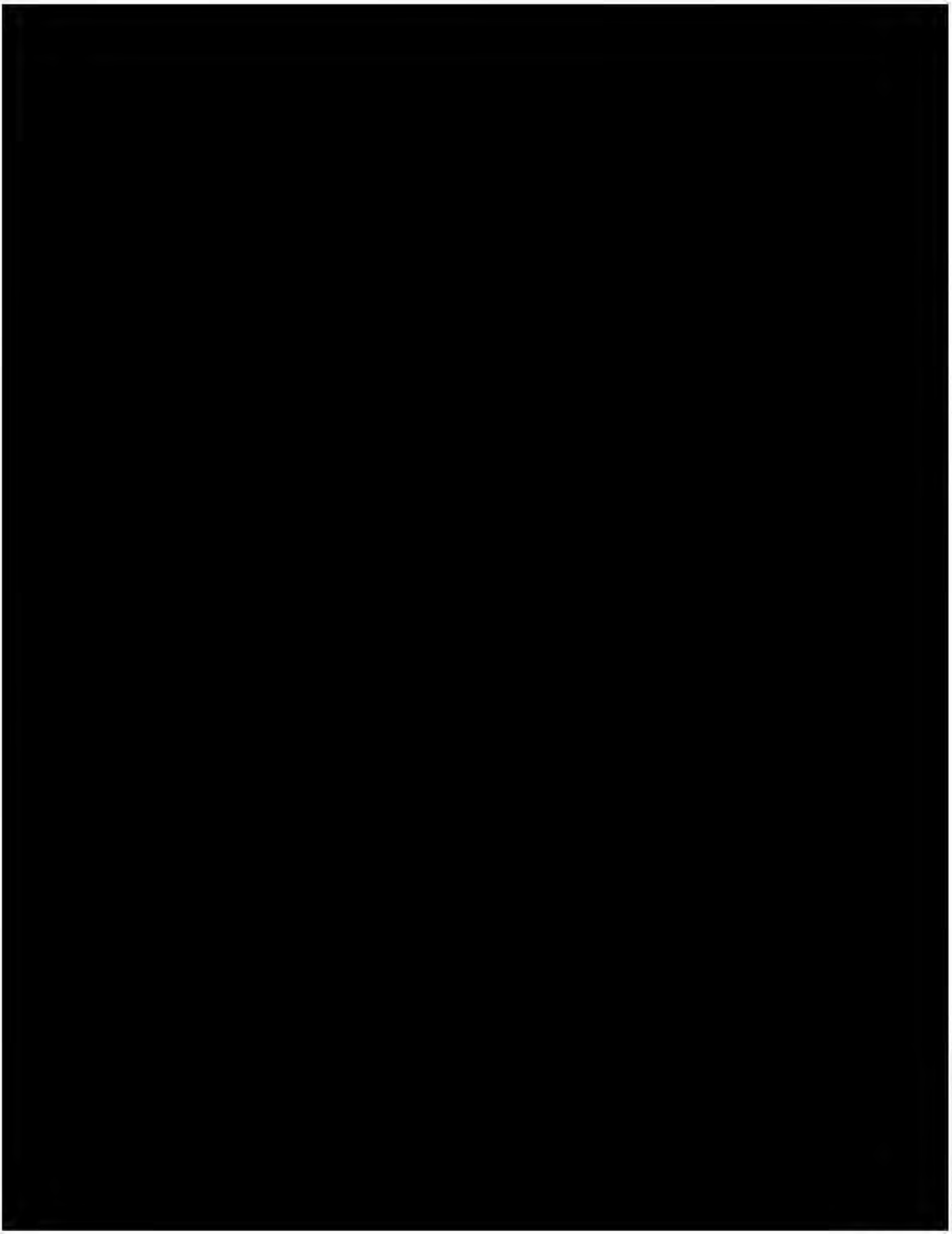
PRIVACY ACT NOTICE: The form will be used to determine allowance to compensation benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration. Your obligation to respond is required in order to obtain or retain benefits. Information that you furnish may be utilized in computer matching programs with other Federal or State agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.

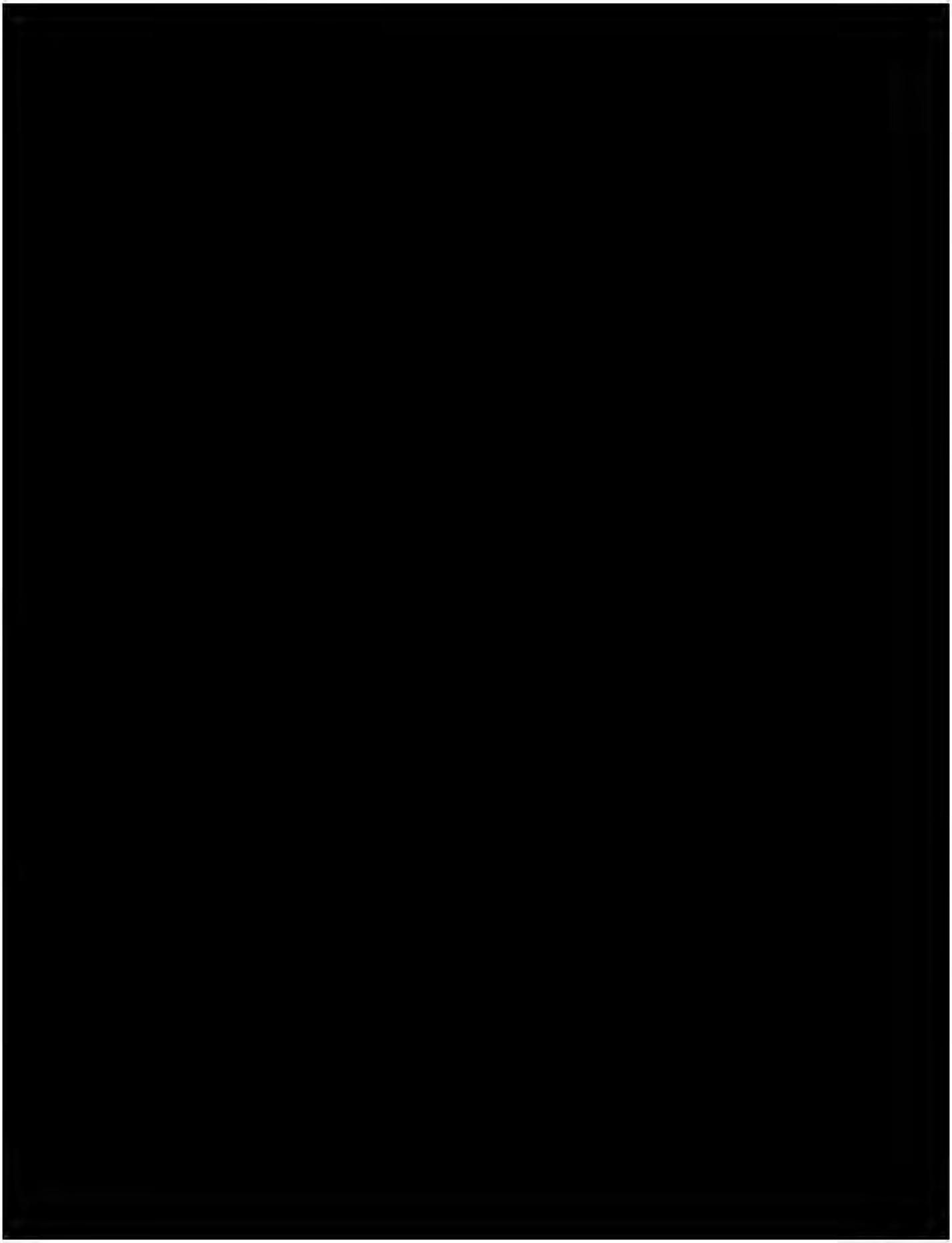
RESPONDENT BURDEN: We need this information to determine your eligibility for compensation. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 25 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.











[redacted]

testing, the result was positive. Then I was sent to [redacted] or confirmed diagnosis and counseling. Treatment was started and then returned to PCM for management. Veteran stated that he is doing well with the medication that he is taking . He stated that he is asymptomatic. He can take an APFT and pass when the time comes in [redacted] He states that he would like to remain on active duty.

b. Is continuous medication required for control of HIV-related illness(es)? Yes

If yes, list only those medications required for the Veteran's HIV-related illness(es) (If the Veteran has more than one HIV-related illness(es), specify the condition for which each medication is required): TRIUMEQ

c. Does the Veteran have any complications due to current or previous medications taken for HIV-related illness(es)? No

3. Signs, symptoms and findings

Does the Veteran have any signs, symptoms or findings attributable to an HIV-related illness? No

4. Complications

a. Does the Veteran have any complications attributable to an HIV-related illness or its treatment? No

b. For each checked condition (except those for which an additional DBQ is completed), describe (providing date of onset, and brief summary of symptoms, treatment and course): No answer provided

5. Infectious and oncologic complications

a. Does the Veteran now have or has he or she ever been had any HIV-related opportunistic infectious or oncologic conditions? No

b. Does the Veteran have recurrent opportunistic infection(s)? No

6. Mental health manifestations due to HIV-related illness or its treatment

a. Does the Veteran have depression, HIV-associated neurocognitive disorder, dementia, or any other mental health conditions attributable to HIV-related illness or its treatment? No

b. Does the Veteran's mental health condition(s) result in gross impairment in thought processes or communication (such that an interview with the Veteran would not yield useful information)? No

7. Summary

a. Level I
[X] Asymptomatic, with or without lymphadenopathy or decreased T4 cell count

b. Level II No answer provided

c. Level III No answer provided

d. Level IV No answer provided

e. Level V No answer provided

8. Other pertinent physical findings, complications, conditions, signs, symptoms and scars

a. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to the conditions listed in the Diagnosis Section above?
[ ] Yes [X] No

[redacted]

b. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis Section above?
[ ] Yes [X] No

c. Comments, if any:
N/A

9. Diagnostic testing

a. Has laboratory testing been performed? Yes

[X] CD4 (T4 cell) lymphocyte count: 503
Date: [redacted]
[X] Lowest (nadir) CD4 (T4 cell) lymphocyte count, if available:
Date, if known:
[X] CBC (if anemia of chronic disease attributable to HIV-related illness is suspected or present):
Date: [redacted]
Hemoglobin: 15.0
Hematocrit: 45.9
White blood cell count: 9.2
Platelets: 275
[X] Other test, specify: HIV
Date of test: [redacted]
Results: POSITIVE

b. Have imaging studies or diagnostic procedures been performed and are the results available? Yes

If yes, provide type of test or procedure, date and results (brief summary):
CHEST IMAGING - NEGATIVE

c. Has an HIV Dementia Scale been administered (if indicated)? No

d. Has neuropsychiatric testing been performed for cognitive impairment (if indicated)? No

e. Are there any other significant diagnostic test findings and/or results?
No

10. Functional impact

Do any of the Veteran's HIV-related illnesses or complications impact his or her ability to work? No

11. Remarks, if any:

Patient Radiology Report
[redacted] M
Priority: Exam#: [redacted]
Procedure: CHEST,PA/LAT Exam date: [redacted] 2:40:00 PM
Reason for exam: [redacted]
Order comment: IFCIII/GBC
[redacted]

[redacted]

Transcription date: [redacted]
Transcriptionist: [redacted]

****

General Medical - Separation Health Assessment
Disability Benefits Questionnaire
* Internal VA or DoD Use Only*

Name of claimant/Servicemember: [redacted]
SSN: [redacted]

Diagnosis Summary

Claimed Condition	Diagnosis
HIV	SEE SPECIFIC DBQ
[redacted]	

List of Symptomatic Systems:
[redacted]

y. Infectious disease, immune disorder or nutritional deficiency:
HIV and Related Illnesses

[redacted]

[redacted]

Was a DD Form 2807-1, Report of Medical History, completed by the Servicemember and available for review at the time of this examination?
[ ] Yes [X] No [ ] N/A

Any changes to his/her health status since DD 2807-1 completed?
[ ] Yes [X] No [ ] N/A

(Proposed) Date of separation from active service: N/A

1. Evidence Review

Evidence reviewed (check all that apply):

[X] VA e-folder (VBMS or Virtual VA)
[X] CPRS
[X] Other (please identify other evidence reviewed):
[redacted]

Evidence Comments:
[redacted]

[redacted]

2. Medical history (Review of Systems)

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

y. Infectious disease, immune disorder or nutritional deficiency:
[X] Yes [ ] No

[X] HIV and Related Illnesses
HIV

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

31. Other, describe:
HIV - SEE SPECIFIC DBQ

[redacted]

[redacted]

Disability Benefits Questionnaire

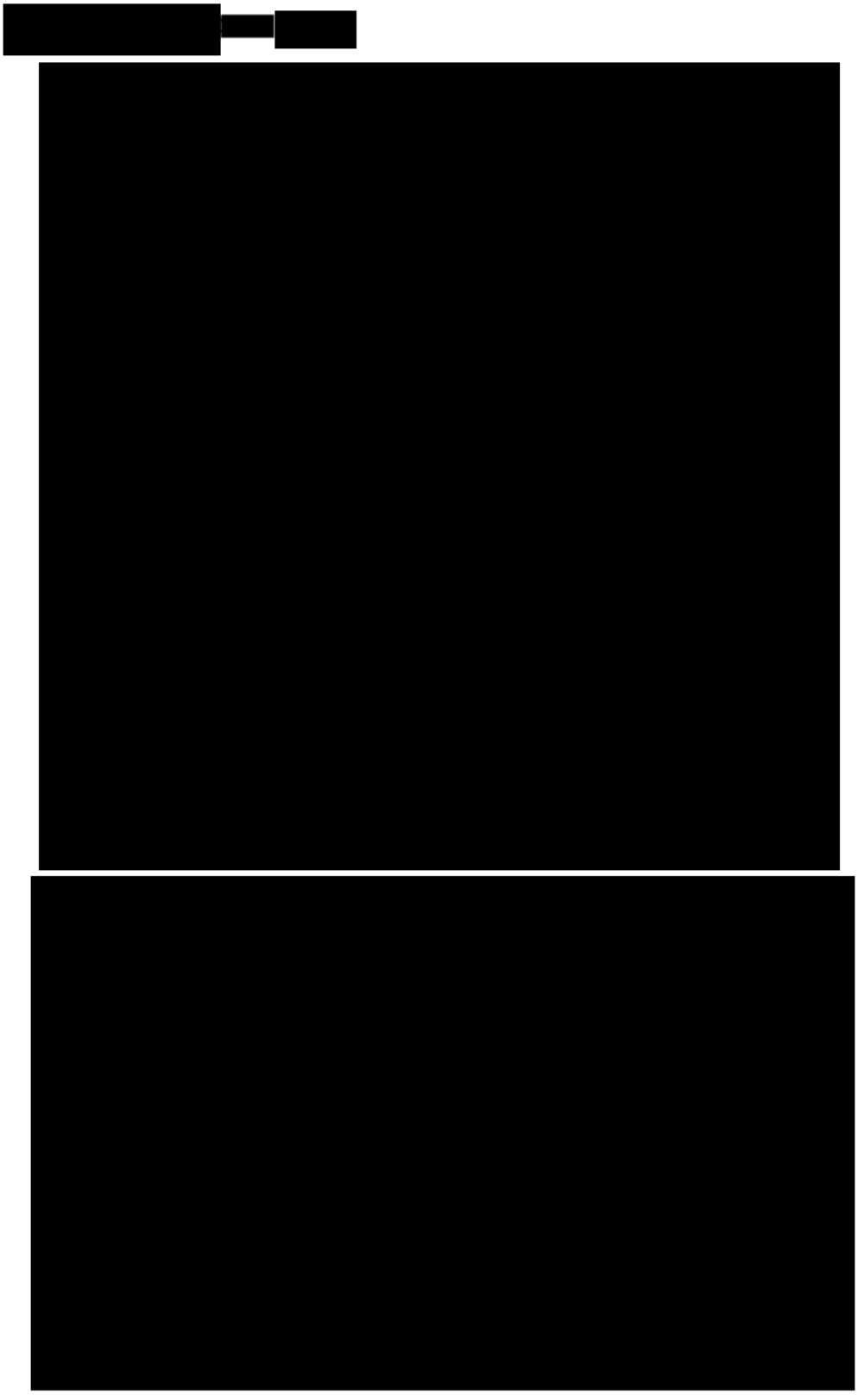
Name of patient/Veteran: [redacted]

[redacted]

[redacted]

[redacted]

[redacted]



[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

****

[redacted]

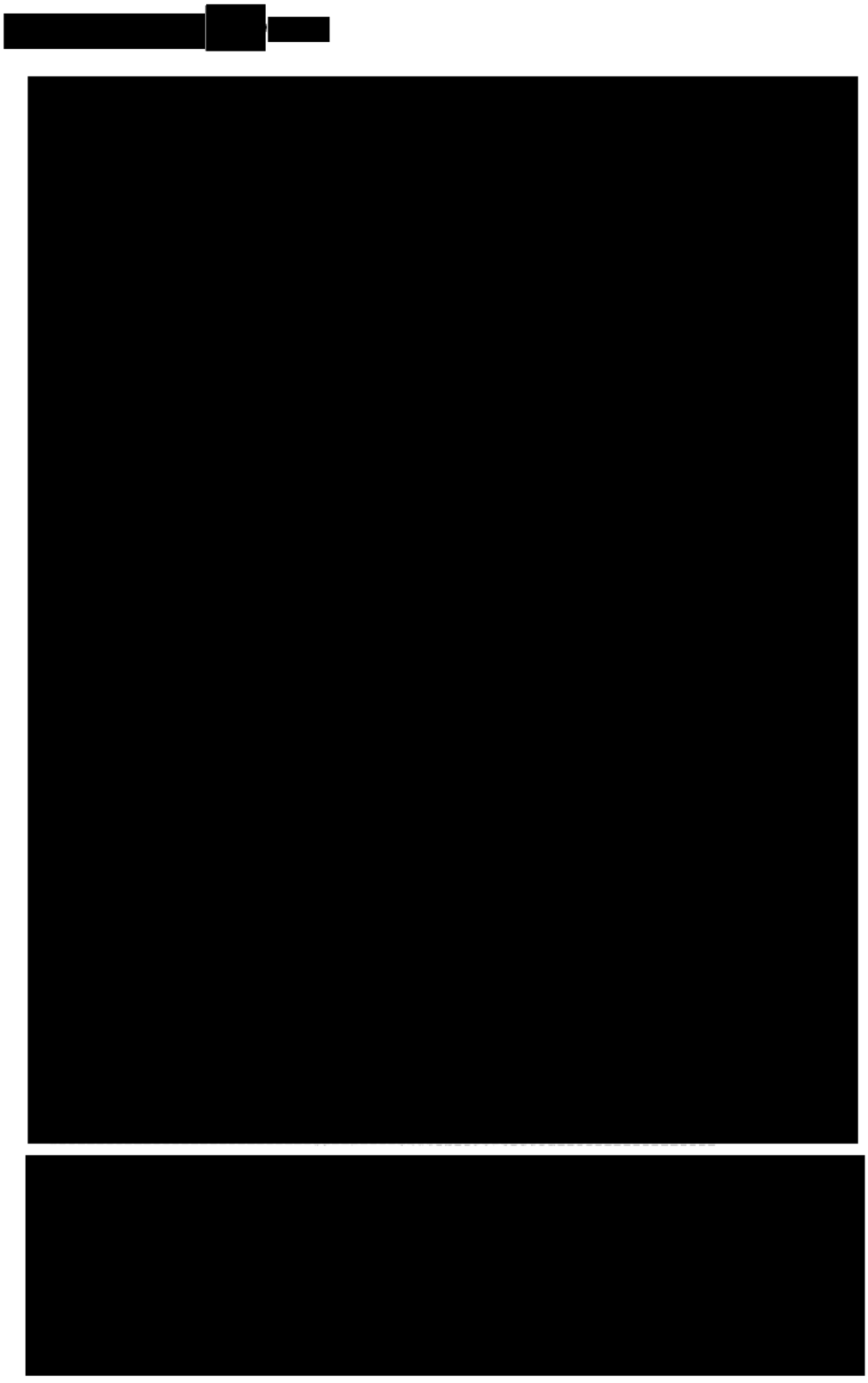
Name of patient/Veteran:

[redacted]

[redacted]

[redacted]

19



[redacted]

[redacted]

[redacted]

Miscellaneous
Disability Benefits Questionnaire

Name of patient/Veteran: [redacted]

Please use this DBQ to address 1151 requests, or other issues that are not specifically addressed by specific DBQs such as Individual Unemployability (UI).

[redacted]

[redacted]

Active duty service dates:

Branch: Air Force

EOD: [redacted]

RAD:

DBQ Medical SHA:

Please review the Veteran's electronic folder in VBMS and state that it was reviewed in your report.

Referred Conditions: Human Immunodeficiency Virus

Claimed Conditions:

[redacted]

Please address the "Correia" questions found near the bottom of this exam request.

****

Additional exam request information:

[redacted]

[redacted]

[redacted]

IF OTHER SPECIALITY EXAMINATIONS ARE REQUIRED, PLEASE ASSOCIATE WITH THIS EXAMINATION.

ADDRESS: SAME
POA: NONE

ANY ISSUES WITH REGARD TO THIS REQUEST CAN BE ADDRESSED WITH:
[redacted]

PEBLO Information:
Additional exam request information:
[redacted]

[redacted]

ANY ISSUES WITH REGARD TO THIS REQUEST CAN BE ADDRESSED WITH:
[redacted]

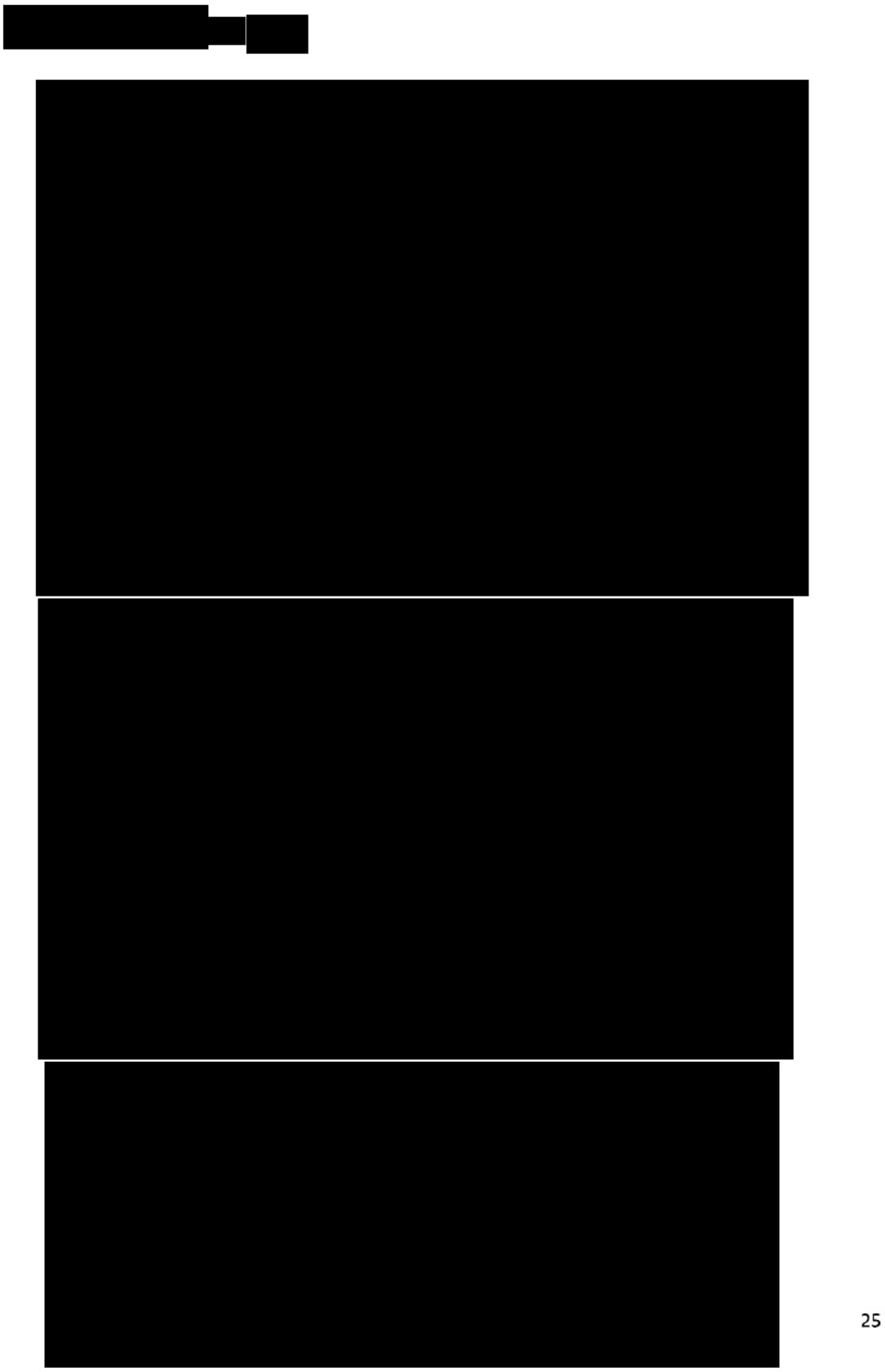
PEBLO Information:
[redacted]

****

Skin Diseases
Disability Benefits Questionnaire

Name of patient/Veteran: [redacted]

[redacted]



[redacted]

[redacted]

[redacted]

[redacted]

****

[redacted]

HIV-Related Illnesses
Disability Benefits Questionnaire

Name of patient/Veteran: [redacted]

[redacted]

[redacted]

1. Diagnosis

Does the Veteran now have or has he/she ever been diagnosed with HIV or an HIV-related illness? Yes

Diagnosis #1: HUMAN IMMUNODEFICIENCY VIRUS DISEASE
ICD code: B20.0
Date of diagnosis: [redacted]

2. Medical history

a. Describe the history (including onset and course) of the Veteran's HIV-related illness(es): [redacted] had a really sore throat, and fever while [redacted] I went to medical for the fever, they gave medication for the fever and the ST went away. Then in [redacted] during the bi-anival HIV testing, the result was positive. Then I was sent to [redacted] or confirmed diagnosis and counseling. Treatment was started and then returned to PCM for management. Veteran stated that he is doing well with the medication that he is taking . He stated that he is asymptomatic. He can take an APFT and pass when the time comes in [redacted] He states that he would like to remain on active duty.

b. Is continuous medication required for control of HIV-related illness(es)? Yes

If yes, list only those medications required for the Veteran's HIV-related illness(es) (If the Veteran has more than one HIV-related illness(es), specify the condition for which each medication is required): TRIUMEQ

c. Does the Veteran have any complications due to current or previous medications taken for HIV-related illness(es)? No

3. Signs, symptoms and findings

Does the Veteran have any signs, symptoms or findings attributable to an HIV-related illness? No

4. Complications

[redacted]

---

a. Does the Veteran have any complications attributable to an HIV-related illness or its treatment? No

b. For each checked condition (except those for which an additional DBQ is completed), describe (providing date of onset, and brief summary of symptoms, treatment and course): No answer provided

5. Infectious and oncologic complications

a. Does the Veteran now have or has he or she ever been had any HIV-related opportunistic infectious or oncologic conditions? No

b. Does the Veteran have recurrent opportunistic infection(s)? No

6. Mental health manifestations due to HIV-related illness or its treatment

a. Does the Veteran have depression, HIV-associated neurocognitive disorder, dementia, or any other mental health conditions attributable to HIV-related illness or its treatment? No

b. Does the Veteran's mental health condition(s) result in gross impairment in thought processes or communication (such that an interview with the Veteran would not yield useful information)? No

7. Summary

a. Level I
[X] Asymptomatic, with or without lymphadenopathy or decreased T4 cell count

b. Level II No answer provided

c. Level III No answer provided

d. Level IV No answer provided

e. Level V No answer provided

8. Other pertinent physical findings, complications, conditions, signs, symptoms and scars

a. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to the conditions listed in the Diagnosis Section above?
[ ] Yes [X] No

b. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis Section above?
[ ] Yes [X] No

c. Comments, if any:
N/A

9. Diagnostic testing

a. Has laboratory testing been performed? Yes

[X] CD4 (T4 cell) lymphocyte count: 503
Date: [redacted]
[X] Lowest (nadir) CD4 (T4 cell) lymphocyte count, if available:
Date, if known:
[X] CBC (if anemia of chronic disease attributable to HIV-related illness is suspected or present):
Date: [redacted]
Hemoglobin: 15.0
Hematocrit: 45.9
White blood cell count: 9.2

[redacted]

Platelets: 275
[X] Other test, specify: HIV
Date of test: [redacted]
Results: POSITIVE

b. Have imaging studies or diagnostic procedures been performed and are the results available? Yes

If yes, provide type of test or procedure, date and results (brief summary):
CHEST IMAGING - NEGATIVE

c. Has an HIV Dementia Scale been administered (if indicated)? No

d. Has neuropsychiatric testing been performed for cognitive impairment (if indicated)? No

e. Are there any other significant diagnostic test findings and/or results?
No

10. Functional impact

Do any of the Veteran's HIV-related illnesses or complications impact his or her ability to work? No

11. Remarks, if any:

Patient Radiology Report
[redacted]M
Priority: Exam#: [redacted]
Procedure: CHEST,PA/LAT Exam date: [redacted]
Reason for exam: 20 y/o M ADAF applying for IFCIII/GBC
Order comment: IFCIII/GBC
Result code: SEE CHCS REPORT TEXT
Finding:
STUDY: CHEST,PA/LAT
EXAM DATE: [redacted]
INDICATION: [redacted]
PRIOR STUDIES: None.
TECHNIQUE: PA and lateral views of the chest.
[redacted]
IMPRESSION: No evidence of acute cardiopulmonary disease.
[redacted]

****

General Medical - Separation Health Assessment
Disability Benefits Questionnaire
* Internal VA or DoD Use Only*

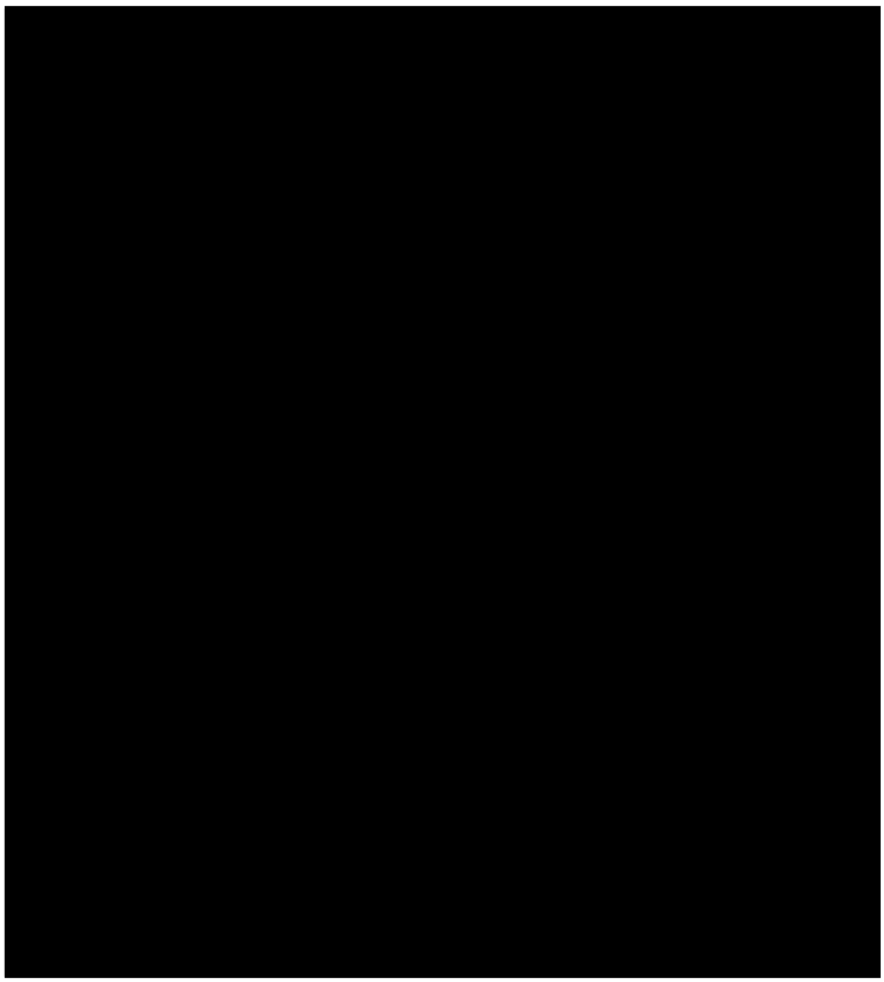
Name of claimant/Servicemember: [redacted]
SSN: [redacted]

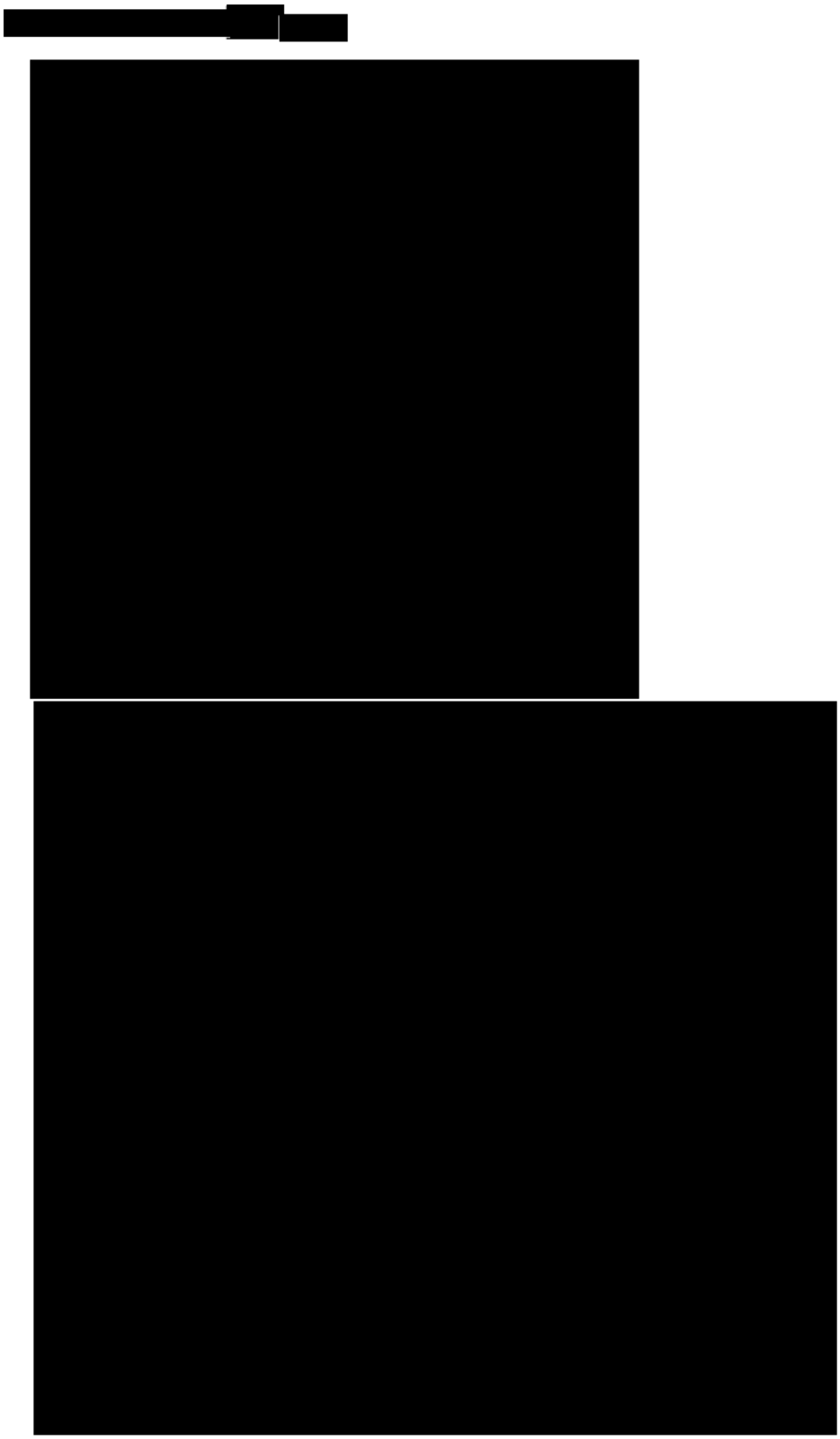
Diagnosis Summary

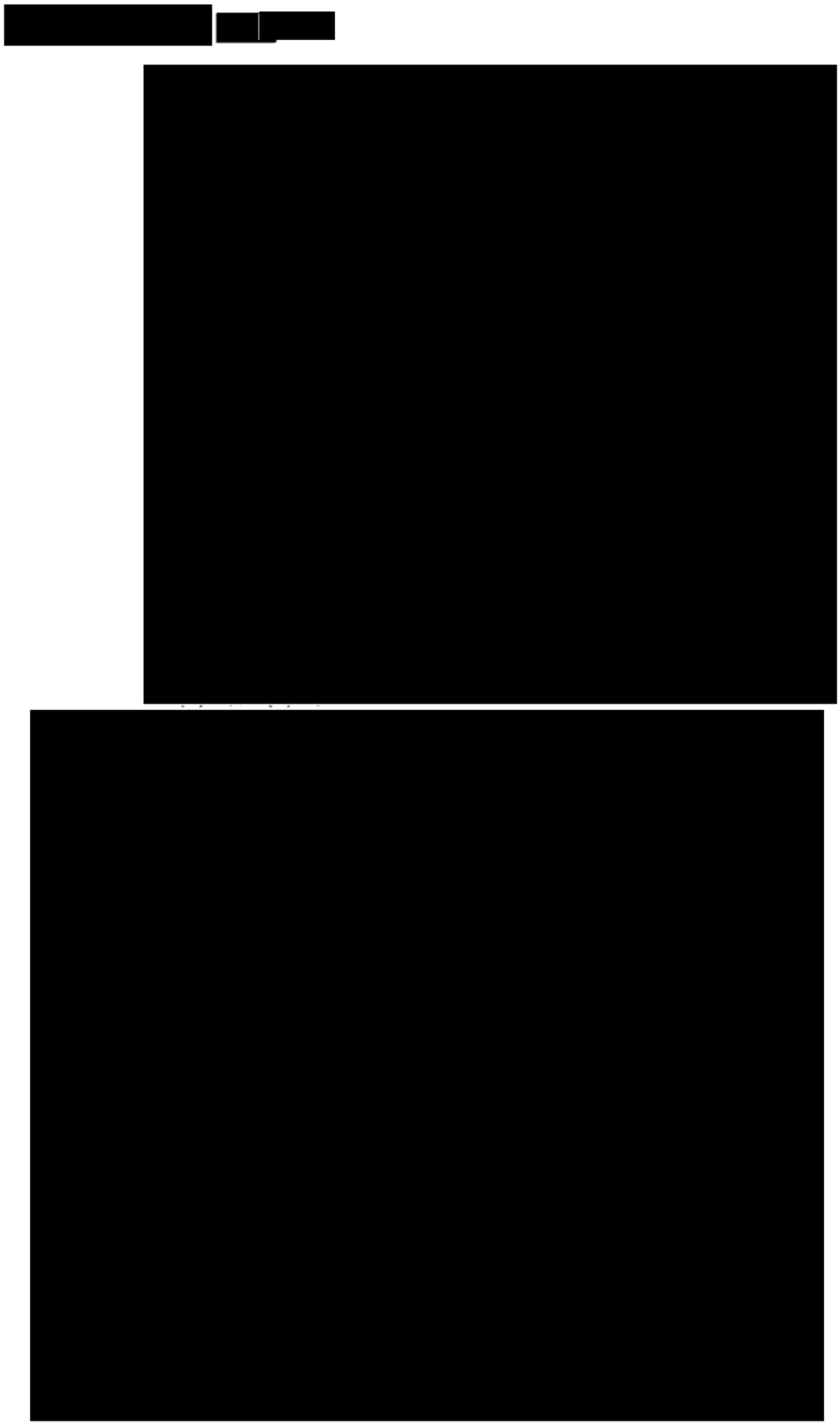
Claimed Condition	Diagnosis
HIV	SEE SPECIFIC DBQ

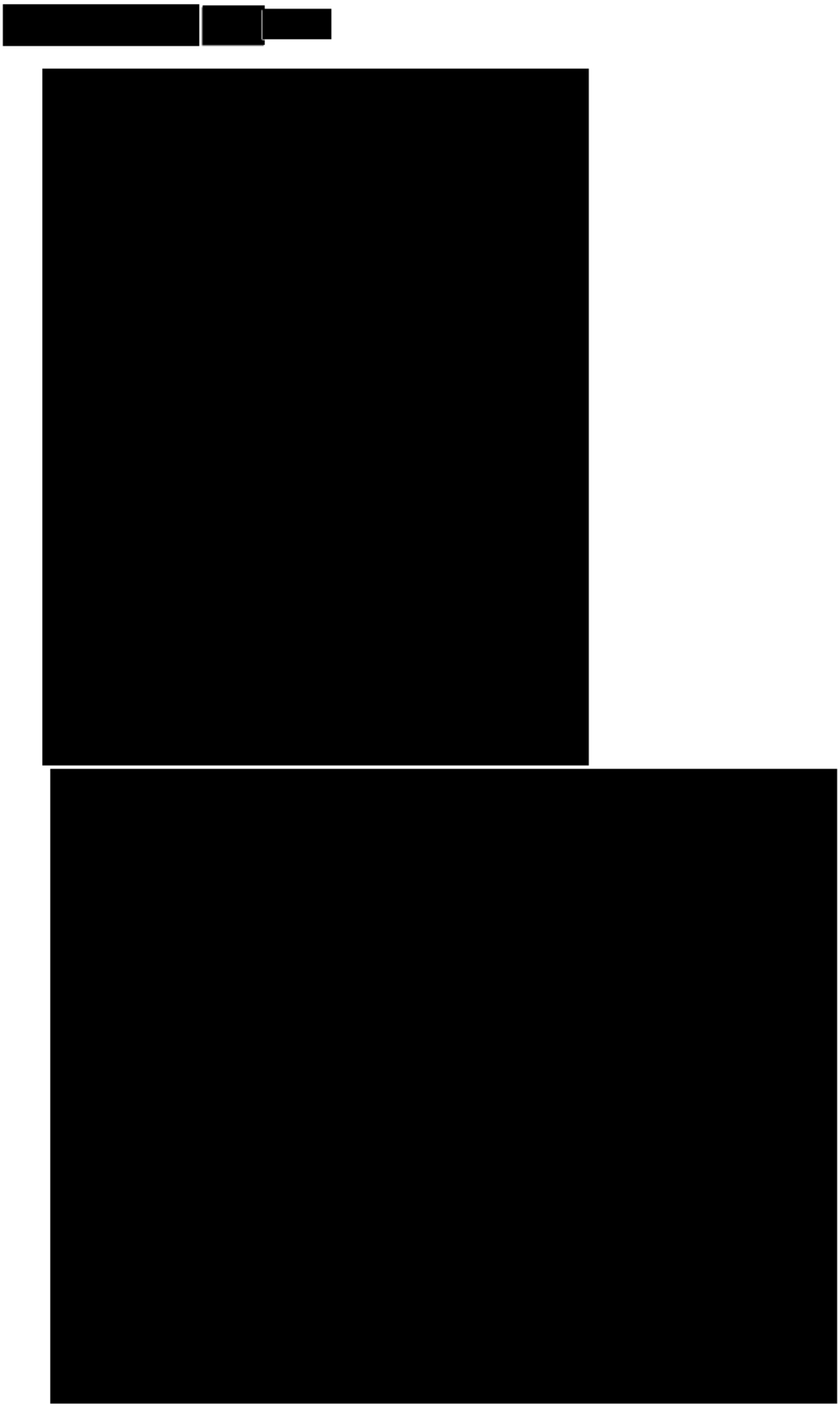
[redacted]

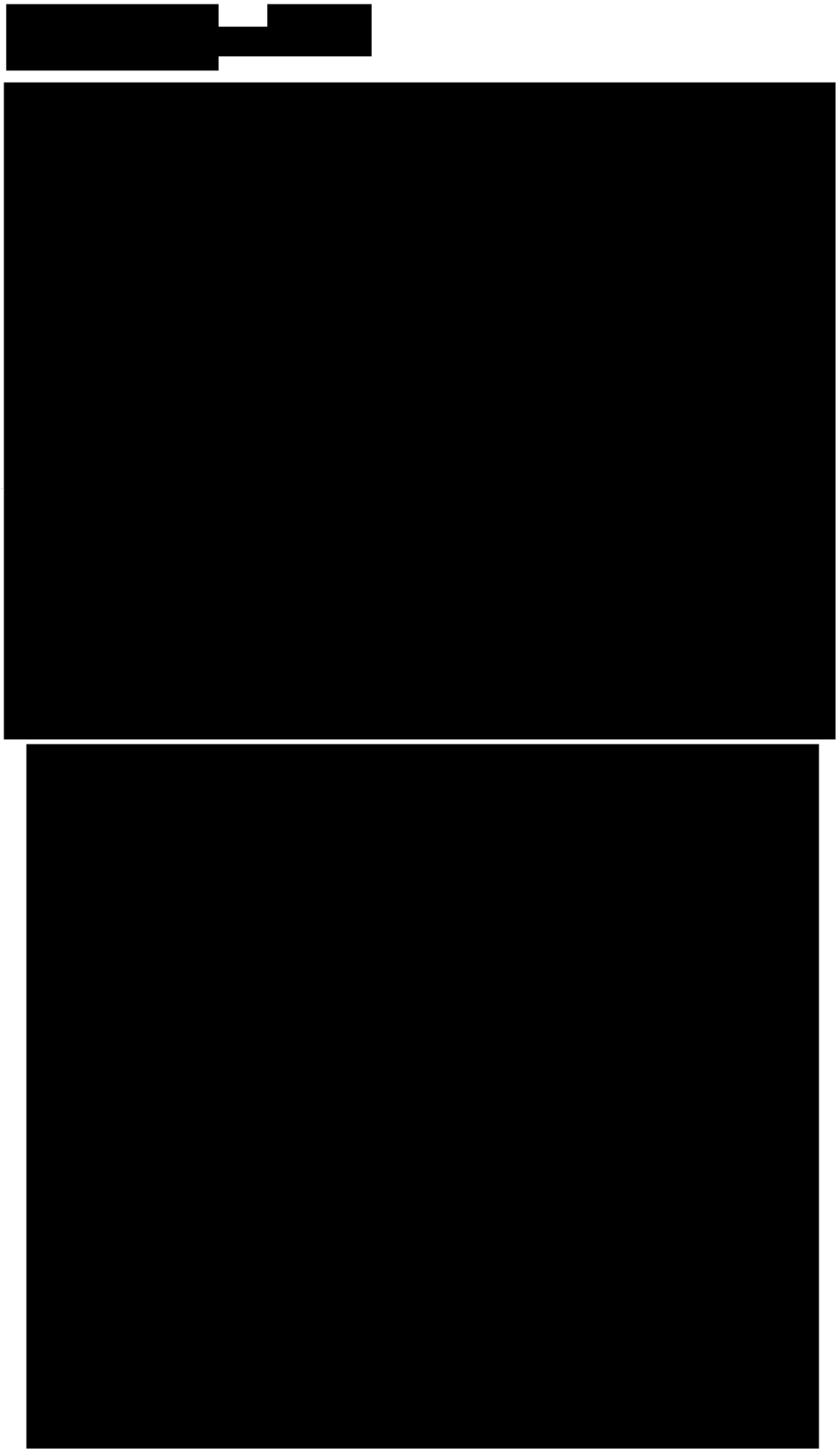
[redacted]











[redacted]

[redacted]

****

[redacted]

Disability Benefits Questionnaire

Name of patient/Veteran: [redacted]

[redacted]

35

[redacted]

AHLTA, VISTAWEB, CAPRI, VIRTUAL VA, JVL,

[redacted]

[redacted]

[redacted]

[redacted]

==========

Patient Radiology Report
[redacted]
Priority: Exam#: [redacted]
Procedure: [redacted]
Reason for exam: [redacted]
Order comment:
Result code: SEE REPORT TEXT
Finding:
Study: [redacted]
Study date: [redacted]
Indication: [redacted]

Comparison: None.

[redacted]

[redacted]

[redacted]

****

[redacted]

Disability Benefits Questionnaire

Name of patient/Veteran: [redacted]

[redacted]

SECTION II: Medical history

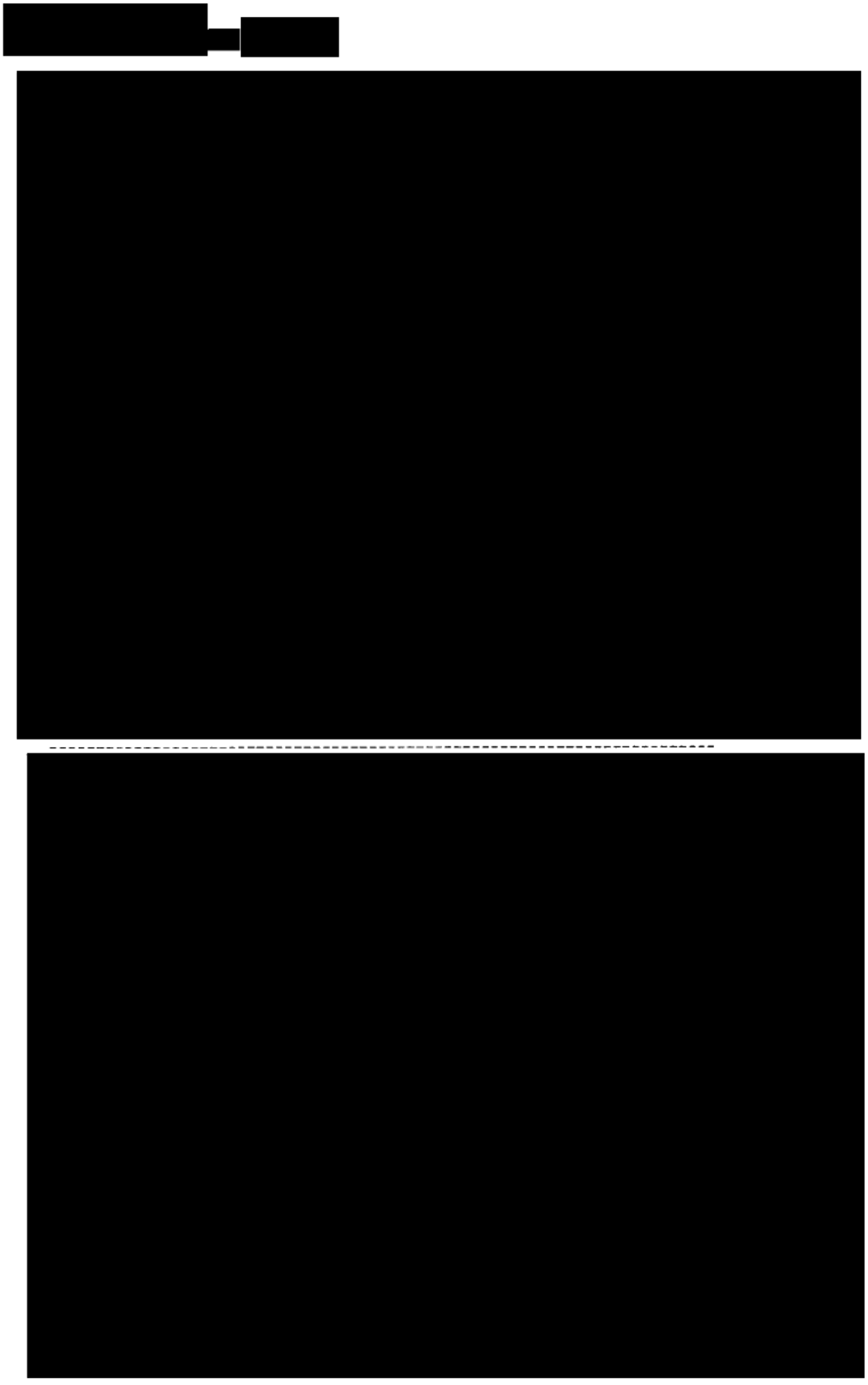
[redacted]

[redacted]

[redacted]

If yes, describe:

[redacted]



[redacted]

[redacted]

No

[redacted]

HEALTH RECORD [redacted]	CHRONOLOGICAL RECORD OF MEDICAL CARE
	Facility: JB San Antonio Military Treatment Facility, TX 78205 Clinic: INFECTIOUS DIS BAMC/BO
	Provider [redacted]

He was diagnosed as being HIV positive on test drawn [redacted] with last negative test ([redacted]). Testing was performed as mandatory periodic screen (or other). He reports an illnesses suggestive of acute antiretroviral syndrome in [redacted], no blood or needle exposures, and no known HIV positive contacts. He has had no illnesses consistent with immunocompromised state [redacted]

Allergies [redacted]

Past [redacted]

Reported: [redacted]

Personal history [redacted]

Family history [redacted]

Review of systems [redacted]

Name [redacted]

FMP/SSN: [redacted]
DOB:
PAT CAT: FIT USAF ACTIVE DUTY
MC Status:
Status
CIC:

Sex: [redacted]
DoD
Tel H
Tel W
CS:
PCM:

Sponsor Name: [redacted]
Rank:
Unit:
OutPAT RR:
Insurance:
Tel. PCM:

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
[redacted]	Facility: JB San Antonio Military Treatment Facility, TX 78205 Clinic: INFECTIOUS DIS BAMC/BO Provider: [redacted]

Physical findings

[redacted]

Lab Result Cited by MARKELZ,ANA E @ 08 Nov 2017 1157 CST

HIV-1/O/2 Ab	Site/Specimen	05 Oct 2015 0525
HIV-1/O/2 Ab	SERUM	NON-REACTIVE <i> <o>

[redacted]

Lab Result Cited by MARKELZ,ANA E @ 08 Nov 2017 1157 CST

HIV-1/O/2 Ab	Site/Specimen	16 Oct 2017 1112
HIV-1/O/2 Ab	SERUM	SCREEN REACTIVE - CONFIRMATION TO FOLLOW (H) <i>

Lab Result Cited by MARKELZ,ANA E @ 08 Nov 2017 1157 CST

HIV Confirmation Panel	Site/Specimen	16 Oct 2017 1112
HIV-1 RNA	SERUM	TEST NOT PERFORMED <i>
HIV Interpretation	SERUM	HIV-1 POSITIVE (H) <r> <i>

Name: [redacted]

FMP/SSN: [redacted]
DOB:
PAT CAT: [redacted] DUTY
MC Status:
Status
CIC:

Sex:
DoD I
Tel H
Tel W
CS:
PCM: [redacted]

Sponsor Name: [redacted]
Rank:
Unit:
OutPAT RR:
Insurance:
Tel. PCM:

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
[redacted]	Facility: JB San Antonio Military Treatment Facility, TX 78205 Clinic: INFECTIOUS DIS BAMC/BO Provider: [redacted]

[redacted]

Rapid Plasma Reagin Panel	Site/Specimen
Reagin Ab	SERUM

Glucose-6-Phosphate Dehydrogenase Quant	
Glucose-6-Phosphate Dehydrogenase	BLOOD

HIV-1 Viral Load Ultrasensitive	Site/Specimen
HIV-1 RNA Ultrasensitive	PLASMA
HIV-1 RNA Log 10 Ultrasensitive	PLASMA

Hepatitis Virus Panel Acute	Site/Specimen
Hepatitis B Virus Surface Ag	SERUM
Hepatitis B Virus Core Ab IgM	SERUM
Hepatitis A Virus Ab IgM	SERUM
Hepatitis C Virus Ab	SERUM

Hepatitis B Virus Core Ab	Site/Specimen
Hepatitis B Virus Core Ab	SERUM

Hepatitis B Virus Surface Ab	Site/Specimen
Hepatitis B Virus Surface Ab	SERUM

Urinalysis Panel	Site/Specimen
Glucose	URINE
Color	URINE
Appearance	URINE
Bilirubin	URINE
Ketones	URINE
Specific Gravity	URINE
Hemoglobin	URINE
pH	URINE
Protein	URINE
Urobilinogen	URINE
Nitrite	URINE
Leukocyte Esterase	URINE
RBC	URINE
WBC	URINE
Mucus	URINE

CDC Basic Panel	Site/Specimen
WBC	BLOOD
Lymphocytes	BLOOD
CD3+CD8+	BLOOD
CD3	BLOOD
CD3+CD4+	BLOOD
CD3-CD19+	BLOOD
CD3-CD56+	BLOOD
T Cells	BLOOD
CD3+CD4+/CD3+CD8+	BLOOD
CD3+CD8+ Absolute	BLOOD
CD3+CD4+ Absolute	BLOOD

Lactate Dehydrogenase	Site/Specimen
Lactate Dehydrogenase	SERUM

Lipid Panel	Site/Specimen
Cholesterol/HDL Cholesterol	SERUM
Cholesterol	SERUM
HDL Cholesterol	SERUM

Name [redacted]

FMP/SSN: [redacted]
DOB:
PAT CAT: FIT USAF ACTIVE DUTY
MC Status:
Status
CIC:

Sex:
DoD ID:
Tel H:
Tel W:
CS:
PCM:

Sponsor Name:
Rank:
Unit:
OutPAT RR:
Insurance:
Tel PCM:

HEALTH RECORD [redacted]	CHRONOLOGICAL RECORD OF MEDICAL CARE
	Facility: JB San Antonio Military Treatment Facility, TX 78205 Clinic: INFECTIOUS DIS BAMC/BO
	Provider: [redacted]

LDL Cholesterol	SERUM
Triglyceride	SERUM
Hemolysis Index	SERUM
Icteric Index	SERUM
Lipemia Index	SERUM
Phosphorus	**Site/Specimen**
Phosphate	SERUM
Hepatic Function Panel	**Site/Specimen**
Albumin	SERUM
Bilirubin	SERUM
Alkaline Phosphatase	SERUM
Aspartate Aminotransferase	SERUM
Alanine Aminotransferase	SERUM
Bilirubin Direct	SERUM
Protein	SERUM
Hemolysis Index	SERUM
Icteric Index	SERUM
Lipemia Index	SERUM
Basic Metabolic Panel	**Site/Specimen**
Glucose	SERUM
Urea Nitrogen	SERUM
Creatinine	SERUM
Sodium	SERUM
Potassium	SERUM
Chloride	SERUM
Carbon Dioxide	SERUM
Anion Gap	SERUM
Calcium	SERUM
Hemolysis Index	SERUM
Icteric Index	SERUM
Lipemia Index	SERUM
GFR Non-Black	SERUM
GFR Black	SERUM
CBC	**Site/Specimen**
Hemoglobin	BLOOD
Hematocrit	BLOOD
WBC	BLOOD
RBC	BLOOD
MCV	BLOOD
MCH	BLOOD
MCHC	BLOOD
RDW CV	BLOOD
Platelets	BLOOD
MPV	BLOOD
Neutrophils	BLOOD
Lymphocytes	BLOOD
Monocytes	BLOOD
Eosinophils	BLOOD
Basophils	BLOOD
ABS Neutrophils	BLOOD
ABS Lymphocytes	BLOOD
ABS Monocytes	BLOOD
ABS Eosinophils	BLOOD
ABS Basophils	BLOOD
Nucleated RBC/100 WBC	BLOOD

Name: [redacted]

FMP/SSN: [redacted]
DOB:
PAT CAT: [redacted] DUTY
MC Status:
Status
CIC:

Sex:
DoD ID:
Tel H:
Tel W:
CS:
PCM:

Sponsor Name:
Rank:
Unit:
OutPAT RR:
Insurance:
Tel. PCM:

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
[redacted]	Facility: JB San Antonio Military Treatment Facility, TX 78205 Clinic: INFECTIOUS DIS BAMC/BO Provider: [redacted]

[redacted]

Follow-up viral load and renal panel should be checked at 1 and 3 months for efficacy and toxicity of the regimen.

[redacted]

Profile: No physical activity restrictions from this diagnosis.
Assignment limitations: Code C

[redacted]

[redacted]

Name: [redacted]		Sex:	[redacted]	Sponsor Name	[redacted]
FMP/SSN:	[redacted]	DoD ID:		Rank:	
DOB:	[redacted]	Tel H:		Unit:	
PAT CAT:	FTI USAF ACTIVE DUTY	Tel W:		OutPAT RR:	
MC Status:		CS:		Insurance:	
Status		PCM:		Tel. PCM:	
CIC:					

HEALTH RECORD [redacted]

CHRONOLOGICAL RECORD OF MEDICAL CARE

Facility: JB San Antonio Military Treatment Facility, TX 78205 Clinic: INFECTIOUS DIS BAMC/BO

Provider: [redacted] ETII

[redacted]

Name: [redacted]

FMP/SSN: [redacted]

DOB:

PAT CAT: F11 USAF ACTIVE DUTY

MC Status:

Status

CIC:

Sex:

DoD ID:

Tel H:

Tel W:

CS:

PCM:

Sponsor Name:

Rank:

Unit:

OutPAT RR:

Insurance:

Tel. PCM:

CHRONOLOGICAL RECORD OF MEDICAL CARE

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974(PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

STANDARD FORM 600 (REV. 5)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

Page 7 of 9

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
[redacted]	Facility: JB San Antonio Military Treatment Facility, TX 78205 Clinic: INFECTIOUS DIS BAMC/BO Provider: [redacted]

[redacted]

Name: [redacted]

FMP/SSN: [redacted]
DOB:
PAT CAT: F11 USAF ACTIVE DUTY
MC Status:
Status
CIC:

DoD ID: [redacted]
Tel H:
Tel W:
CS:
PCM:

Sponsor Name: [redacted]
Rank:
Unit:
OutPAT RR:
Insurance:
Tel. PCM:

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
[redacted]	Facility: JB San Antonio Military Treatment Facility, TX 78205 Clinic: INFECTIOUS DIS BAMC/BO Provider: [redacted]

[redacted]

Name: [redacted]

FMP/SSN: [redacted]
DOB: [redacted]
PAT CAT: F11 USAF ACTIVE DUTY
MC Status:
Status
CIC:

Sex:
DoD ID
Tel H:
Tel W:
CS:
PCM: [redacted]

Sponsor Name: [redacted]
Rank:
Unit:
OutPAT RR:
Insurance:
Tel. PCM:

CHRONOLOGICAL RECORD OF MEDICAL CARE
THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974(PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

STANDARD FORM 600 (REV. 5)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

REPORT OF MEDICAL EXAMINATION

1. DATE OF EXAMINATION (YYYYMMDD)	2. SOCIAL SECURITY NUMBER
[redacted]	[redacted]

PRIVACY ACT STATEMENT

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

3. LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	4. HOME ADDRESS (Street, Apartment Number, City, State and ZIP Code)	5. HOME TELEPHONE NUMBER (Include Area Code)
[redacted]	[redacted]	[redacted]

6. GRADE	7. DATE OF BIRTH (YYYYMMDD)	8. AGE	9. SEX	10.a. RACIAL CATEGORY (X one or more)	10.b. ETHNIC CATEGORY
CIVILIAN	[redacted]	[redacted]	[ ] Female [X] Male	[redacted]	

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

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

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

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

	Normal	Abnorm	NE
[redacted]			

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

[redacted]

35. FEET *(Continued) (Circle category)*

[redacted]

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

[redacted]

[redacted]

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX) [redacted] | DFR | SOCIAL SECURITY NUMBER [redacted]

[redacted]

MEASUREMENTS AND OTHER FINDINGS

[redacted]

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

[redacted]

DD FORM 2808, OCT 2005

DESIGNED USING MIRS, USMEPCOM; OUSD(P&R)
OVERPRINT/EXCEPTION APPROVED, MAY 7, 2001

[redacted]

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX) [redacted]	DFR	SOCIAL SECURITY NUMBER [redacted]

74.a. EXAMINEE/APPLICANT *(check one)*	75. I have been advised of my disqualifying condition. I have been advised to see my private medical care provider within 24-48-72 hours/30 days / Routine Follow-up (circle one) for further evaluation and/or treatment.
[X] IS QUALIFIED FOR SERVICE IN SPF DFR [ ] IS NOT QUALIFIED FOR SERVICE	a. SIGNATURE OF EXAMINEE [redacted] b. DATE *(YYYYMMDD)*

[redacted]

79. MEPS WORKLOAD *(For MEPS use only)* [redacted]

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

81.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. S
82.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. S
83.a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)*	b. S
84.a. TYPED OR [redacted] PROVING AUTHORITY	b. S

[redacted]

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

a. SIGNATURE [redacted]	b. GRADE [redacted]	c. DATE *(YYYYMMDD)* [redacted]

86. WAIVER GRANTED *(If yes, date and by whom)*	87. NUMBER OF ATTACHED SHEETS
[ ] YES [ ] NO	3

DD FORM 2808, OCT 2005

DESIGNED USING MIRS, USMEPCOM; OUSD(P&R)
OVERPRINT/EXCEPTION APPROVED, MAY 7, 2001
Page 3 of 4 Pages

[redacted]

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	DFR	SOCIAL SECURITY NUMBER
[redacted]		[redacted]

88. Additional Remarks (extension of blocks 77 or 78).

[redacted]

DD FORM 2808, OCT 2005

DESIGNED USING MIRS, USMEPCOM; OUSD(P&R)
OVERPRINT/EXCEPTION APPROVED, MAY 7, 2001
Page 4 of 4 Pages

REPORT OF MEDICAL HISTORY

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

Form Approved
OMB No. 0704-0413
Expires Oct 31, 2006

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

PRIVACY ACT STATEMENT

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

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a $10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	2. SOCIAL SECURITY NUMBER	3. TODAY'S DATE *(YYYYMMDD)*
[redacted]	[redacted]	[redacted]

4.a. HOME ADDRESS *(Street, Apartment No., City, State, ZIP Code)*	5. EXAMINING LOCATION AND ADDRESS *(Include ZIP Code)*
[redacted]	[redacted]
b. HOME TELEPHONE *(Include Area Code)* [redacted]	

X ALL APPLICABLE BOXES:

6.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION	7.a. POSITION *(Title, Grade, Component)*
[ ] Army [ ] Coast Guard	[X] Active Duty	[X] Enlistment	[ ] Medical Board [ ] Other *(Specify)*
[ ] Navy	[ ] Reserve	[ ] Commission	[ ] Retirement
[ ] Marine Corps	[ ] National Guard	[ ] Retention	[ ] U.S. Service Academy
[X] Air Force		[ ] Separation	[ ] ROTC Scholarship Program

CIVILIAN

b. USUAL OCCUPATION [redacted]

8. CURRENT MEDICATIONS *(Prescription and Over-the-counter)*	9. ALLERGIES *(Including insect bites/stings, foods, medicine or other substance)*
[redacted]	[redacted]

Mark each item "YES" or "NO".

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
[redacted]		

[redacted]

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) [redacted]	SOCIAL SECURITY NUMBER [redacted]

Mark each item "YES" or "NO".	Mark each item "YES" or "NO". For items 19 - 28, every item marked "YES" must be fully explained in item 29 below.
HAVE YOU EVER HAD OR DO YOU NOW HAVE: YES NO [redacted]	[redacted]

29. EXPLANATION OF "YES" ANSWER(S) *(Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current status.)*

[redacted]

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED, MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

[redacted]

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER
[redacted]	[redacted]

30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician/practitioner shall comment on all positive answers in questions 8 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)*

a. COMMENTS

[redacted]

EXAMINEE. I certify the information on this form is true and complete to the best of my knowledge and belief, and no person has advised me to conceal or falsify any information about my physical and mental history. I further understand that I may be requested to provide medical documentation regarding issues within my medical history. I authorize any of the doctors, hospitals, clinics or insurance company(ies) to furnish the Department of Defense medical authority a complete transcript of my medical record for purposes of processing my application for military service.

[redacted]

b. TYPED OR PRINTED NAME OF EXAMINER	c. [redacted]	d. DATE SIGNED (YYYYMMDD)
		[redacted]

DD FORM 2807-1, OCT 2003

DoD exception to [redacted]

DESIGNED USING MIRS, USMEPCOM; OUSD(P&R)
OVERPRINT/EXCEPTION APPROVED, MAY 7, 2001

[redacted]

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) [redacted]	SOCIAL SECURITY NUMBER [redacted]

31. ADDITIONAL REMARKS. *(Extention of blocks 29 or 30).*

[redacted]

MEDICAL HISTORY PROVIDER INTERVIEW

(For use of this form, see USMEPCOM Reg 40-1)

DD Form 2807-1 and DD Form 2807-2 provide guidance for your MEPS Medical Provider to request additional medical history during your provider interview. Please complete the following questions to facilitate this interview.

1. Name

First, Last, MI (Please print)

Date

2. Social Security Number

3. Date of Exam

YEAR | MO | DAY

4. Sex
- ○ Female
- ● Male

5a. Service
- ○ Marine Corps
- ○ Army
- ○ Navy
- ● Air Force
- ○ Coast Guard

5b. Component
- ○ National Guard
- ● Active Duty
- ○ Reserve

6. Screening Questions Part 1 – fill in the bubble that corresponds to your answer for each of the following questions.

7. Screening Questions Part 2 – fill in the bubble that corresponds to your answer for each of the following questions.

PRIVACY ACT STATEMENT

Authority:	Title 10, United States Code (USC), Sections 504, 505, 507, 532, 978, 1201, 1202, and 4346; Executive Orders 9397 and 13478 (SSN)
Principal purpose:	To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.
Routine uses:	None. The Department of Defense "Blanket Routine Uses" set forth at the beginning of the Army's compilations of system of records notices applies to this system.
Disclosure:	Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

USMEPCOM Form 40-1-15-1-E (Jun 11, TEMPORARY, Expires: Dec 12)

Please mark the bubble in the column that corresponds to your answer to each of the following questions.
Note: An answer is required for every question.

[redacted]

MEPS CODES

Indicate MEPS location by marking the code below.

EAST

[redacted]

WEST

[redacted]

PROVIDER 3 INITIALS

(first name, middle name, last name)

○ CMO

Initials

○ ACMO

Initials

[redacted]

DO NOT MARK IN THIS BOX

SEQUENCE NUMBER

0251314

*U.S. GOVERNMENT PRINTING OFFICE : 1980 0 - 341-526 (6198)

rt on ______________

or

nuation of S.F. ___[redacted]

(Strike out one [redacted]

(Sign and date)

[redacted]

[redacted]0260

11112590 Initial:

20120308

<YYYYMMDD>

[redacted]

[redacted]0260

11112590 Initial:

20120308

<YYYYMMDD>

[redacted]

[redacted]0260

11112590 Initial:

20120308

<YYYYMMDD>

[redacted]

[redacted]0260

11112590 Initial:

20120308

<YYYYMMDD>

[redacted]

[redacted]0260

11112590 Initial:

20120308

<YYYYMMDD>

[redacted]

[redacted]0260

11112590 Initial:

20120308

<YYYYMMDD>

(Continue on reverse side)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

REPO[redacted]

[redacted]

DFR

MEDICAL PRESCREEN OF MEDICAL HISTORY REPORT

(Chapter #2 Physicals Only)

OMB No. 0704-0413
OMB approval expires Mar 31, 2010

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397 (SSAN).

PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed

ROUTINE USE(S): None.

DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a $10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.

1. APPLICANT

a. LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	b. DATE OF BIRTH (YYYYMMDD)	c. SOCIAL SECURITY NUMBER
[redacted]	[redacted]	[redacted]

d. HEIGHT	e. WEIGHT	f. MAXIMUM WEIGHT	g. SERVICE/COMPONENT				h. DATE SCREENED (YYYYMMDD)
[redacted]	[redacted] lbs.	[redacted]	☐ ARMY	☐ USMC	☐ USCG	☑ REGULAR	[redacted]
			☐ NAVY	☑ USAF		☐ RESERVE	
						☐ NATIONAL GUARD	

2. Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 2b.

a. HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
[redacted]		

MEDICAL PRESCREEN

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER
[redacted]	[redacted]

2a. *(Continued)* HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO		YES	NO
[redacted]					

b. EXPLAIN ALL "YES" ANSWERS TO QUESTIONS (1) - (78) ABOVE. *(Describe answer(s), give date(s) of problems, name doctor(s), clinic(s), hospital(s), treatment given and current medical status. Attach additional sheet(s) if necessary.)*

[redacted]

[redacted]

MEDICAL PRESCREEN

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER
[redacted]	[redacted]

b. EXPLAIN ALL "YES" ANSWERS TO QUESTIONS (1) - (74) ABOVE. *(Continued)*

[redacted]

3. CURRENT PRIMARY CARE PHYSICIAN(S)/PRACTITIONER(S) AND/OR CLINIC(S) *(Attach additional sheets if necessary)*

a. NAME(S)	b. ADDRESS *(Include ZIP Code)*	c. TELEPHONE *(Include Area Code)*
None [redacted]	[redacted]	[redacted]

4. PREVIOUS PRIMARY CARE PHYSICIAN(S)

a. NAME(S)	b. ADDRESS *(Include ZIP Code)*	c. TELEPHONE *(Include Area Code)*
[redacted]	[redacted]	

5. CURRENT INSURANCE PROVIDER

a. NAME	b. ADDRESS *(Include ZIP Code)*	c. INSURANCE ID NUMBER
None [redacted]	[redacted]	

6. PREVIOUS INSURANCE PROVIDER(S)

a. NAME(S)	b. ADDRESS *(Include ZIP Code)*	c. INSURANCE ID NUMBER
None [redacted]	[redacted]	

STOP AND READ: THE FOLLOWING STATEMENTS APPLY TO SIGNATURES AT ITEMS 7 AND 8

- I certify the information on this form is true and complete to the best of my knowledge and belief, and no person has advised me to conceal or falsify any information about my physical and mental history.
- I further understand that I may be requested to provide medical documentation regarding issues within my medical history.
- I authorize any of the doctors, hospitals, clinics or insurance company(ies) to furnish the Department of Defense medical authority a complete transcript of my medical record for purposes of processing my application for military service.

7. APPLICANT

a. SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*
[redacted]	[redacted]

8. PARENT OR GUARDIAN SIGNATURE FOR MINOR *(Mandatory)* OR PARENT ASSISTING TO COMPLETE FORM *(Voluntary)*

a. NAME *(Last, First, Middle Initial)*	b. SIGNATURE	c. DATE SIGNED *(YYYYMMDD)*
		[redacted]

9. RECRUITING REPRESENTATIVE: I certify all information is complete and true to the best of my knowledge. I have conducted the medical prescreening requirements as directed by service regulations.

a. NAME *(If representative was used)* *(Last, First, Middle Initial)*	b. PAY GRADE	c. SIGNATURE	d. DATE SIGNED *(YYYYMMDD)*
[redacted]	[redacted]	[redacted]	[redacted]

MEDICAL PRESCREEN

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER
[redacted]	[redacted]

10. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician shall comment on all positive answers in questions (1) - (74). Physician may develop by interview any additional medical history deemed important, and record any significant findings here.)*

a. COMMENTS

[redacted]

11. MEDICAL OFFICER'S PRESCREENING COMMENTS: Based on information provided, further processing is:

a. ON PRESCREEN:

- ☑ (1) AUTHORIZED
- ☐ (2) NOT JUSTIFIED *(Permanent Disqualification (PDQ))*:
  - ☐ (a) Profile Serial _____ ICD _____
  - ☐ (b) Process for Waiver *(CMO initials)* _____
- ☐ (3) DEFERRED *(See Comments above)*:
  - ☐ (a) Pending review of additional documentation
  - ☐ (b) RJ Date *(If applicable)* _____ *(CMO initials)* _____

b. ON EXAM:

- ☑ (1) APPROVED
- ☐ (2) DEFERRED:/
- ☐ (3) NOT JUSTIFIED:
  - ☐ (a) Additional information needed *(See DD Form 2808)*
  - ☐ (b) Information different than on prescreen
  - ☐ (c) Form not prescreened by MEPS
- (4) MEPS USE:
  - ☐ (a) AE ☐ (c) PRI
  - ☐ (b) RE ☐ (d) N/A

c. TYPED OR PRINTED NAME OF EXAMINER	d. SIGNATURE	e. DATE SIGNED *(YYYYMMDD)*	12. NUMBER OF ATTACHED SHEETS
[redacted]	[redacted]	[redacted]	3

DD FORM 2807-2, MAR 2007

MEDICAL PRESCREEN

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX) [redacted]	SOCIAL SECURITY NUMBER [redacted]

13. COMMENTS *(Continued)*

[redacted]

HIV ANTIBODY TESTING ACKNOWLEDGMENT FORM

For use of this form, see USMEPCOM Reg 40-8

FOR OFFICIAL USE ONLY

1. I acknowledge I have been informed by verbal briefing and this document that all statements apply to my medical processing.
2. Medical examinations include blood tests for the presence of antibodies to the Human Immunodeficiency Virus (HIV).
3. This virus causes Acquired Immune Deficiency Syndrome (AIDS).
4. This is not a test for AIDS. Positive tests mean persons have contracted the virus and built antibodies in their blood. Positive tests do not mean the persons have AIDS.
5. HIV tests are conducted by serum testing at contract laboratories.
6. Negative tests mean there are no detectable antibodies, but do not guarantee against future positive tests.
7. Positive tests are rechecked by different laboratory tests to confirm results.
8. Confirmed positive HIV tests are permanently disqualifying for entry into the Armed Forces.
9. MEPS physician will tell me personally if my test is positive and offer a second test to double check the accuracy of the first test.
10. MEPS physician will also tell parents or legal guardians if my test is positive and I am a minor.
11. MEPS commander will notify my chain of command of all test results if I am a member of the Armed Forces.
12. All tests results are recorded on my medical examination and in MEPS computer records. MEPS will not remove either positive or negative results from computer records or medical forms, regardless of circumstances.
13. As part of my processing, I must give a current, correct address for notification.
14. All states require by-name reporting of positive HIV results.
15. If a needlestick (or needlestick injury) occurs while my blood is being drawn, I understand that I will be required to provide a second blood specimen to continue processing.
16. My signature in this block indicates that I understand the HIV testing requirement, consequences of positive results, and use of all results.

[redacted] [redacted]

Print first, middle, and last name | Social security number

[redacted] [redacted]

Date

USMEPCOM FORM 40-8-1-E, NOV 2009 | Replaces USMEPCOM Form 40-8-1-R-E, Mar 2004, which is obsolete

DRUG AND ALCOHOL TESTING ACKNOWLEDGMENT FORM

(For use of this form, see USMEPCOM Reg 40-8)

1. I acknowledge that I have been informed that all statements apply to my medical administrative processing as performed by the United States Military Entrance Processing Command (USMEPCOM) or other approved organization or agency. Examination processing includes drug testing consistent with Department of Defense (DoD) and USMEPCOM policy and may include, without limitation, test for alcohol, amphetamines, marijuana, and cocaine. Other drug testing may be performed as specified by policy.

2. I hereby consent: to submit to a breathalyzer and urinalysis, and/or other drug test methods, to the collection and forwarding of any specimen(s) to the testing laboratory(ies), and to the reporting/release of results to all parties as defined in USMEPCOM policy. If I fail or refuse to provide the necessary sample(s), I understand that this may cause me to be found disqualified for further processing.

3. If I am processing for a position with the DoD, and if I were to test positive for any drug or drugs, I understand that a positive test constitutes use of that substance and that:
   a. I will be found disqualified for military service in accordance with DoD and USMEPCOM policies; the Services may elect to enforce stricter disqualification policies.
   b. I will have actions taken on my file based upon the positive results, even if a specimen were collected when not specifically required.
   c. I will be disallowed to continued processing for any Service in accordance with the appropriate standards; I may be found permanently disqualified, or my sponsoring Service may inform me if and when I may become eligible to provide subsequent specimen(s) for drug testing.

4. If I am processing for a position outside the DoD, I understand that other rules or standards may apply.

5. I understand that I may be notified by mail of the positive test results(s), and I am responsible for providing an accurate, current mailing address for receipt of such notification. If I am a minor, I understand that positive test results may be forwarded to my parent or guardian in accordance with USMEPCOM policy.

6. I understand that, in some instances, such as a sample being damaged during shipment, if I do not receive notification by mail of positive test results, I cannot assume that my test results are negative; also, due to the nature of the testing protocols, a negative test does not necessarily mean that no drug or drug metabolite was found.

7. As part of my processing, I must provide a sample under direct observation by Military Entrance Processing Station (MEPS) employees. I am also required to complete forms and verify the accuracy of information on documents and my drug sample bottle. If I were to sign documents or initial bottle labels with incorrect information without challenging them or leave the MEPS without filing a formal complaint with the MEPS commander (or other MEPS officers), I acknowledge that I accept the results without further rebuttal.

8. All test results will be documented in my medical record and in DoD computer records; positive results will not be removed from computer records or medical forms, even at the end of a disqualification period or upon receipt of subsequent negative results. Information I provide about drug and alcohol use and my test results may be used as evidence in punitive or administrative actions, including cases of fraudulent enlistment (Article 83, UCMJ if applicable), or to contradict any future statements I make about drug or alcohol use, abuse, or dependency.

9. I understand that if I cannot provide a sample today, I must provide a sample within three (3) MEPS working days or I will be temporarily disqualified for 180 days.

10. I understand that this document applies to any specimen(s) provided from this date forward. I acknowledge that I have carefully read this document and fully understand its contents. I acknowledge that my signing of this form is voluntary and without any coercion by anyone. My signature indicates that I understand the drug testing requirements, use of all results, and consequences of positive results.

[redacted] Print First, Middle, and Last Name

[redacted] Social Security Number

[redacted]

[redacted] Date

USMEPCOM FORM 40-8-E, NOV 2009 Replaces USMEPCOM Form 40-8-R-E, Dec 2004, which is obsolete

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN)

Sections 133, 1071-87, 3012, 5031 and 8012, title 10, United States Code and Executive Order 9397.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

This form provides you the advice required by the Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) of member or sponsor is required to identify and retrieve health care records.

3. ROUTINE USES

The primary use of this information is to provide, plan and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: Aid in preventive health and communicable disease control programs and report medical conditions required by law to federal, state and local agencies; compile statistical data; conduct research; teach; determine suitability of persons for service or assignments; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state, or local government upon request in the pursuit of their official duties.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

In the case of military personnel, the requested information is mandatory because of the need to document all active duty medical incidents in view of future rights and benefits. In the case of all other personnel/ beneficiaries, the requested information is voluntary. If the requested information is not furnished, comprehensive health care may not be possible, but CARE WILL NOT BE DENIED.

This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

SIGNATURE OF PATIENT OR SPONSOR	SSN OF MEMBER OR SPONSOR	DATE
[redacted]	[redacted]	[redacted]

DD FORM 2005, 1 Feb 76 PREVIOUS EDITION IS OBSOLETE *U.S. Government Printing Office: 1989-242-450/80265

[redacted]

[redacted] FROM- [redacted] 8144388281 [redacted] T-102 P0002/0004 F-162

[redacted]

PATIENT NAME: [redacted] DATE: [redacted]

AGE: [redacted] REFERRING PHYSICIAN: [redacted]

PRIMARY CARE PHYSICIAN: [redacted]

BURGE, MITCHELL 4/28/11

HP [redacted]

[redacted]

[redacted]

[redacted] 8144388281 T-102 P0003/0004 F-162

[redacted]

Page 1 of 1

[redacted]

[redacted]

6/8

8148648634

[redacted] 8144388281 [redacted] T-102 P0004/0004 F-162

[redacted]

[redacted]

[redacted]

PATIENT NAME: [redacted] MED REC #: 49338
ATTENDING PHYSICIAN: [redacted]
DD: [redacted] TT: 4:39 PM Job #: 5458762 df / 1078

[redacted]

[redacted]

8148648634

TATTOO/BRAND/BODY MARKING SCREENING/VERIFICATION

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 8013, Secretary of the Air Force, Executive Order 9397 (SSN), as amended.

PURPOSE: To provide personnel management support to commanders and supervisors.

ROUTINE USE: Disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act. DoD 'Blanket Routine Uses' apply.

DISCLOSURE: Voluntary, failure to provide SSN may impede proper placement in member's military personnel file.

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a $10,000 fine or both), to anyone making a false statement. If you knowingly and willingly provide a false statement you can be tried by military courts -martial or meet an administrative board for discharge and could receive a less than honorable service characterization.

SECTION I. AIRMAN

a. [redacted]	b. DATE OF BIRTH *(YYYYMMDD)*	c. SOCIAL SECURITY NUMBER
	[redacted]	[redacted]

SECTION II. IDENTIFICATION

- Commander marks all tattoo/brand/body markings with a number and Airman initials
- Commander describes tattoo/brand/body marking information below and Airman initials

[redacted]

Number on Body Diagram	Location	Description, Size, Shape and Meaning	Initials
[redacted]			

AF FORM 4428, 20110831 PREVIOUS EDITIONS ARE OBSOLETE PRIVACY ACT INFORMATION: The information in this form is FOR OFFICIAL USE ONLY. Protect IAW the Privacy Act of 1974

SECTION II. TATTOO/BRAND/BODY MARKING IDENTIFICATION OVERFLOW

[redacted]

SECTION III. AIR FORCE TATTOO/BRAND/BODY MARKING POLICY

Unauthorized (content): Tattoos/brands/body markings anywhere on the body that are obscene, commonly associated with gangs, extremist, and/or supremacist organizations, or that advocate sexual, racial, ethnic, or religious discrimination are prohibited in and out of uniform.

Excessive tattoos/brands/body markings will not be exposed or visible (includes visible through the uniform) while wearing any/all uniform combination(s) except the PTU. This includes any combination of short sleeve, long sleeve, open collar uniform, utility uniform sleeves rolled up or worn down, flight duty uniform, etc. This policy does not apply when wearing the PTU. Excessive is defined as any tattoos/brands/body markings that exceed 1/4 (25%) of the exposed body part and are readily visible when wearing any/all uniform combination(s).

The exposed body part is defined as the total area, to include front, sides and back of limb or other body part protruding from a uniform item.

SECTION IV. INITIAL CERTIFICATION			**INITIALS**
I hereby certify that the markings in section II are a true and accurate representation of all tattoos/brands/body markings.			
I have read and fully understand the information contained on this form and have been briefed on Air Force tattoo/brand/body marking policy.			
DATE	Airman NAME *(Last, First, M.I.)* RANK/GRADE	SIGNATURE	
SUPERVISOR			
I CERTIFY THE ABOVE INDIVIDUAL SIGNED THIS CERTIFICATE			
DATE	NAME *(Last, First, M.I.)* RANK/GRADE	SIGNATURE	
FIRST SERGEANT			
I CERTIFY THE ABOVE INDIVIDUAL SIGNED THIS CERTIFICATE			
DATE	NAME *(Last, First, M.I.)* RANK/GRADE	SIGNATURE	

SECTION V. COMMANDER'S ACTION			**INITIALS**
The tattoo/brand/body marking complies with policy and is approved.			
The tattoo/brand/body marking does not comply with policy and requires further action IAW AFI 36-2903.			
DATE	NAME *(Last, First, M.I.)*RANK/GRADE	SIGNATURE	
AIRMAN ACKNOWLEDGEMENT			
DATE	NAME *(Last, First, M.I.)*RANK/GRADE	SIGNATURE	

AF FORM 4428, 20110831 PREVIOUS EDITIONS ARE OBSOLETE.

PRIVACY ACT INFORMATION: The information in this form is FOR OFFICIAL USE ONLY. Protect IAW the Privacy Act of 1974.

SECTION II. TATTOO/BRAND/BODY MARKING IDENTIFICATION

a. LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)

[redacted]

AF FORM 4428, 20110831 PREVIOUS EDITIONS ARE OBSOLETE. PRIVACY ACT INFORMATION. The information in this form is FOR OFFICIAL USE ONLY. Protect IAW the Privacy Act of 1974

DEPARTMENT OF VETERANS AFFAIRS
Veterans Benefits Administration
Regional Office

[redacted]

VA File Number
[redacted]

Disability Evaluation System Proposed Rating
[redacted]

INTRODUCTION

This is a disability determination under the Disability Evaluation System (DES) Pilot Program, a joint initiative between the Department of Defense (DoD) and the Department of Veterans Affairs (DVA) in the case of [redacted] currently a Member of the Air Force, who has been referred to a Physical Evaluation Board (PEB) as unfit for continued military service. This disability determination is being prepared to assign evaluations to the service member's unfit conditions for use by DoD in determining a final disposition for unfit conditions as well as to determine the member's potential entitlement to DVA disability compensation.

The determination of entitlement to DVA benefits is contingent upon the Member's discharge from active duty and upon the Member having the requisite character of discharge, as specified in the regulations. In the event that the Member is not separated from service as a result of the DES process or, upon discharge, lacks the requisite character of discharge, this rating is null and void for purposes of entitlement to DVA benefit.

For purposes of determining potential entitlement to DVA disability compensation, service connection may be established for a disease or disability that began in military service or was caused by some event or experience in service. Based on a review of the evidence listed below, we have made the following proposed decisions on your claim.

DECISION

[redacted]
2 of 5

1. For purposes of entitlement to Department of Veterans Affairs (VA) benefits, it is proposed to establish service connection for human immunodeficiency virus (HIV) [redacted] as directly related to military service with a 10 percent evaluation.

2. For purposes of entitlement to Department of Veterans Affairs (VA) benefits, it is proposed to establish service connection for [redacted]

3. For purposes of entitlement to Department of Veterans Affairs (VA) benefits, it is proposed to establish service connection for [redacted]

4. For purposes of entitlement to Department of Veterans Affairs (VA) benefits, it is proposed to establish service connection [redacted]

EVIDENCE

- VA Form 21-0819, VA/DOD Joint Disability Evaluation Board Claim, received [redacted]
- VA Form 21-526 EZ: Application for Disability Compensation and Related Compensation Benefits, [redacted]
- VA General Medical Exam dated [redacted] from the [redacted]
- Service Treatment Records, from [redacted] through [redacted], received [redacted]
- Physical Evaluation Board Case File, received [redacted]

REASONS FOR DECISION

1. Proposed entitlement to service connection of human immunodeficiency virus (HIV) [redacted] for Department of Veterans Affairs (VA) benefits.

Service connection for human immunodeficiency virus (HIV) [redacted] is proposed as directly related to military service.

We have assigned a 10 percent evaluation for your human immunodeficiency virus (HIV) [redacted] based on:

- On approved medication(s)

Additional symptom(s) include:

[redacted]
3 of 5

• Asymptomatic

A higher evaluation of 30 percent is not warranted for hiv-related illness unless the evidence shows:
• Hairy cell leukoplakia; or,
• Intermittent diarrhea, and on approved medication(s; or,
• Oral candidiasis; or,
• Recurrent constitutional symptoms; or,
• T4 cell count less than 200.

[redacted]

[redacted]

[redacted]
4 of 5

[redacted]

4. Proposed entitlement to service connection of [redacted] for Department of Veterans Affairs (VA) benefits.

Service connection for [redacted] is proposed as directly related to military service.

[redacted]

[redacted] 0260
5 of 5

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 website, www.va.gov.

Disability Evaluation System Proposed Rating	*Department of Veterans Affairs* *Veterans Benefits Administration*	Page 1 of 2 [redacted]

NAME OF VETERAN	VA FILE NUMBER	SOCIAL SECURITY NR	POA	COPY TO
[redacted]	[redacted]	[redacted]		

ACTIVE DUTY			
EOD	RAD	BRANCH	CHARACTER OF DISCHARGE
[redacted]		Air Force	

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

JURISDICTION: Request for DES Rating [redacted]

ASSOCIATED CLAIM(s): 689; Disability Evaluation System [redacted]

PROPOSED DISABILITIES FOR DISABILITY EVALUATION SYSTEM RATING (DES)

Proposed DES Service Connected Disabilities

6351 HUMAN IMMUNODEFICIENCY VIRUS (HIV) [redacted]

Proposed DES Service Connected, Gulf War, Incurred
10%

[redacted]

PROPOSED SERVICE CONNECTED COMBINED EVALUATION FOR DISABILITY EVALUATION SYSTEM (DES) PURPOSES

10%

Disability Evaluation System Proposed Rating	*Department of Veterans Affairs* *Veterans Benefits Administration*		Page 2 of 2 [redacted]	
NAME OF VETERAN [redacted]	VA FILE NUMBER [redacted]	SOCIAL SECURITY NR [redacted]	POA	COPY TO

[redacted]

eSign: certified by VSCALANZ, RVSR

REQUEST AND AUTHORIZATION FOR SEPARATION

This contains information which must be protected IAW AFI 33-332 and DoD Regulation 5400 00; Privacy Act of 1974 as Amended Applies, and it is for Official Use Only (FOUO). It must be protected or Privacy Act information removed prior to further disclosure.

1. TYPE OF SEPARATION:

[X] DISCHARGE [ ] ENTRY LEVEL SEPARATION [ ] RELEASE FROM VOID ENLISTMENT [ ] RELEASE FROM EAD/REVERTS TO ANG

[ ] RELEASE FROM ACTIVE DUTY/TRANSFERS TO RESAF [ ] RELEASE FROM EAD/REVERTS TO RESAF [ ] DISMISSAL

2. AUTHORITY: [ ] BY DIRECTION OF THE PRESIDENT [ ] RESIGNATION ACCEPTED BY THE PRESIDENT

3 a. NAME *(Last, First, MI)*	3 b. GRADE	3 c. SSAN	4. PLACE OF ENTRY ON ACTIVE DUTY OR ENLISTMENT
[redacted]	[redacted]	[redacted]	[redacted]

5. HOME OF RECORD	6. FUTURE MAILING ADDRESS	7. UNDER 2 YEARS SERVICE
[redacted]	[redacted]	[ ] (E-4 Only)

8. PAFSC	9. RESERVE AF GRADE	10. MIL SVC OBLIGATION DATE	11. AERONAUTICAL RATING	12. FLYING STATUS
[redacted]		NO		[ ] YES [X] NO

13. EFFECTIVE DATE	14. CHARACTER OF SERVICE		15. CERTIFICATE ISSUED
[redacted]	[X] HONORABLE	[ ] UNDER OTHER THAN HONORABLE CONDITIONS	[ ] DD FORM 256 AF
	[ ] GENERAL *(Under Honorable Conditions)*	[ ] BAD CONDUCT DISCHARGE	[X] DD FORM 214
	[ ] UNCHARACTERIZED	[ ] DISHONORABLE DISCHARGE	[redacted]

16. RELIEVED FROM ASSIGNMENT *(Unit, Major Command, Address and Servicing MPF)*	17. WILL PROCEED TO
[redacted]	[ ] PLACE OF ENTRY ON ACTIVE DUTY OR ENLISTMENT
	[X] HOME OF RECORD [ ] OTHER *(See Remarks)*
	[ ] HOME OF SELECTION

18. TRAVEL BY PRIVATE CONVEYANCE (TPC) [X] NO [ ] YES, WITH 0 DAYS TRAVEL TIME PERMITTED.

19. MEMBER QUALIFIES FOR FULL TRAVEL/TRANSPORTATION ENTITLEMENT UNDER THE JTR [X] YES [ ] NO

20. ASSIGNED TO *(Check if Applicable)*

a. ARPC DENVER, CO	b. PROJECTED UNIT OF ACCESSION	c. TYPE OF POSITION:
[ ] YES [X] NO		[ ] MOBILIZATION AUGMENTEE
		[ ] REINFORCEMENT DESIGNEE
		[ ] UNIT [ ] AGR [ ] TR

d. UNIT OF ASSIGNMENT AND MPF	e. TRAINING/PAY CATEGORY	f. RESERVE SECTION CODE	g. FUNCTIONAL ACCT CODE
	h. AUTHORIZED GRADE	i. AUTHORIZED AFSC	j. POSITION CONTROL NO.

21a. ELIGIBLE FOR (PER 10 U.S.C. 1174)	b. ENTITLED TO SEVERANCE/SEPARATION PAY			c. CHAPTER 61, 10 U.S.C. DISABILITY
[ ] SEPARATION PAY	SERVICE FOR PAY IS:			[ ] NOT ENTITLED TO BENEFITS
[ ] READJUSTMENT PAY	YEARS	MONTHS	DAYS	[ ] NOT APPLICABLE
CREDITABLE ACTIVE FEDERAL SERVICE				[redacted]
YEARS / MONTHS / DAYS				

22. DEPENDENTS

23. REMARKS

01. SEPARATION PROGRAM DESIGNATOR (SPD) CODE IS JEB

02. FOR INFORMATION ON ORDER AMENDMENTS, PLEASE REFER TO MYPERS AMENDING SEPARATION ORDERS AT HTTPS://MYPERS.AF.MIL/APP/DYNAMICFORMS/DISPLAY/FORM/137

24. DATE	25. ORDERS ISSUING/APPROVING OFFICIAL *(Name, Grade, Title, DSN Phone)*	26. SIGNATURE
[redacted]	[redacted]	// SIGNED //

27. EXPENSES CHARGEABLE TO: 5793500 329 5881.0* 05 525725 (*INSERT M, D, H, I, T, G, OR Y)

NONTEMPORARY STORAGE CHARGABLE TO: 57$3500 32$ 5888.0N 05 525725 TAC: F8SN

CIC: 4 5 948 0081 525725 TAC: F8S1

SDN HHG: PB58819001MP0H SDN NTS: PB58889001MP0N SDN INT: --

28. DESIGNATION AND LOCATION OF HEADQUARTERS	29. AUTHORITY	30. SPECIAL ORDER NO.	31. DATE
DEPARTMENT OF THE AIR FORCE	AFI 36-3212	AM-034318	[redacted]
AFPC RANDOLPH AFB TX 78150-0000	32. TDN FOR THE COMMANDER		

33. DISTRIBUTION	34. SIGNATURE ELEMENT OF ORDERS AUTHENTICATING OFFICIAL
AA	//signed// JESSICA R. JULGA, MSGT, USAF MANAGER, SEPARATIONS

AF IMT 100, 20030915 (V1) PREVIOUS EDITION IS OBSOLETE

0207

A-00666

REQUEST AND AUTHORIZATION FOR SEPARATION (Continued)

This contains information which must be protected IAW AFI 33-332 and DoD Regulation 5400.00; Privacy Act of 1974 as Amended Applies, and it is for Official Use Only (FOUO). t must be protected or Privacy Act information removed prior to further disclosure.

NAME (Last, First, MI): [redacted]

35. CONTINUATION OF DEPENDENTS AND REMARKS

23. CONTINUED
03. GOVERNMENT TRAVEL CARD MANDATE IAW PUBLIC LAW 105-264, GOVERNMENT TRAVEL CARD (GTC) USE IS MANDATORY FOR ALL AUTHORIZED EXPENSES UNLESS OTHERWISE EXEMPTED UNDER SPECIFIC PROVISIONS DETAILED IN PARA E OF THE TRAVEL TRANSPORTATION REFORM ACT. IF AN AIRMAN IS A GTC HOLDER, USE OF HIS/HER INDIVIDUALLY BILLED ACCOUNT IS MANDATORY FOR ALL COMMERCIAL TRANSPORTATION ARRANGEMENTS AND ADVANCE TRAVEL PAY IS NOT AUTHORIZED. IF AN AIRMAN IS A NON-CARD HOLDER, THE CENTRALLY BILLED ACCOUNT WILL BE UTILIZED FOR ALL COMMERCIAL TRANSPORTATION ARRANGEMENTS.

04. MEMBER IS AUTHORIZED PERMISSIVE TDY LEAVE IN CONJUNCTION WITH SEPARATION. YOU MAY BE ELIGIBLE FOR VALUABLE TRANSITION BENEFITS (ID CARD FOR AN ADDITIONAL 2-YEARS, EXTENDED MEDICAL COVERAGE, ETC.). CONTACT THE LOCAL AIRMAN AND FAMILY READINESS CENTER FOR DETAILS CONCERNING THESE BENEFITS.