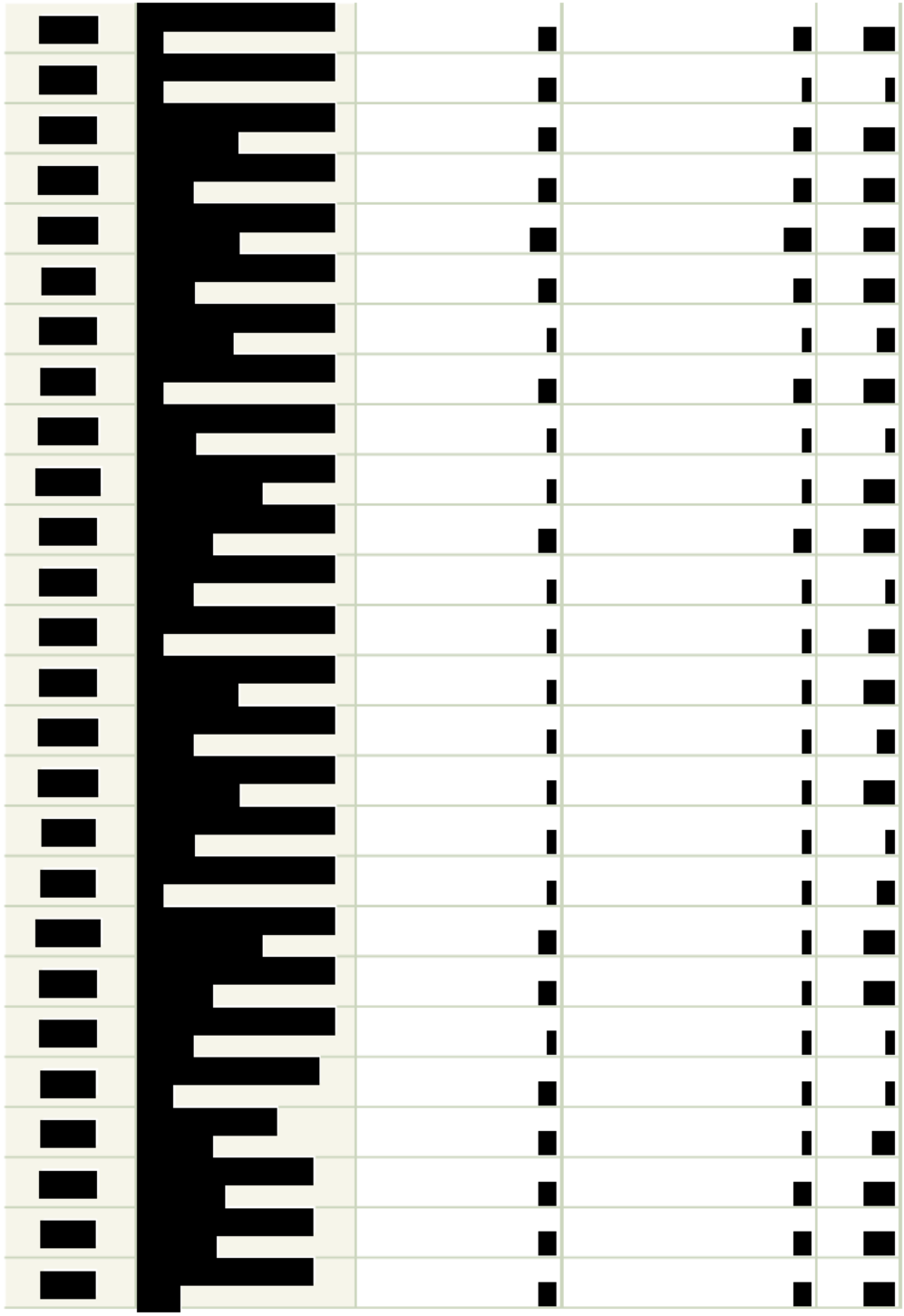
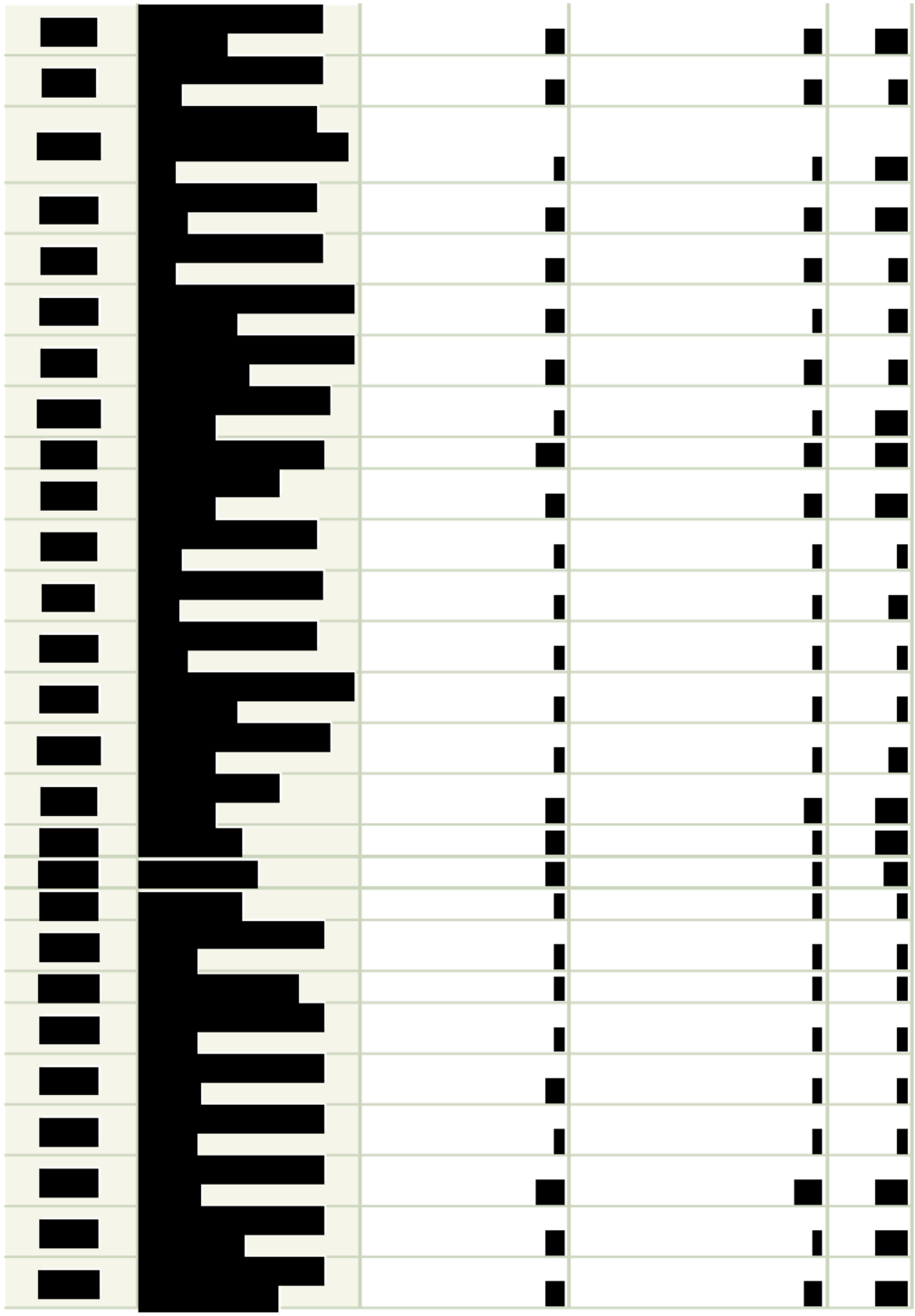
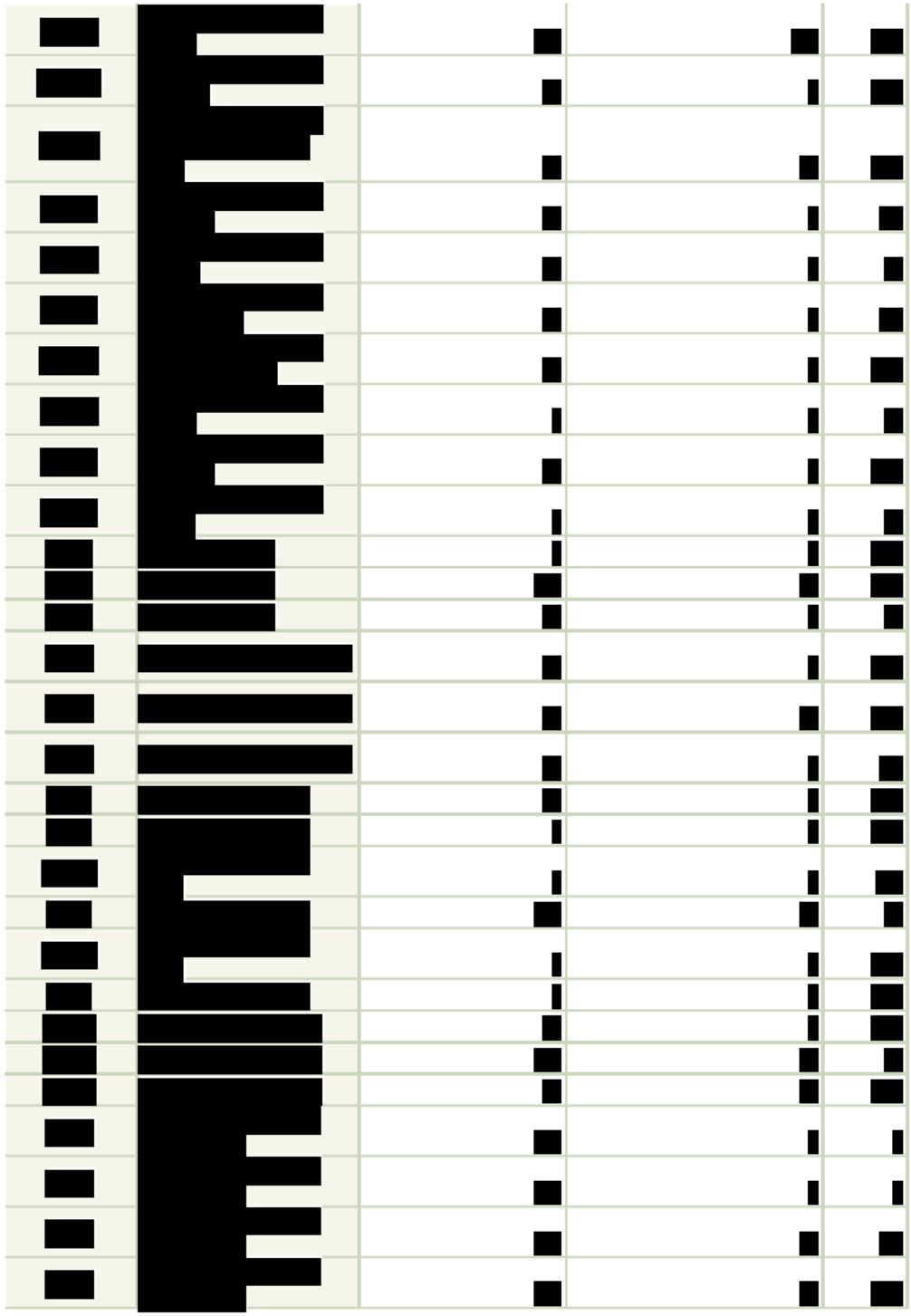
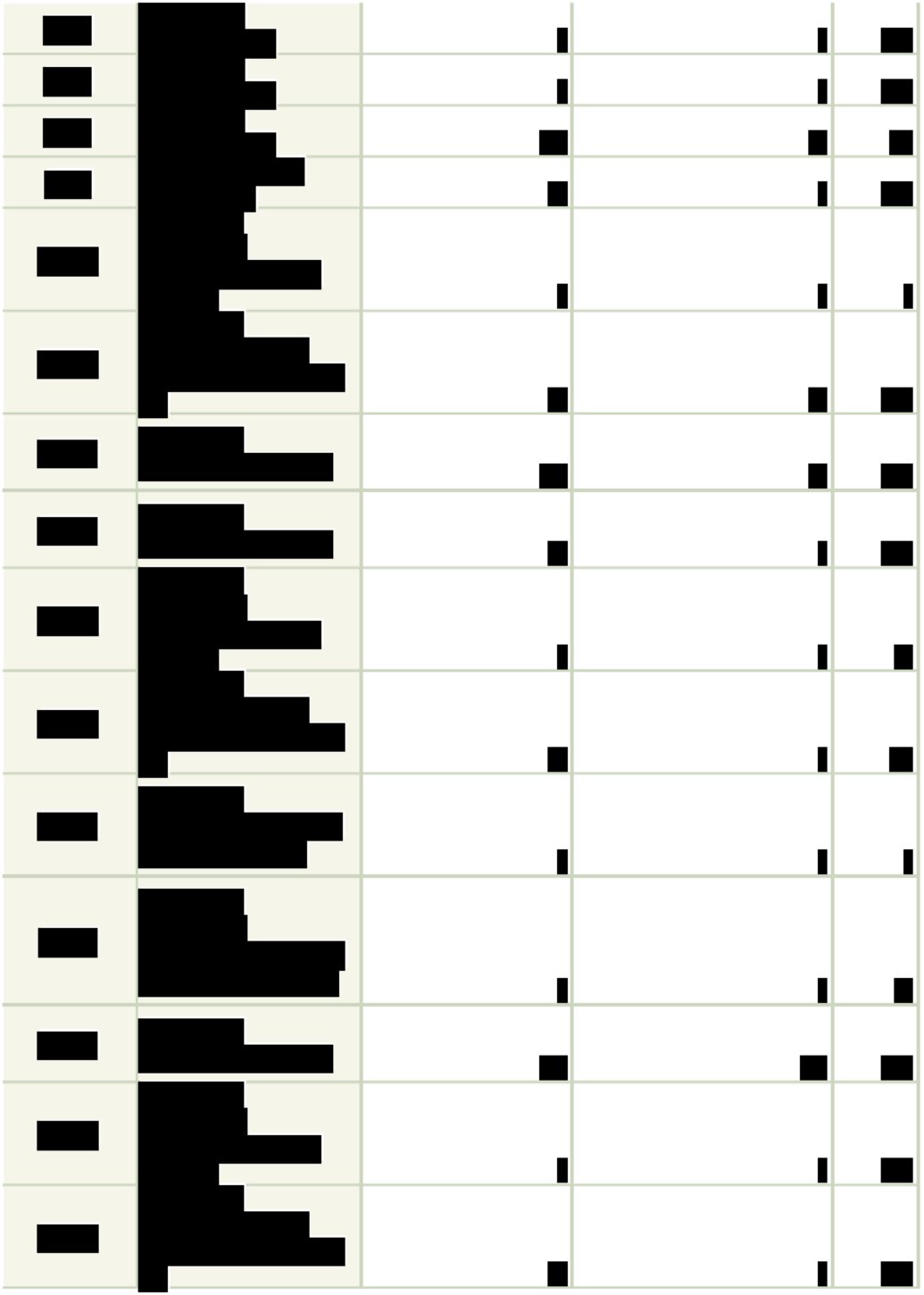
**Active Duty Deployment TDY Rate for Fiscal Year 2018**
****For Official Use Only****

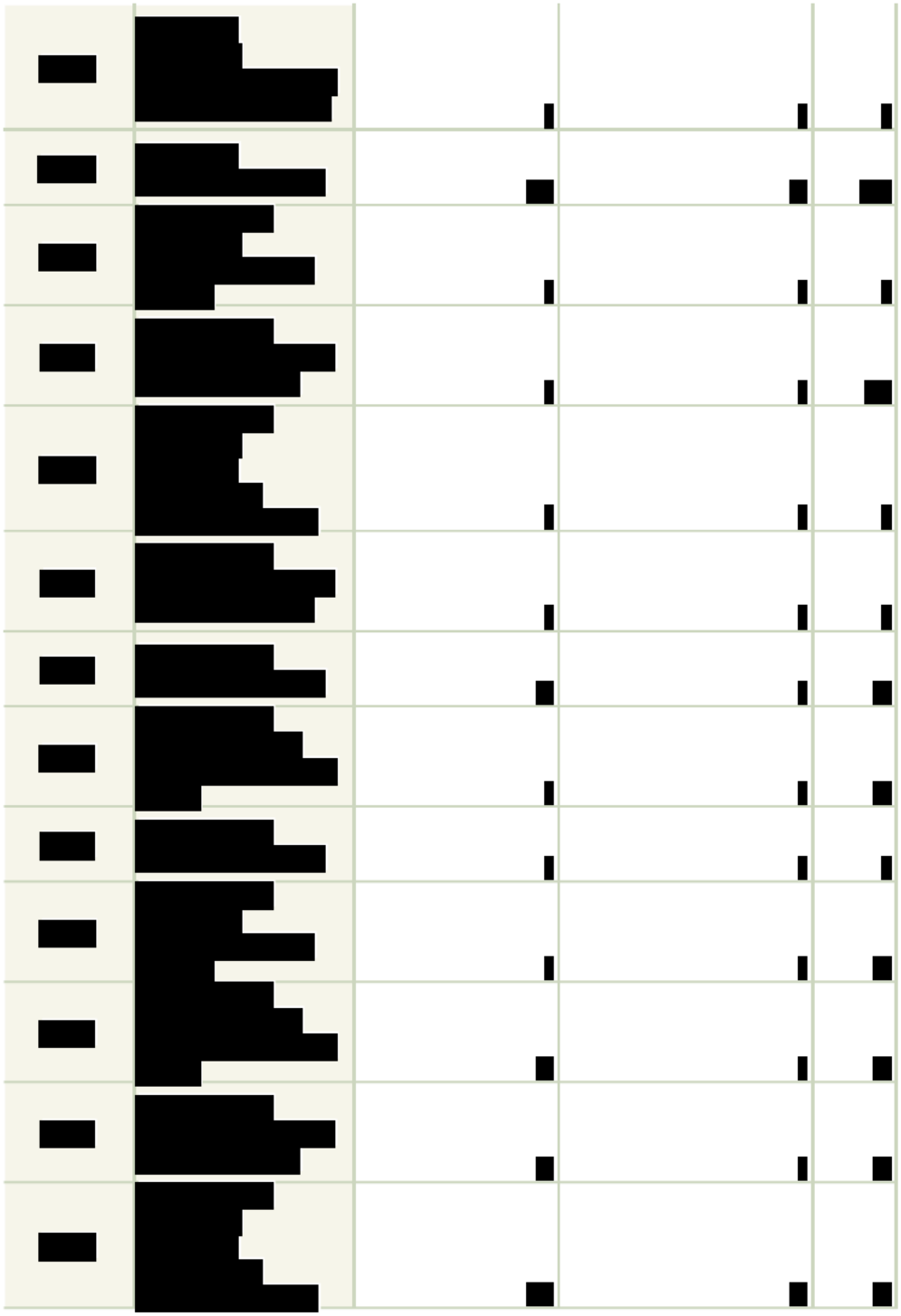
| | # Manning as of Sep 2018 | # Contingency TDY (Type 1) | % |
|---|---|---|---|
| [redacted] | | | |

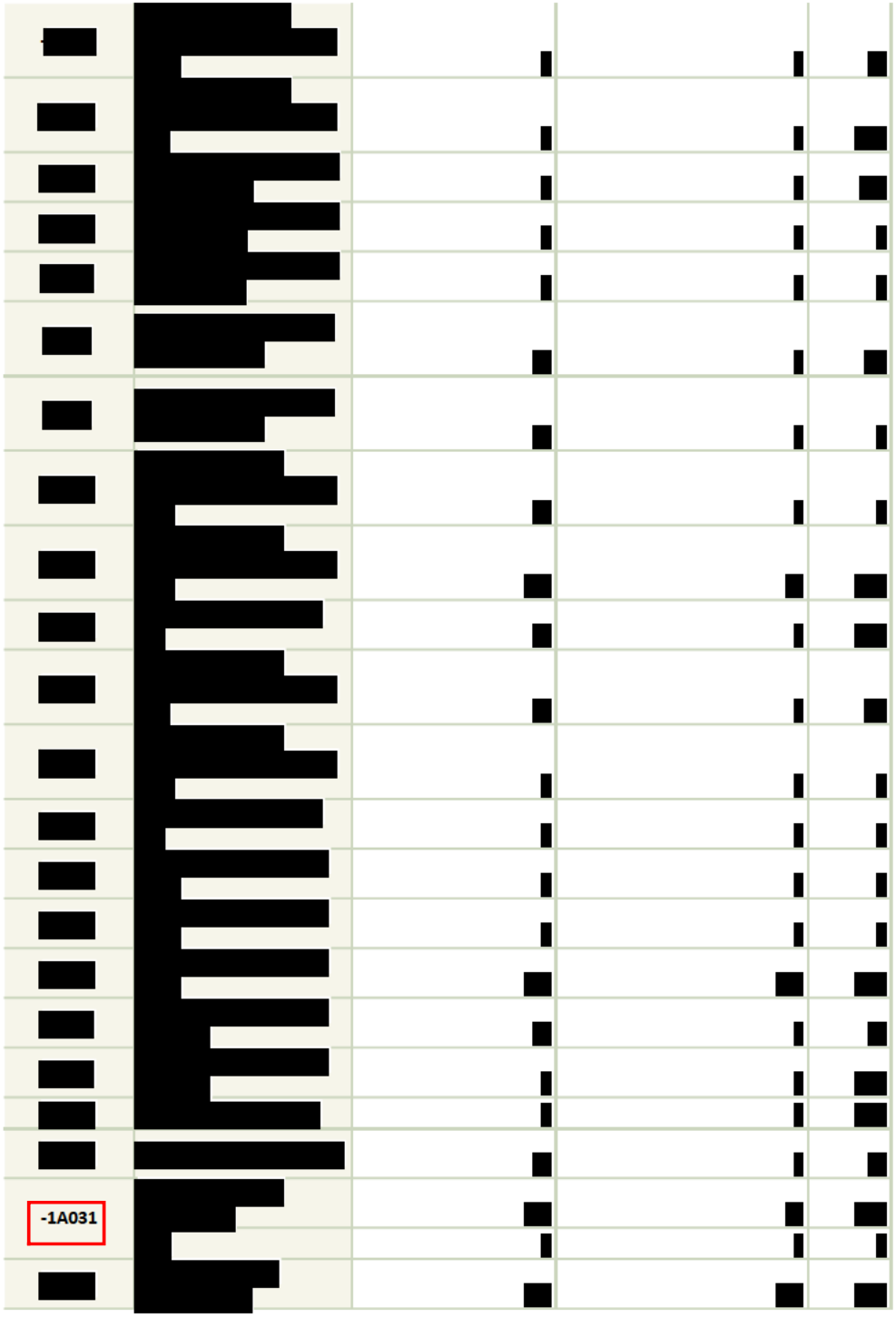








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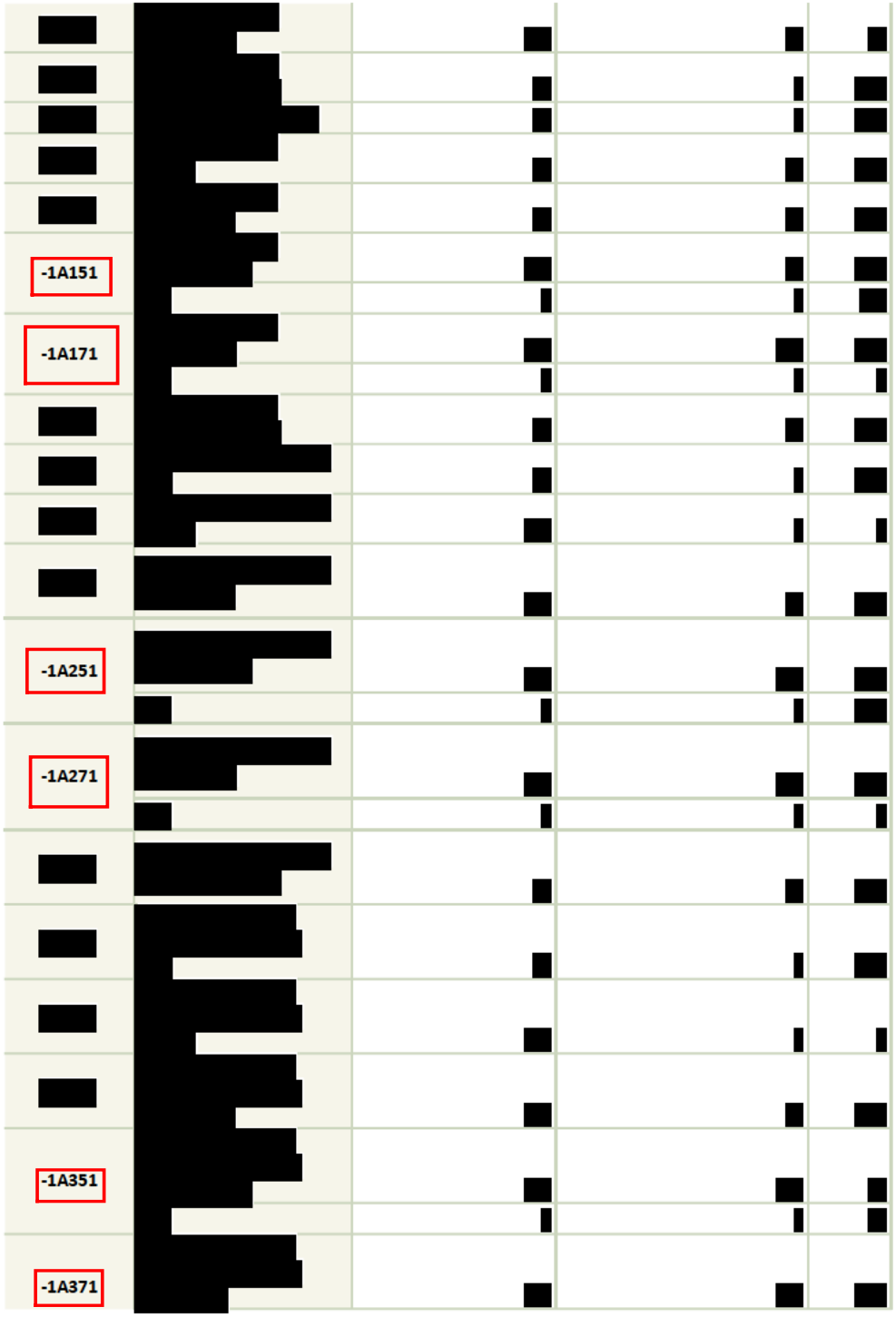
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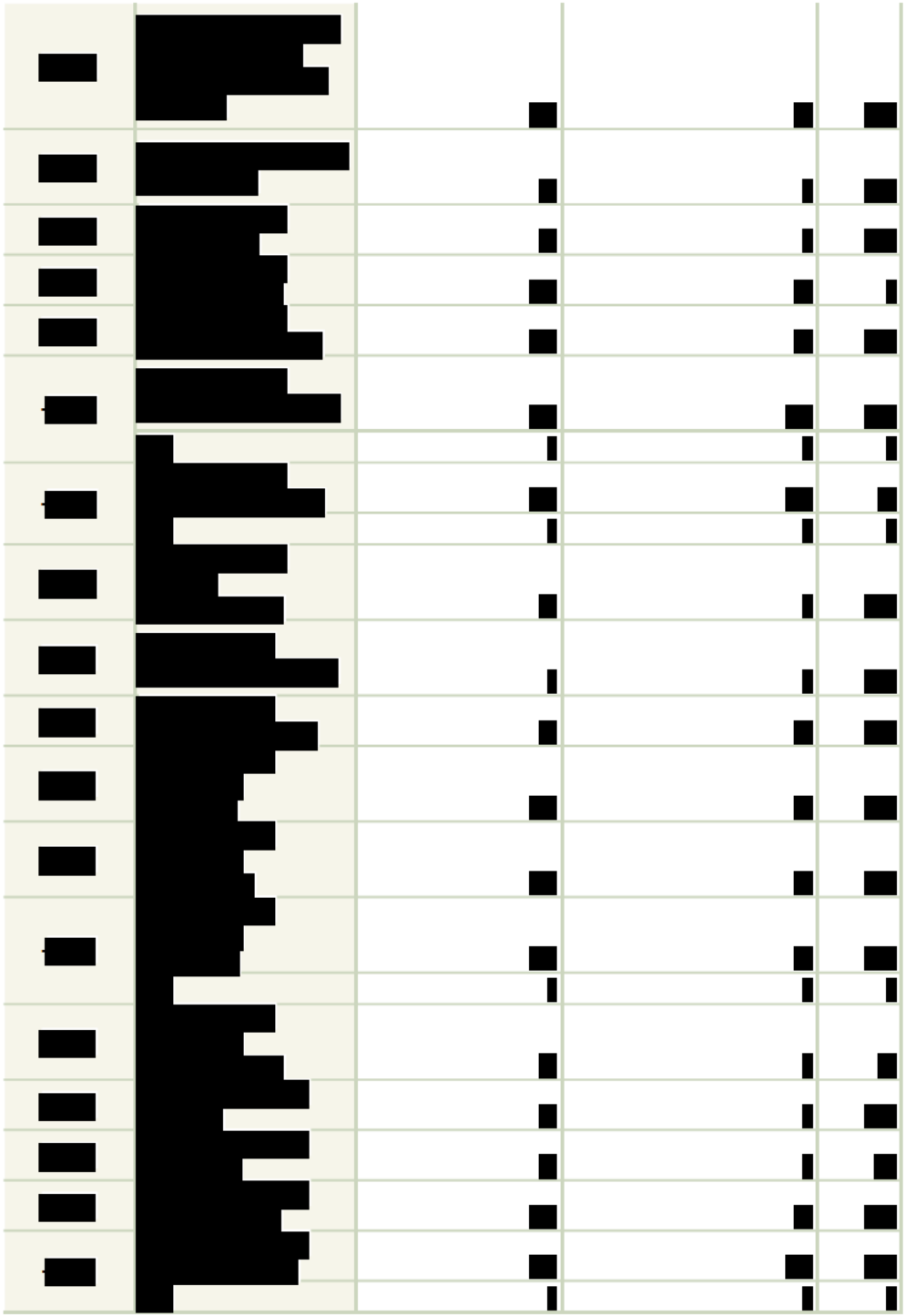
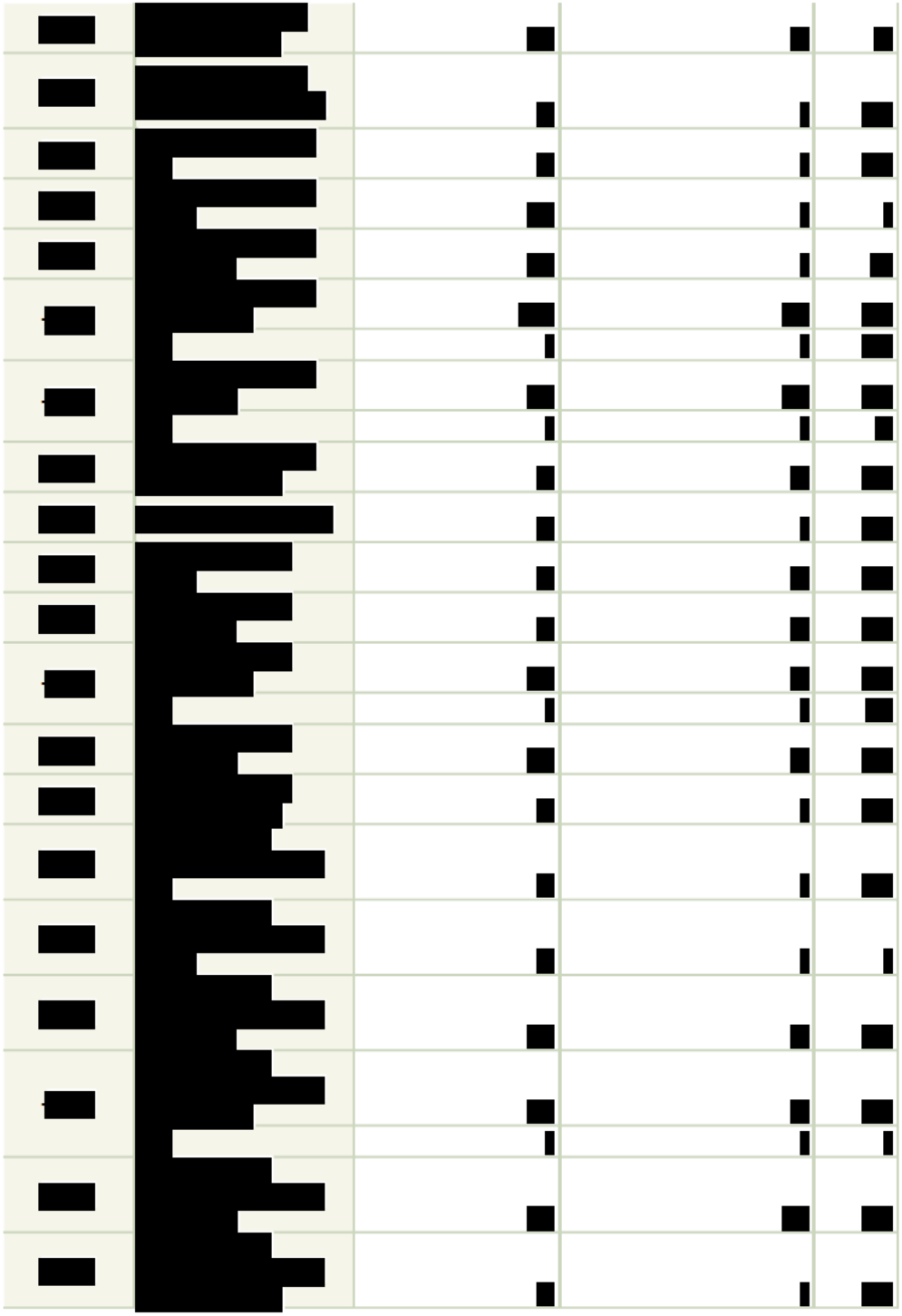
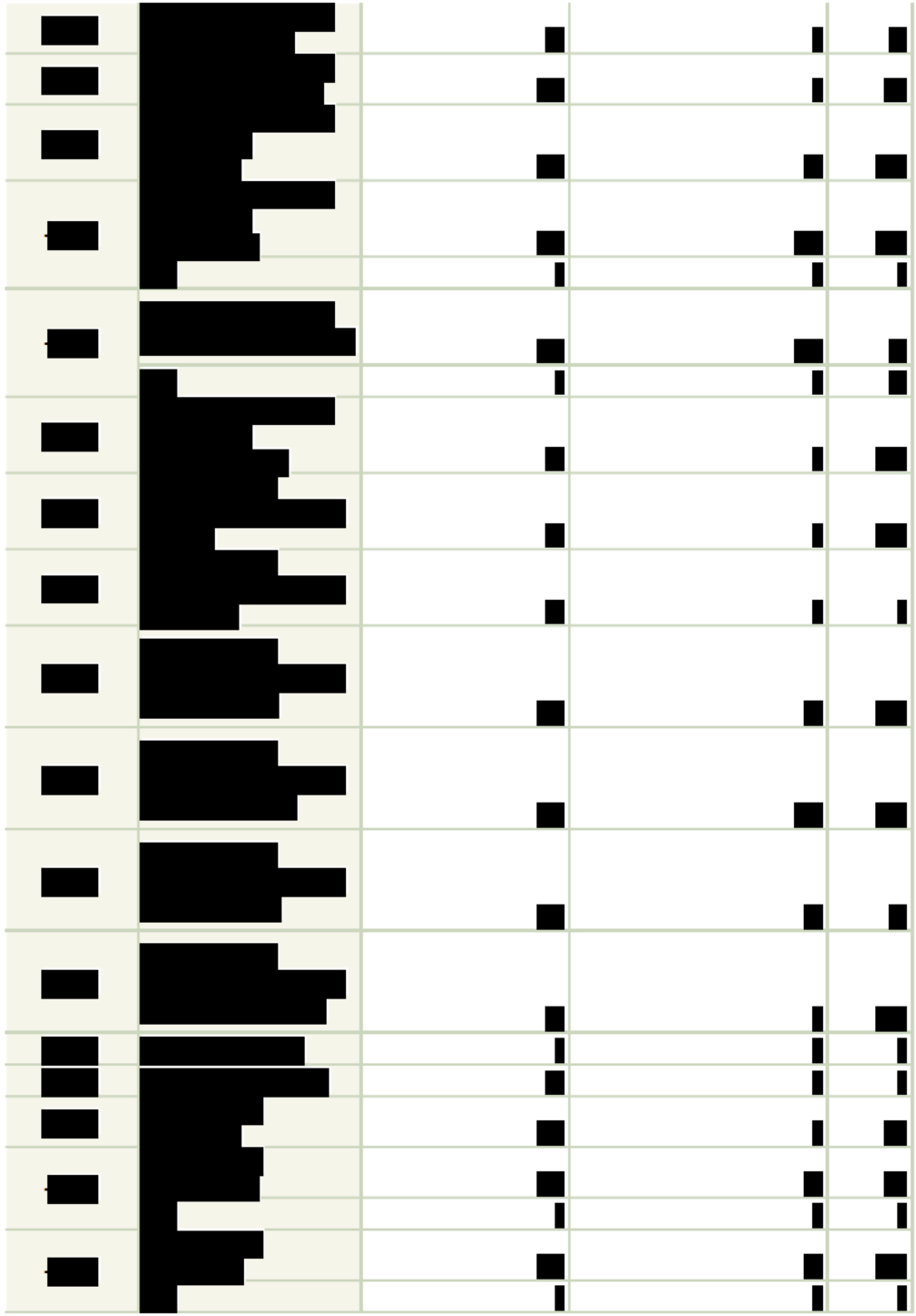
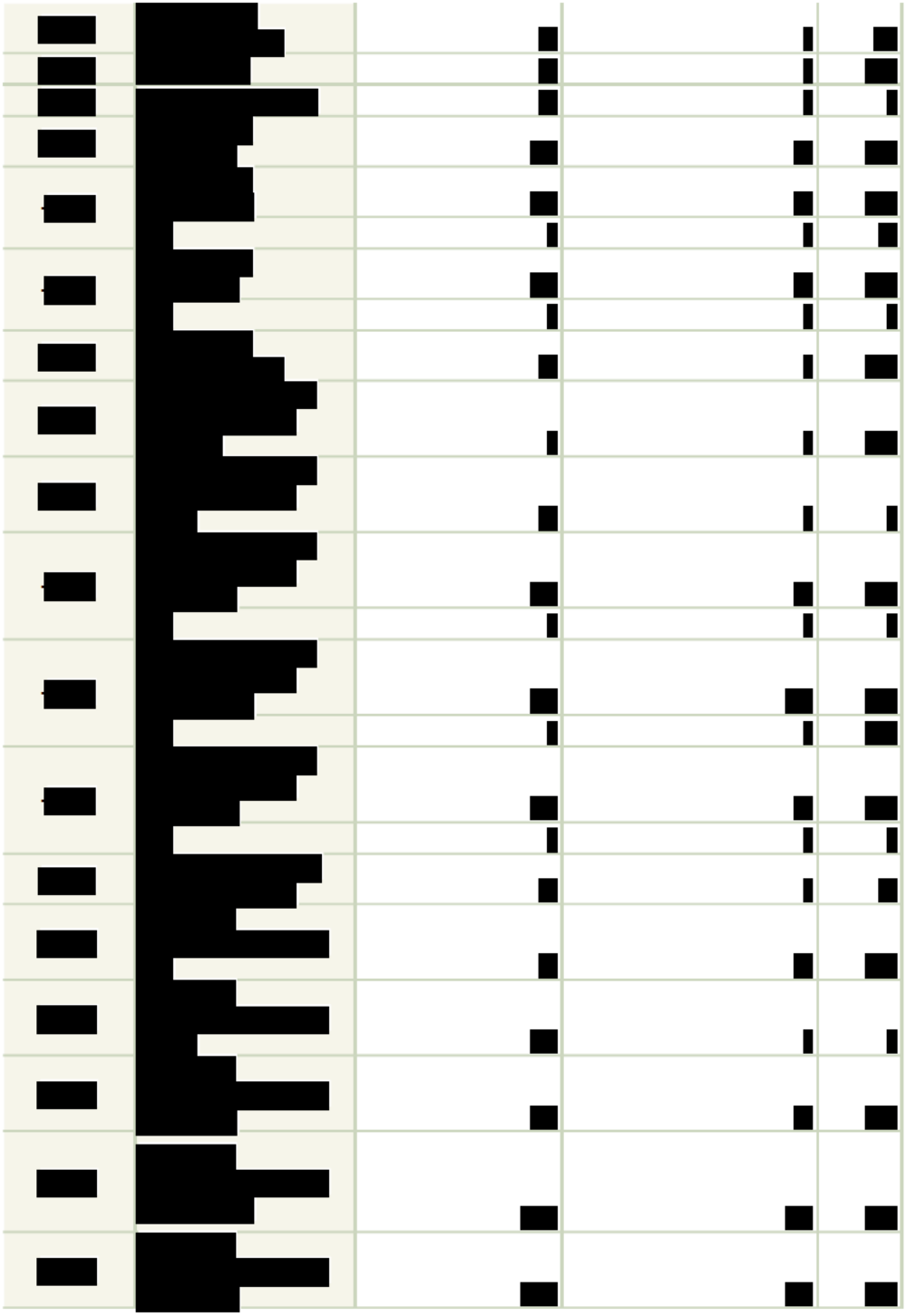
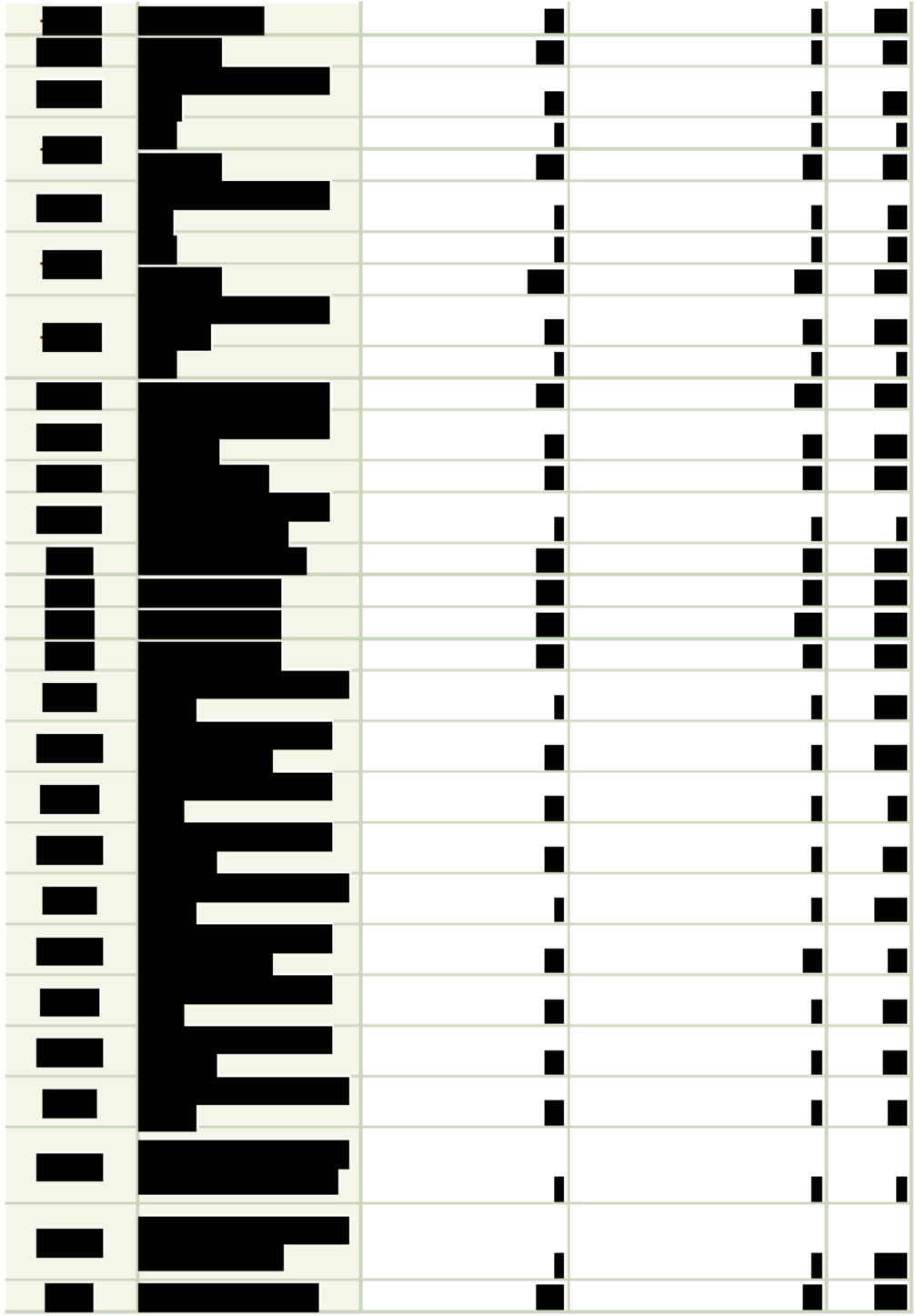
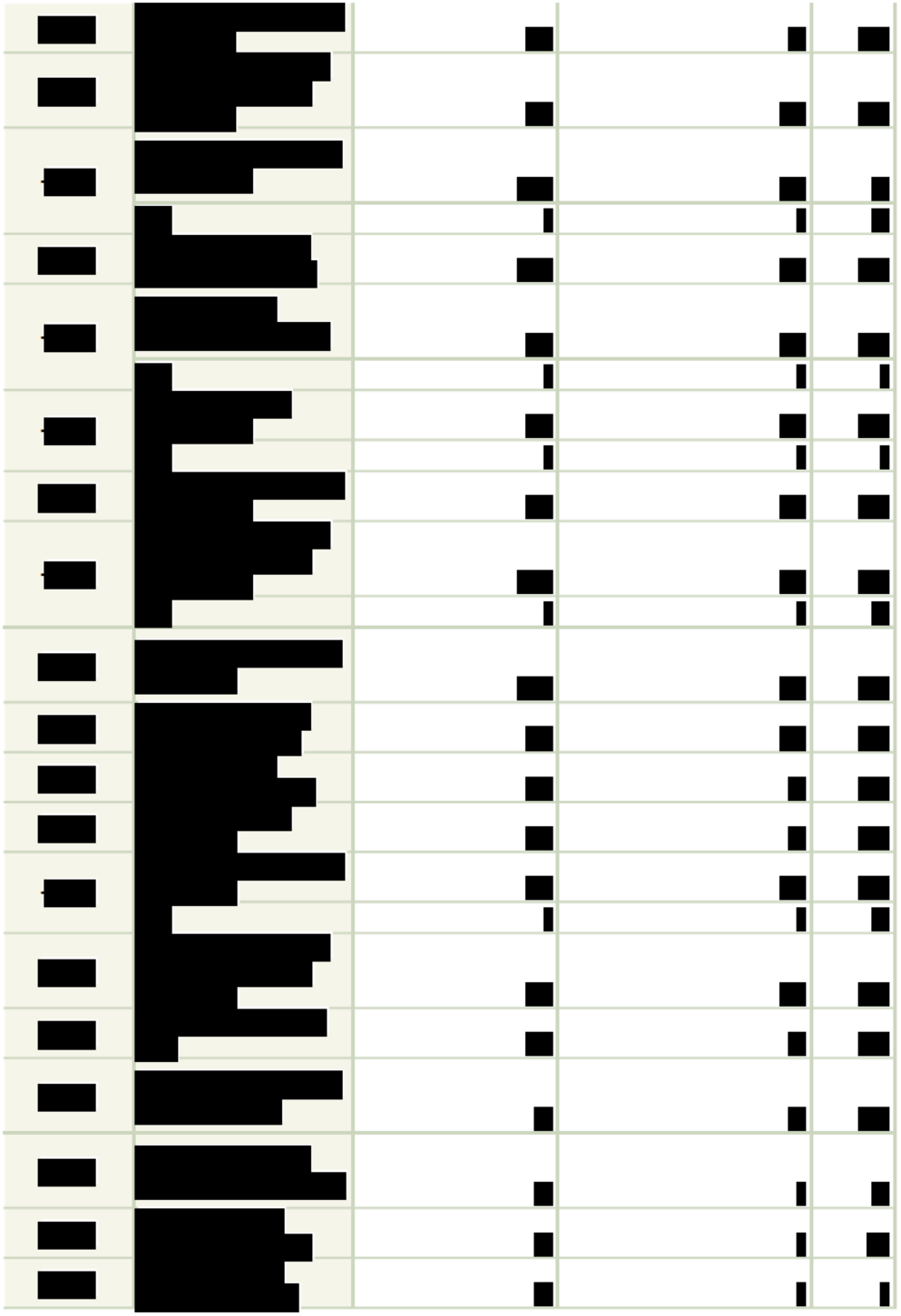


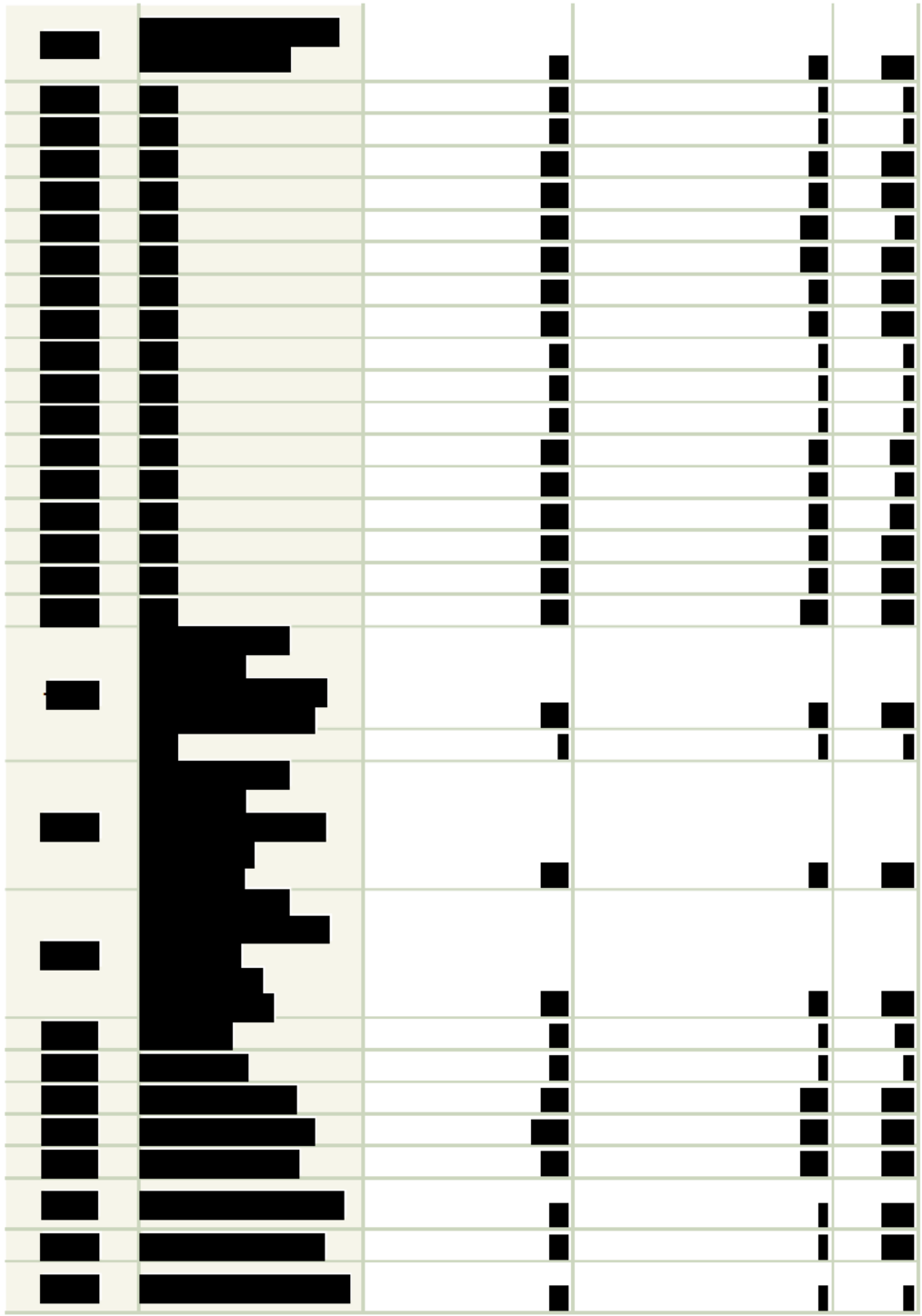


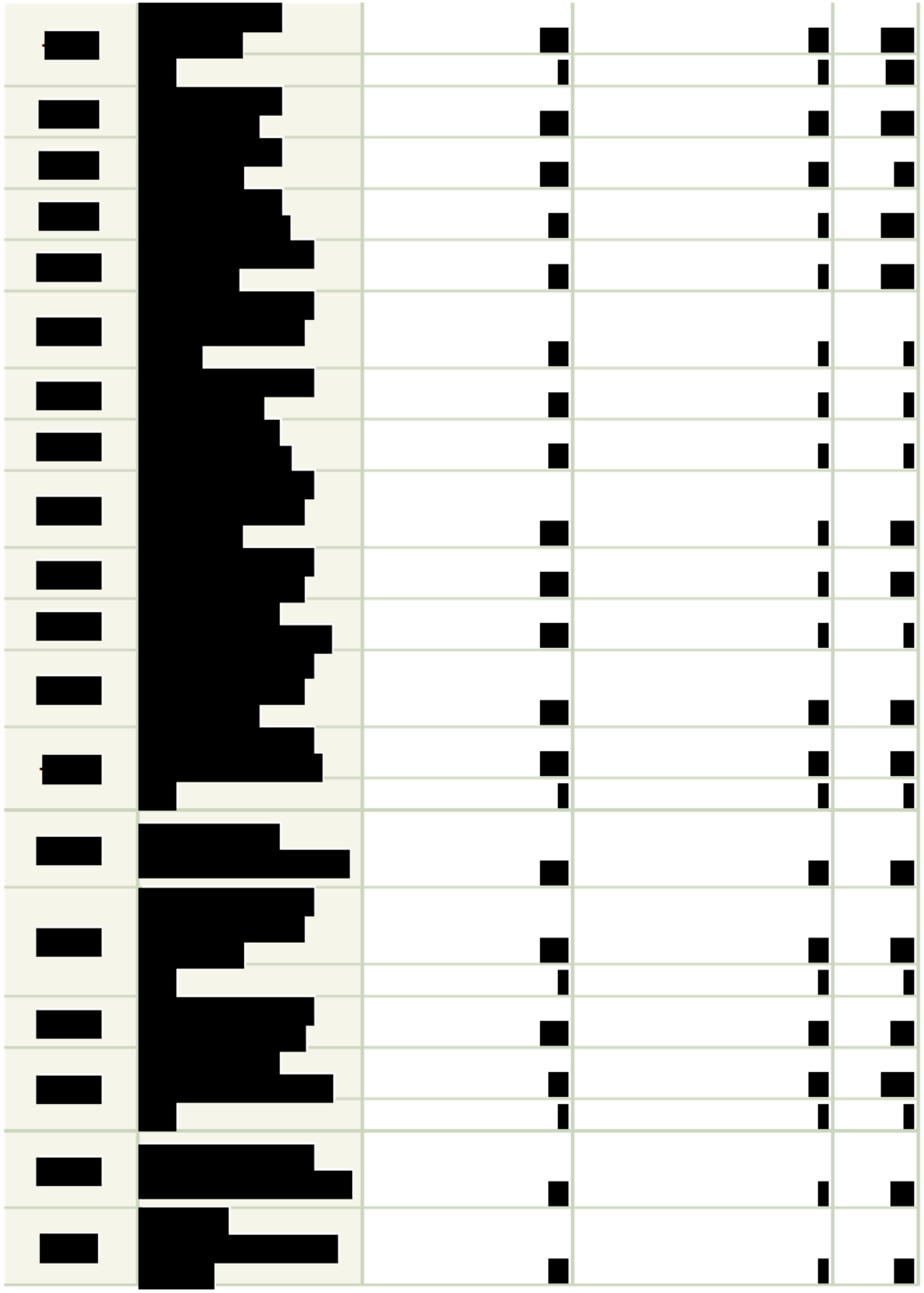


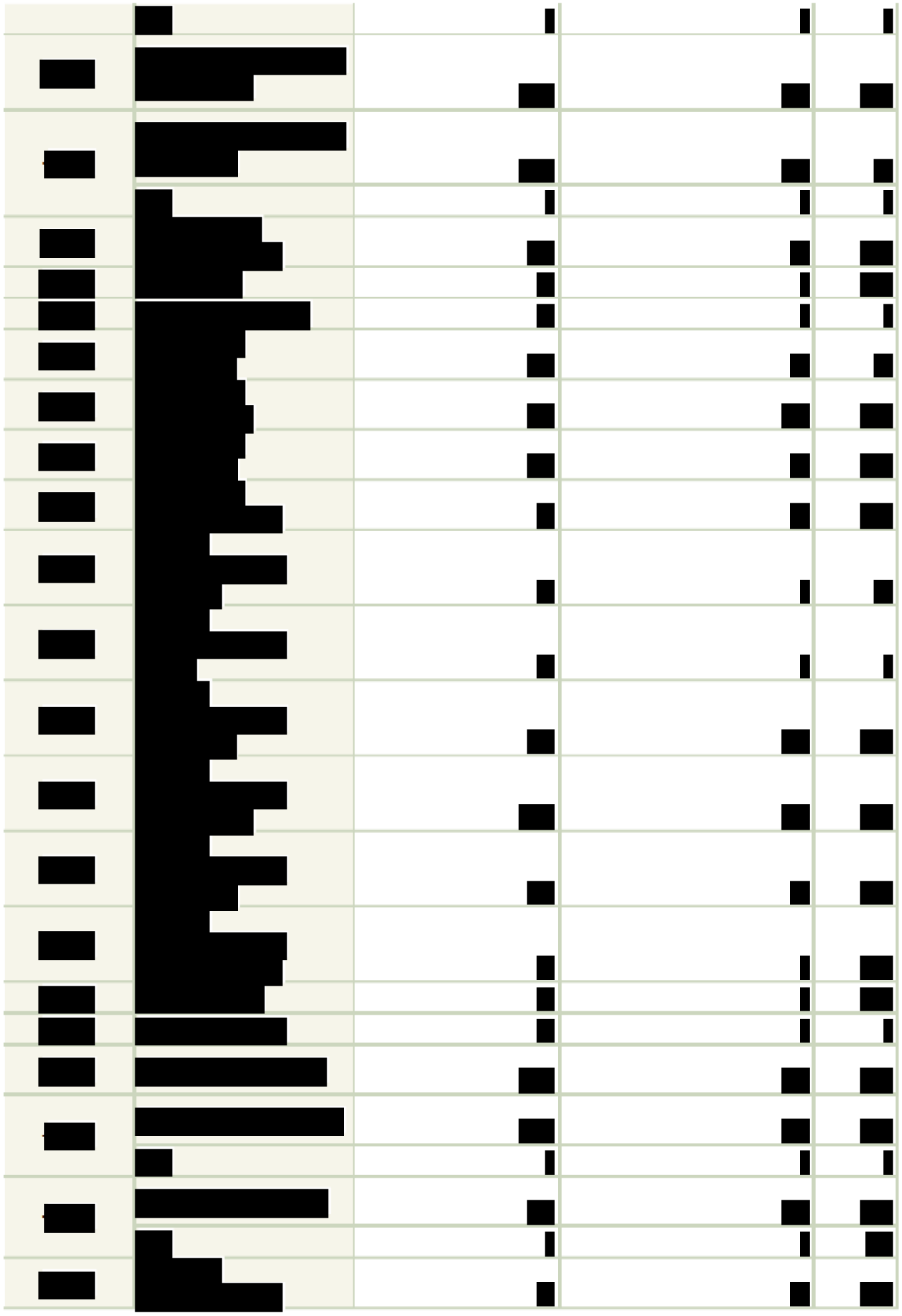


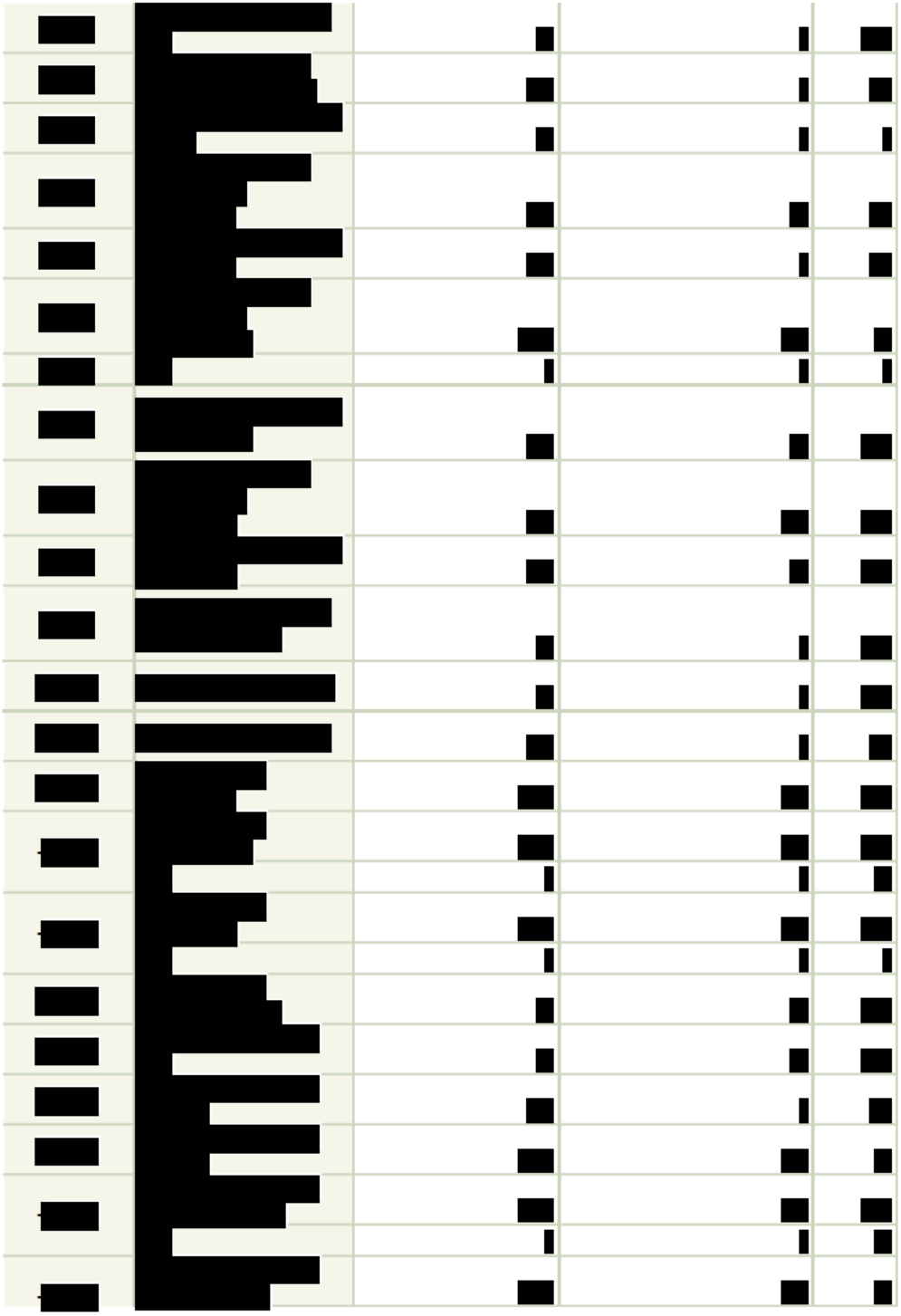


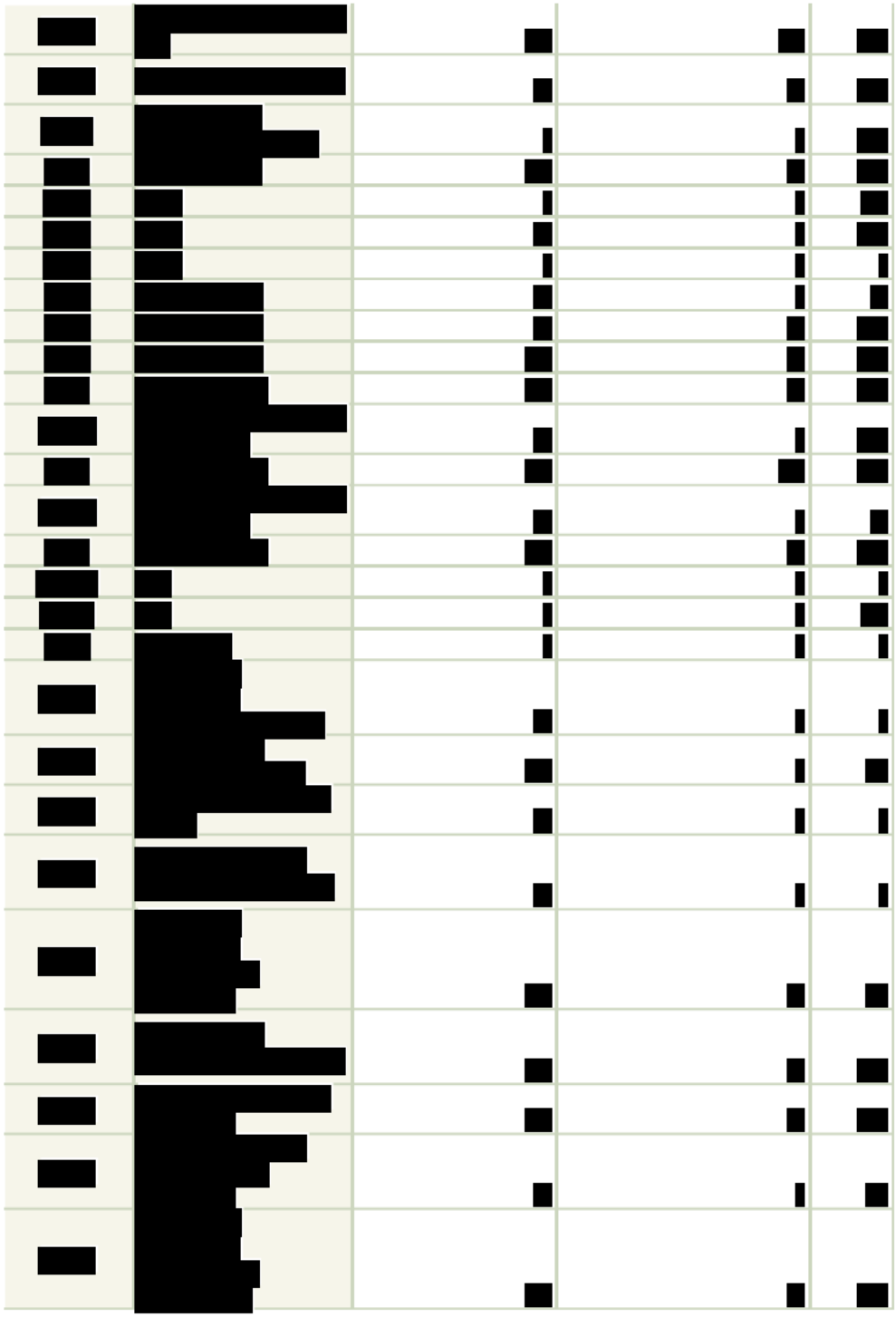


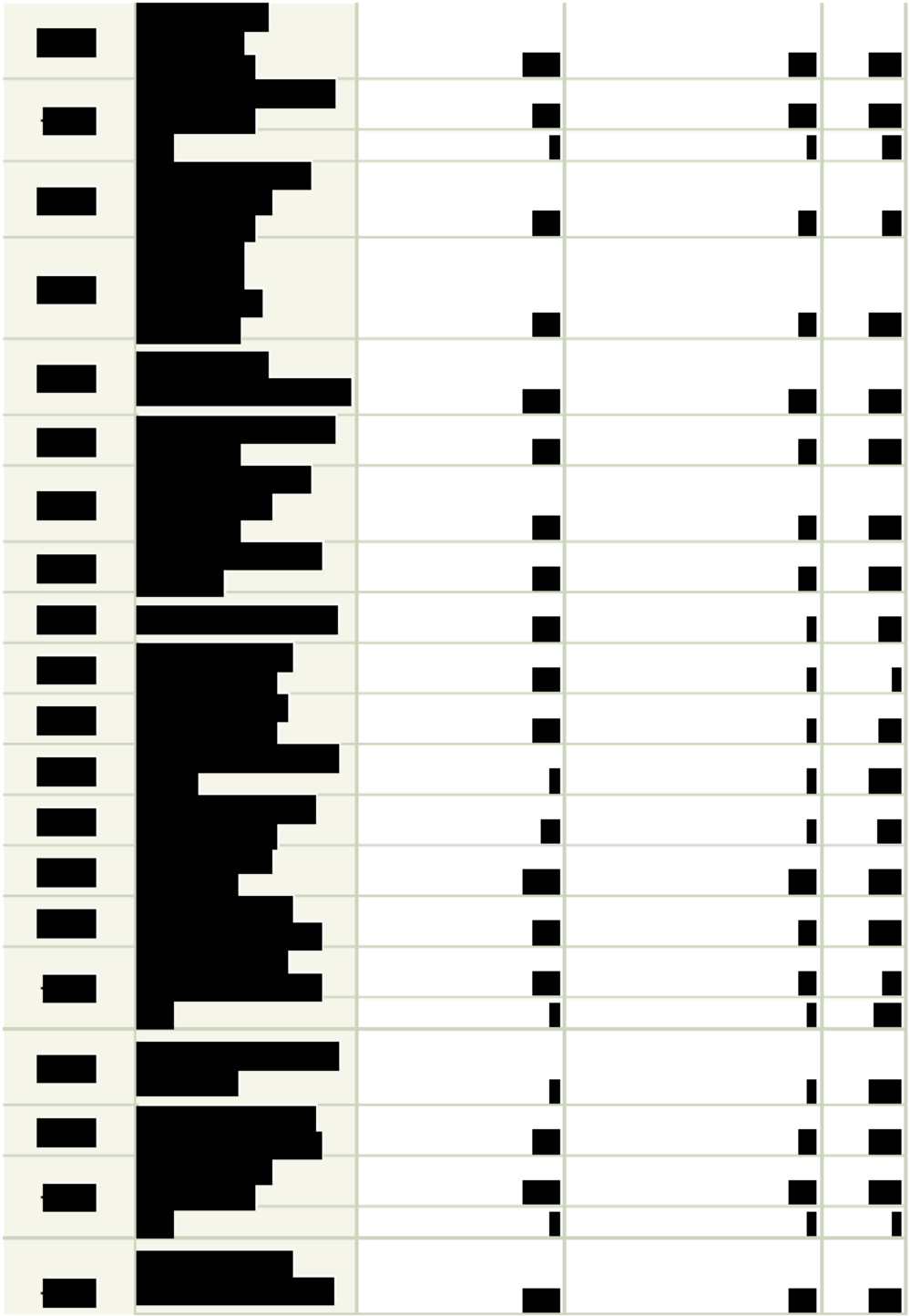


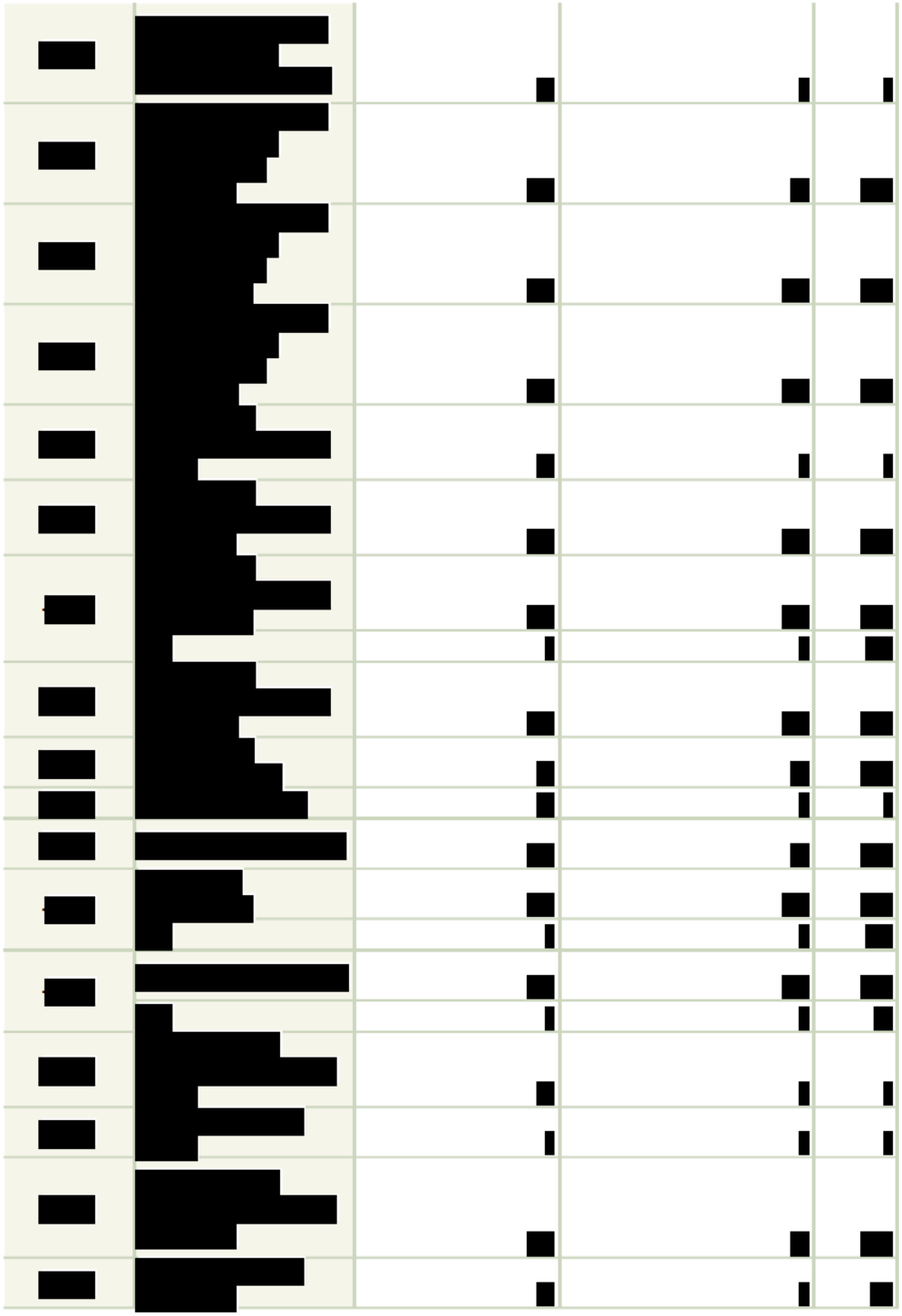


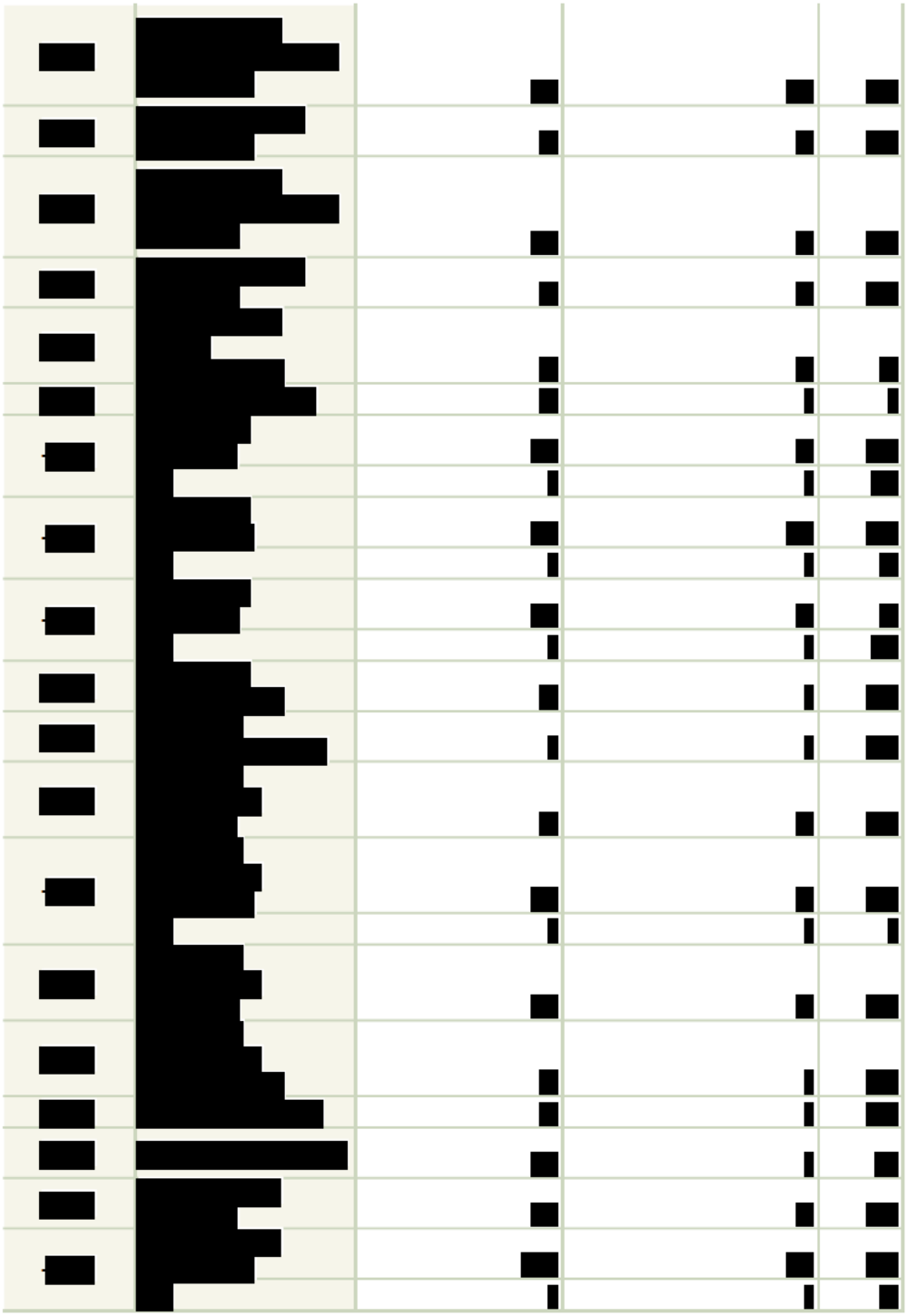


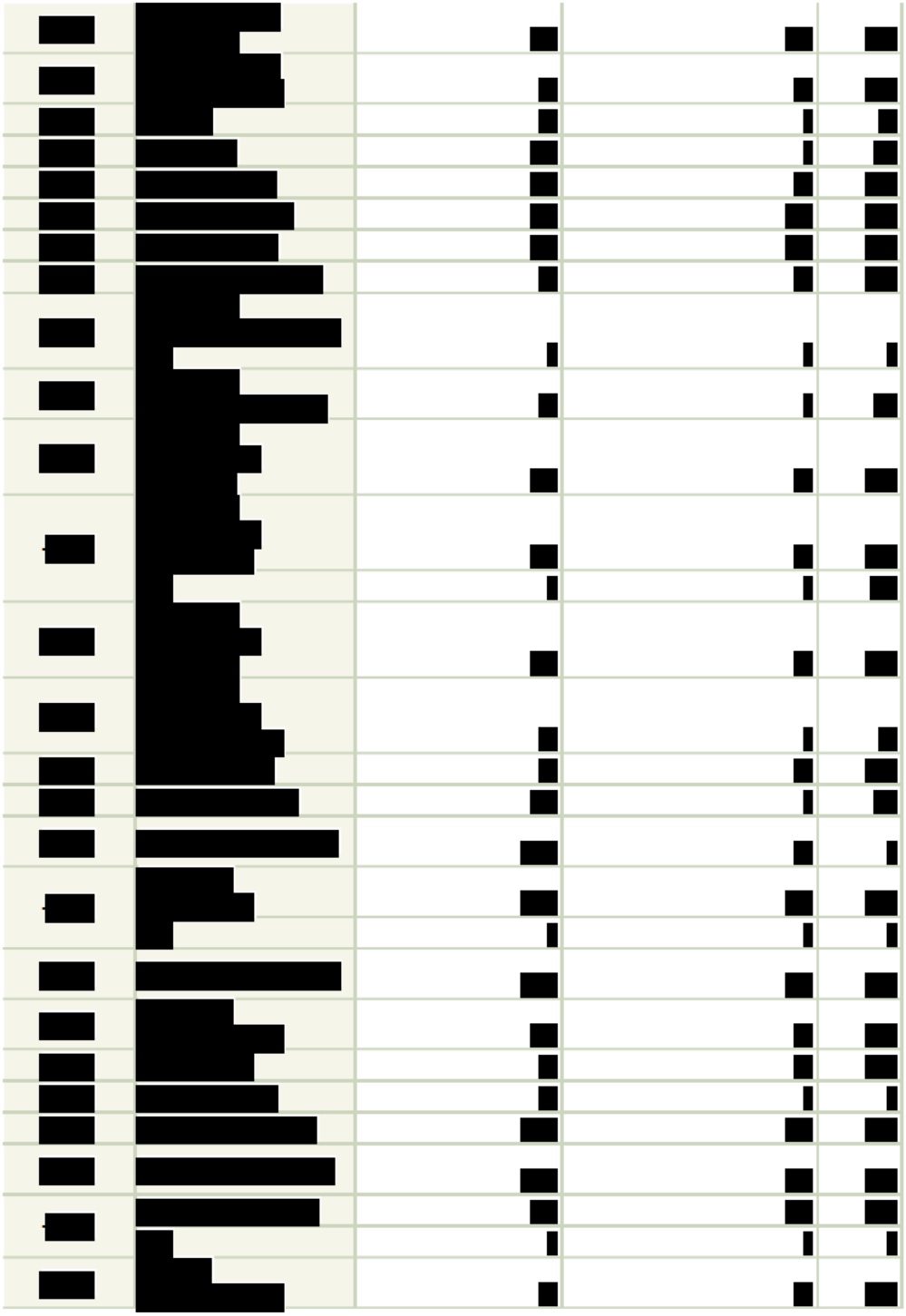


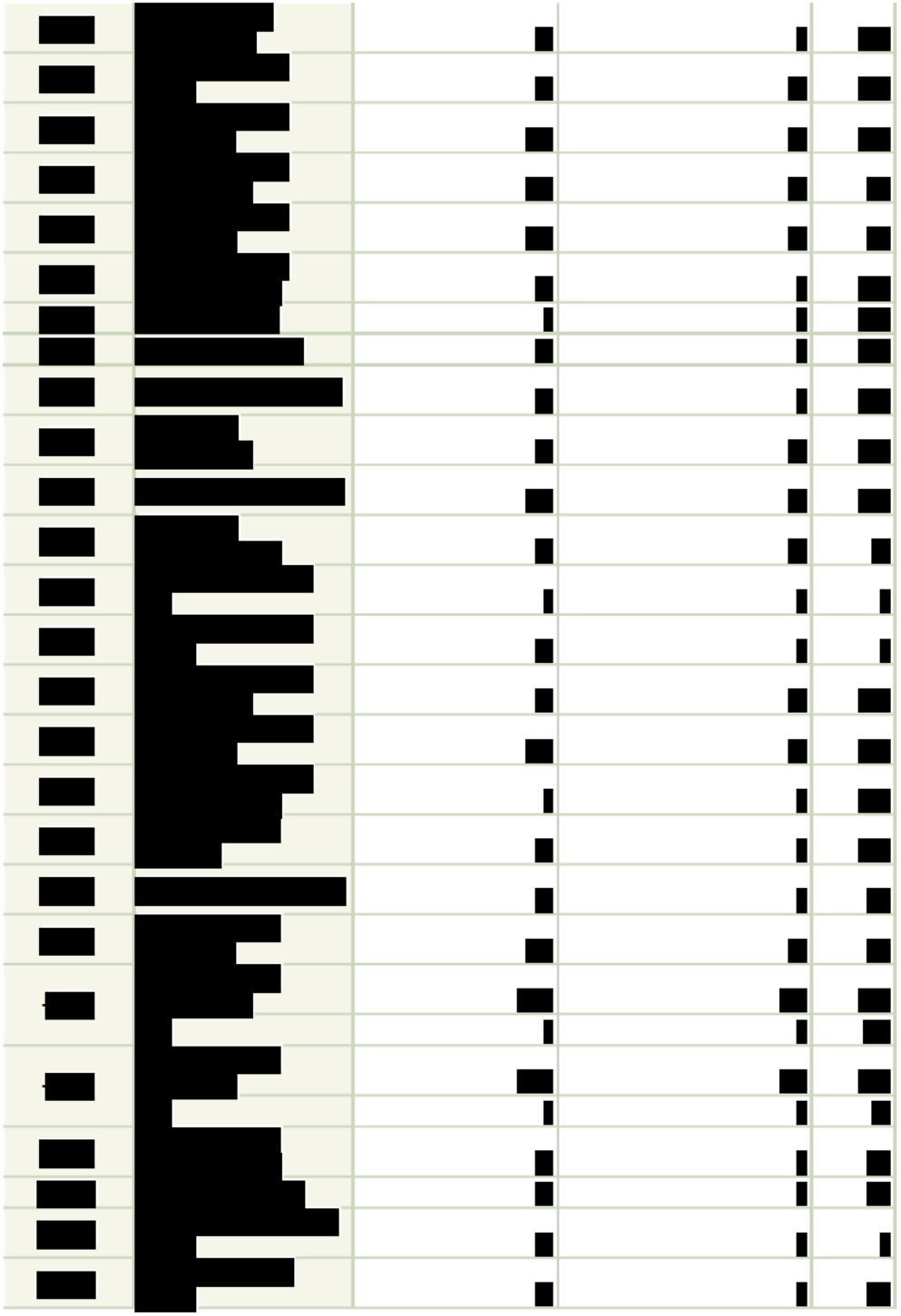


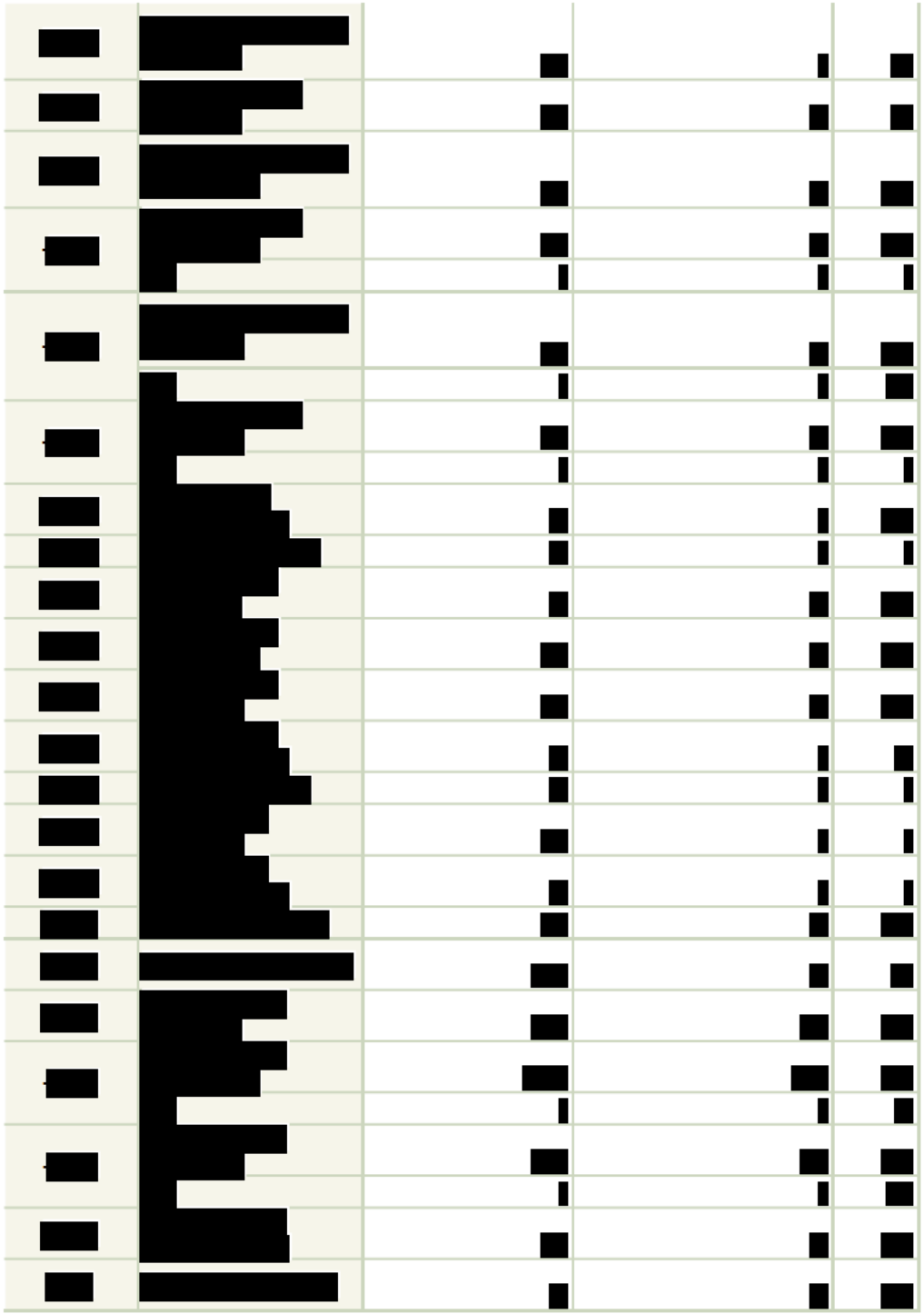


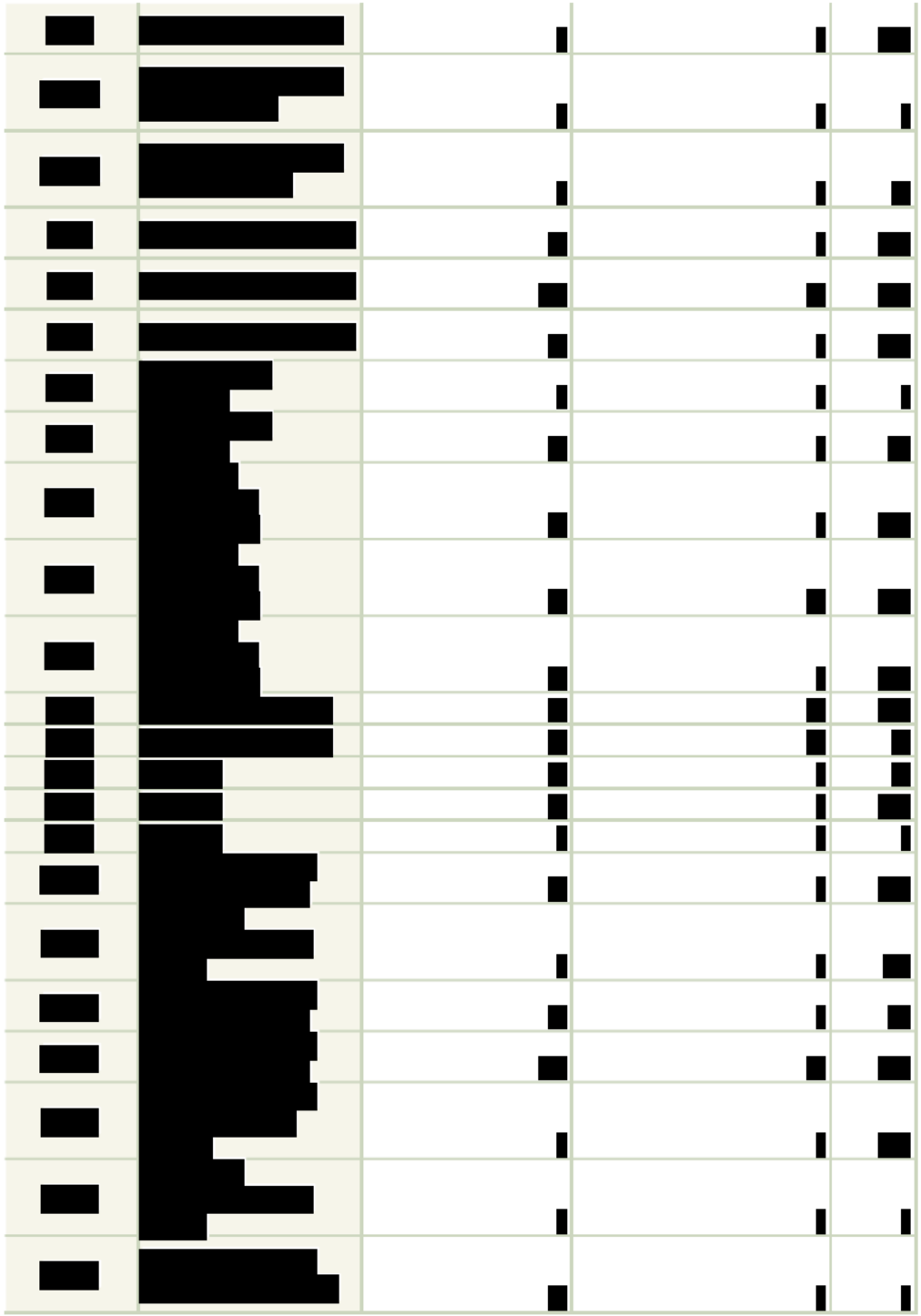


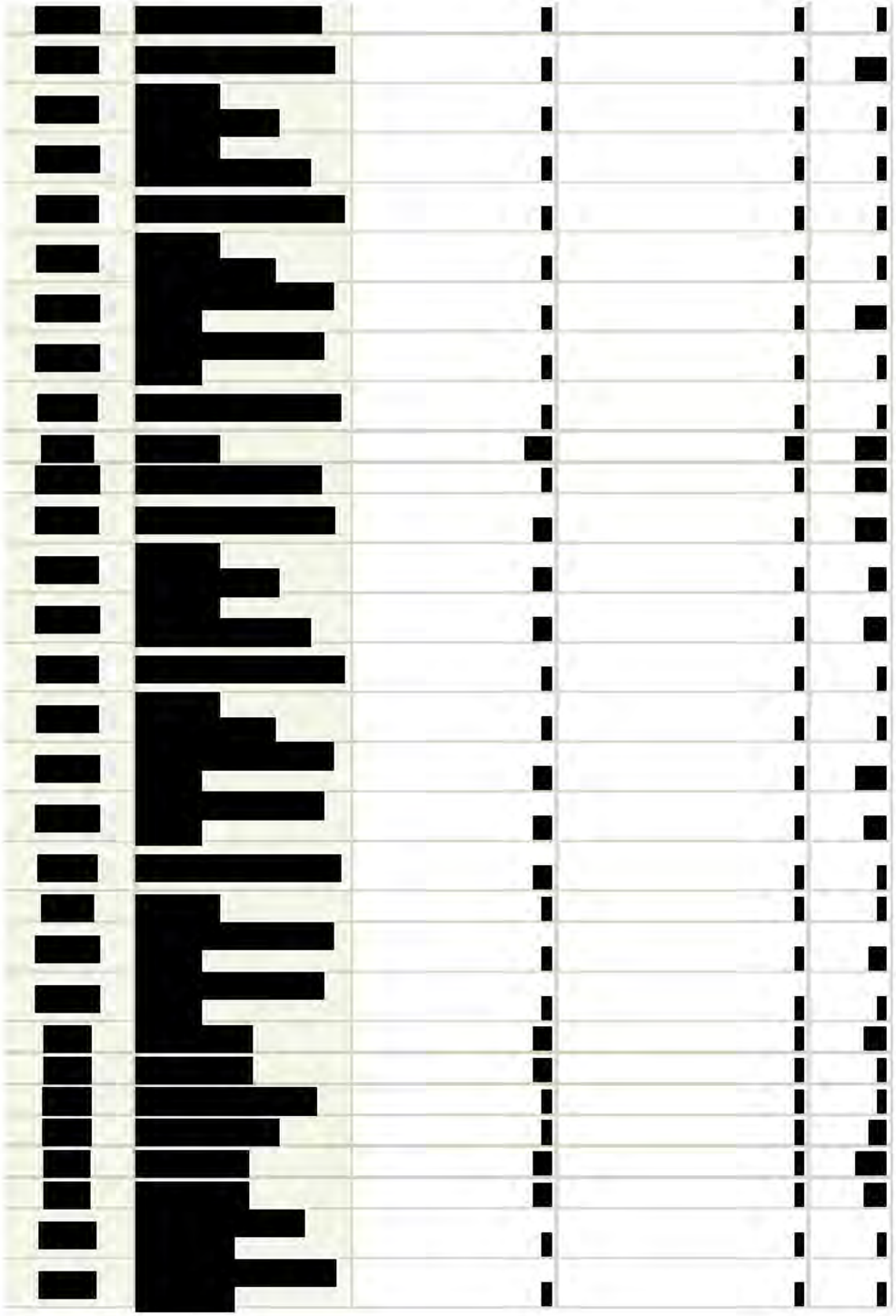


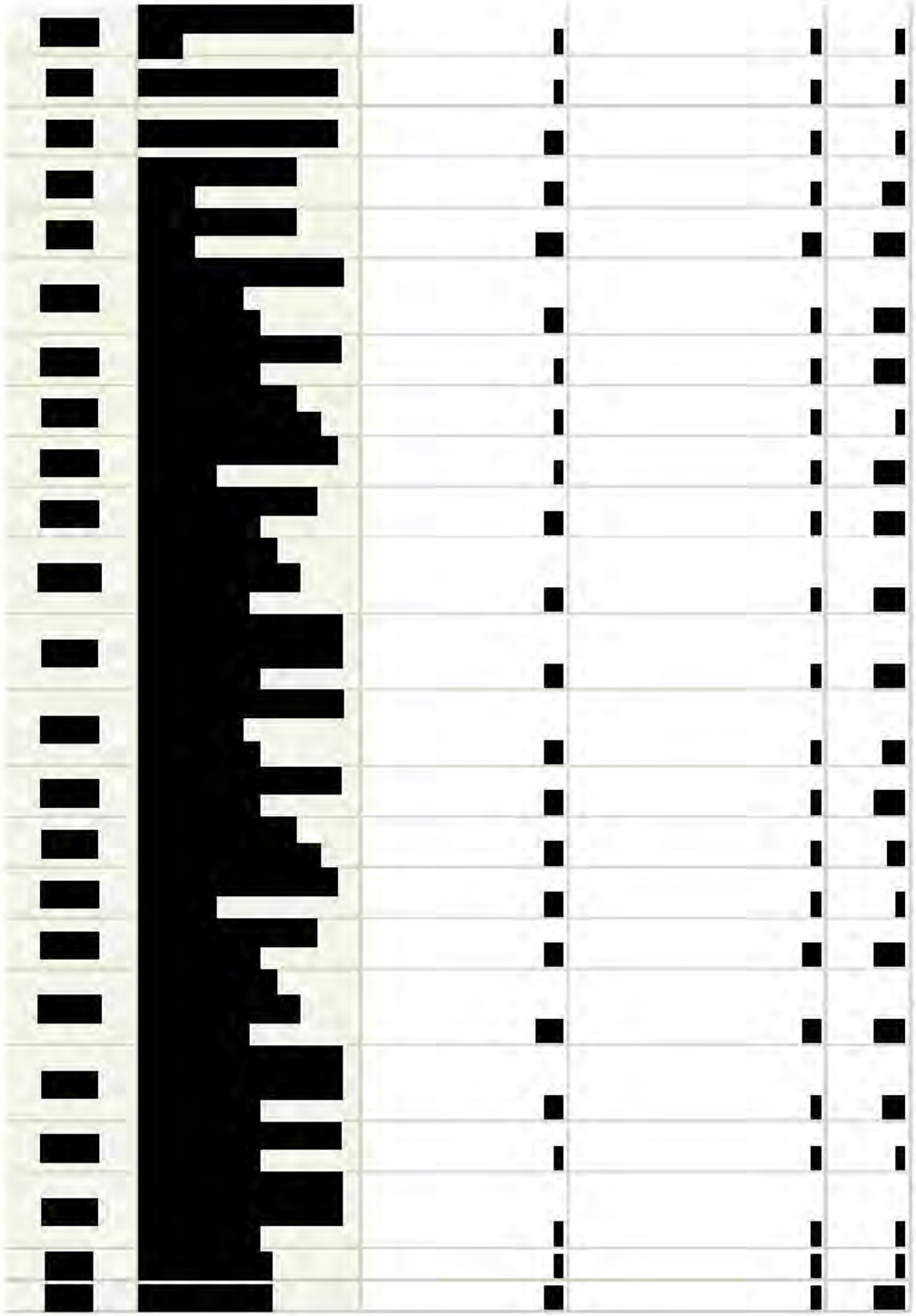


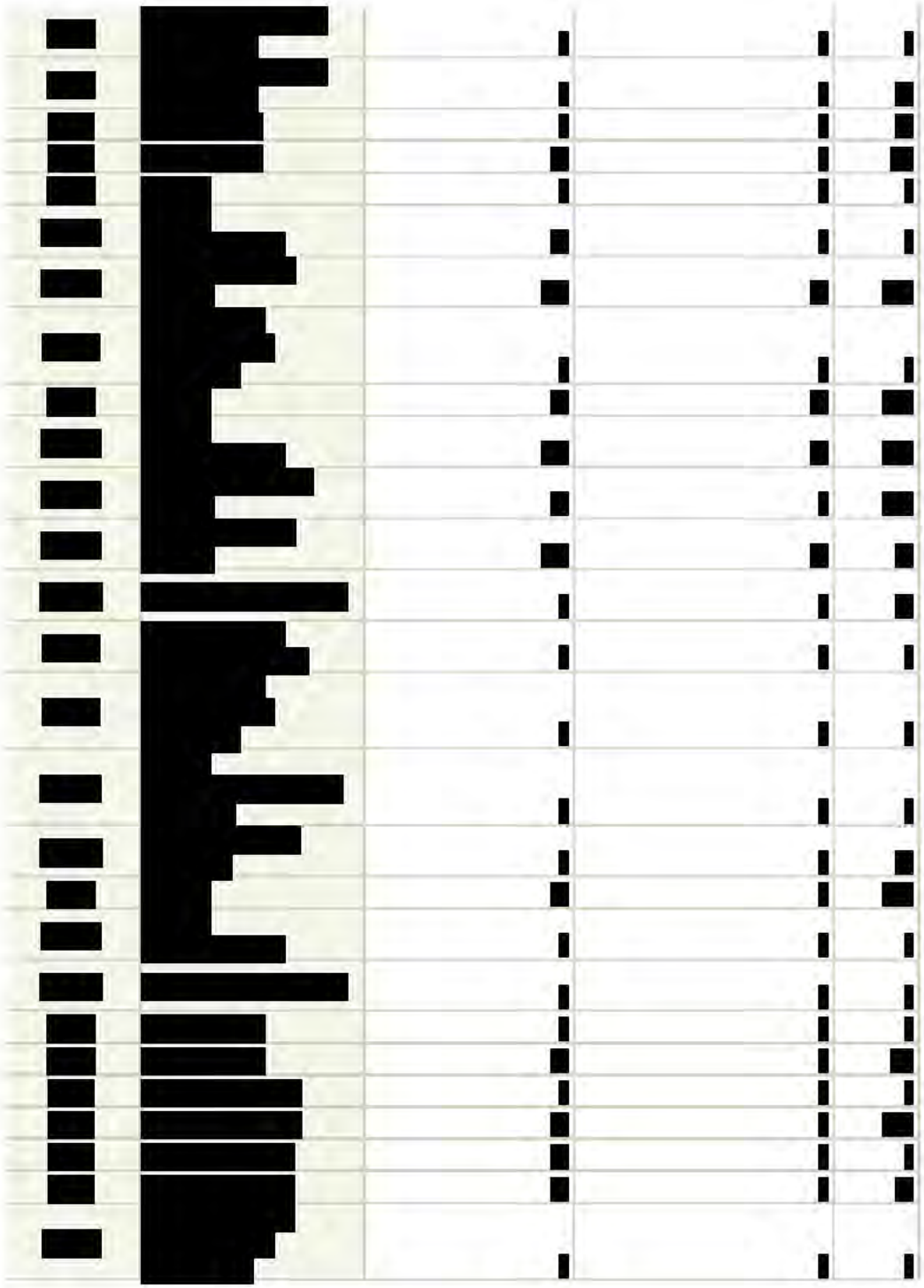


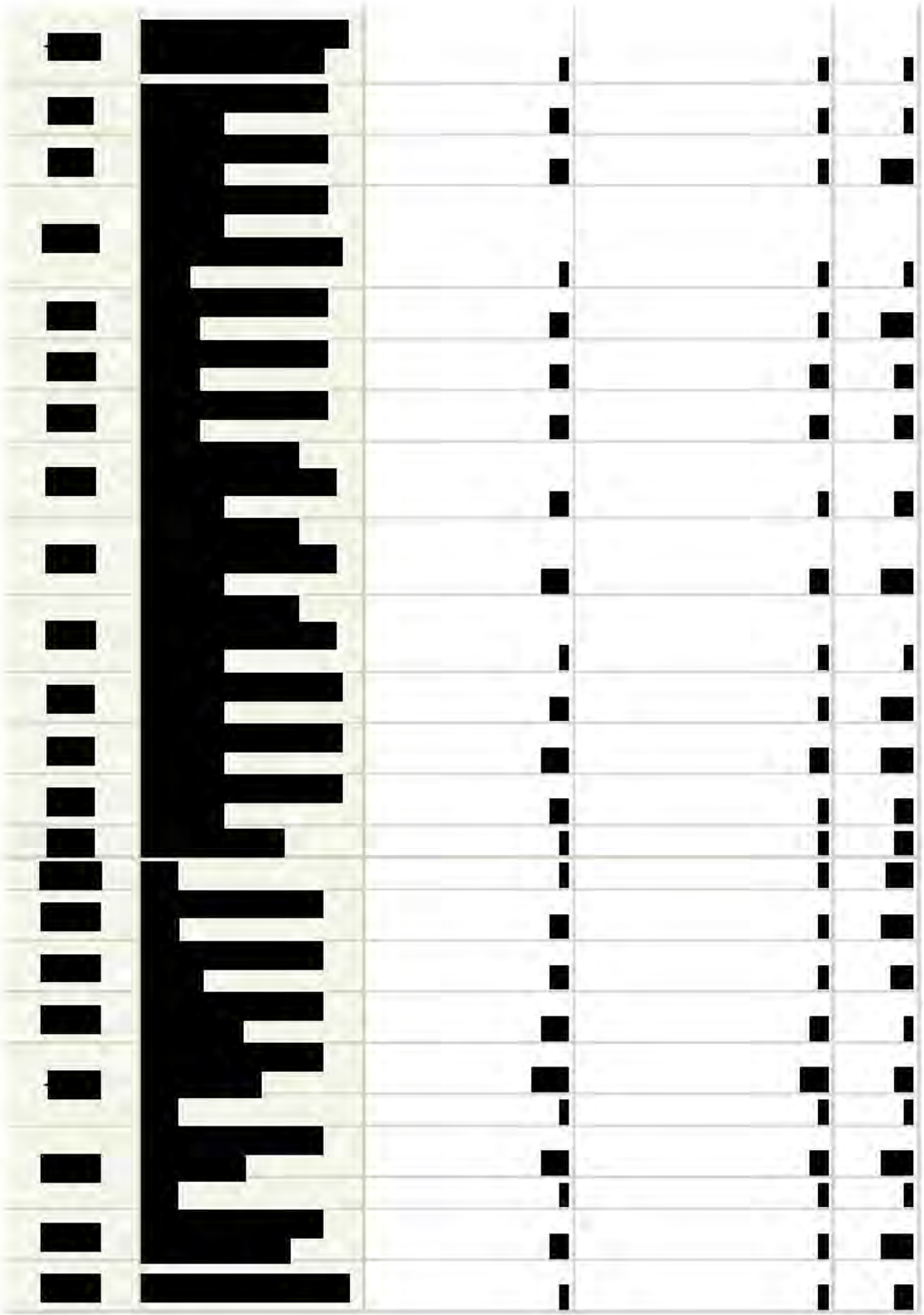


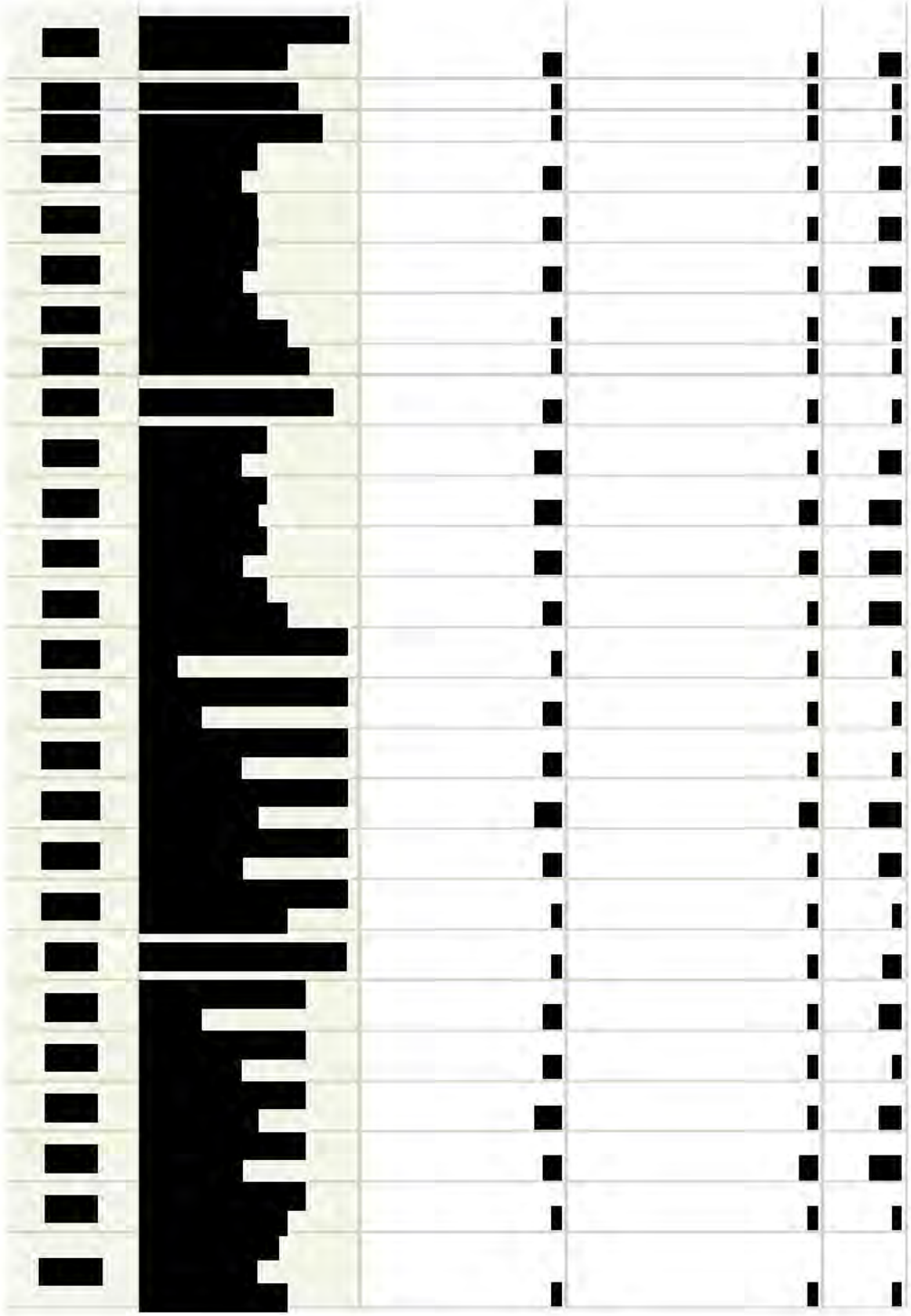


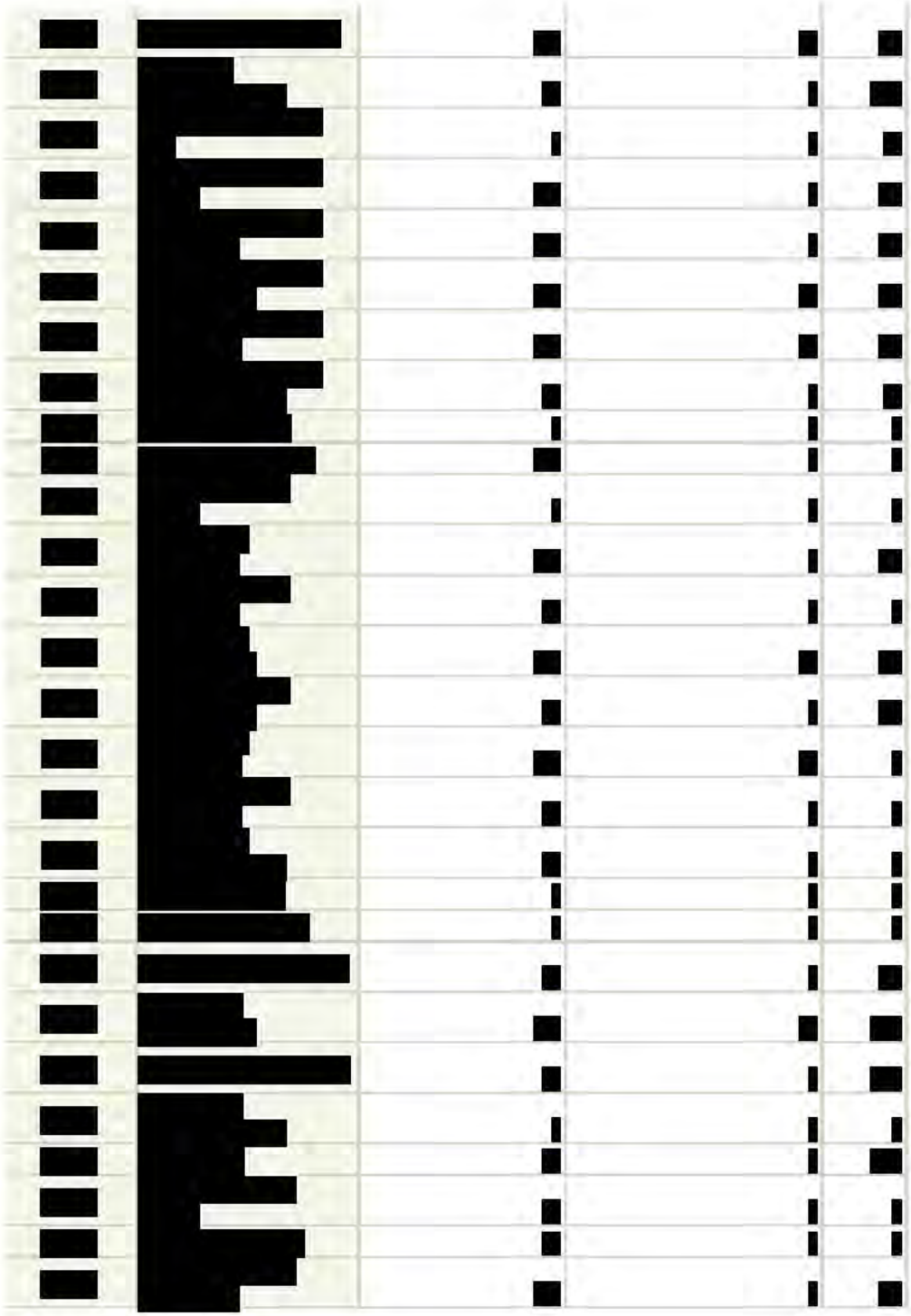


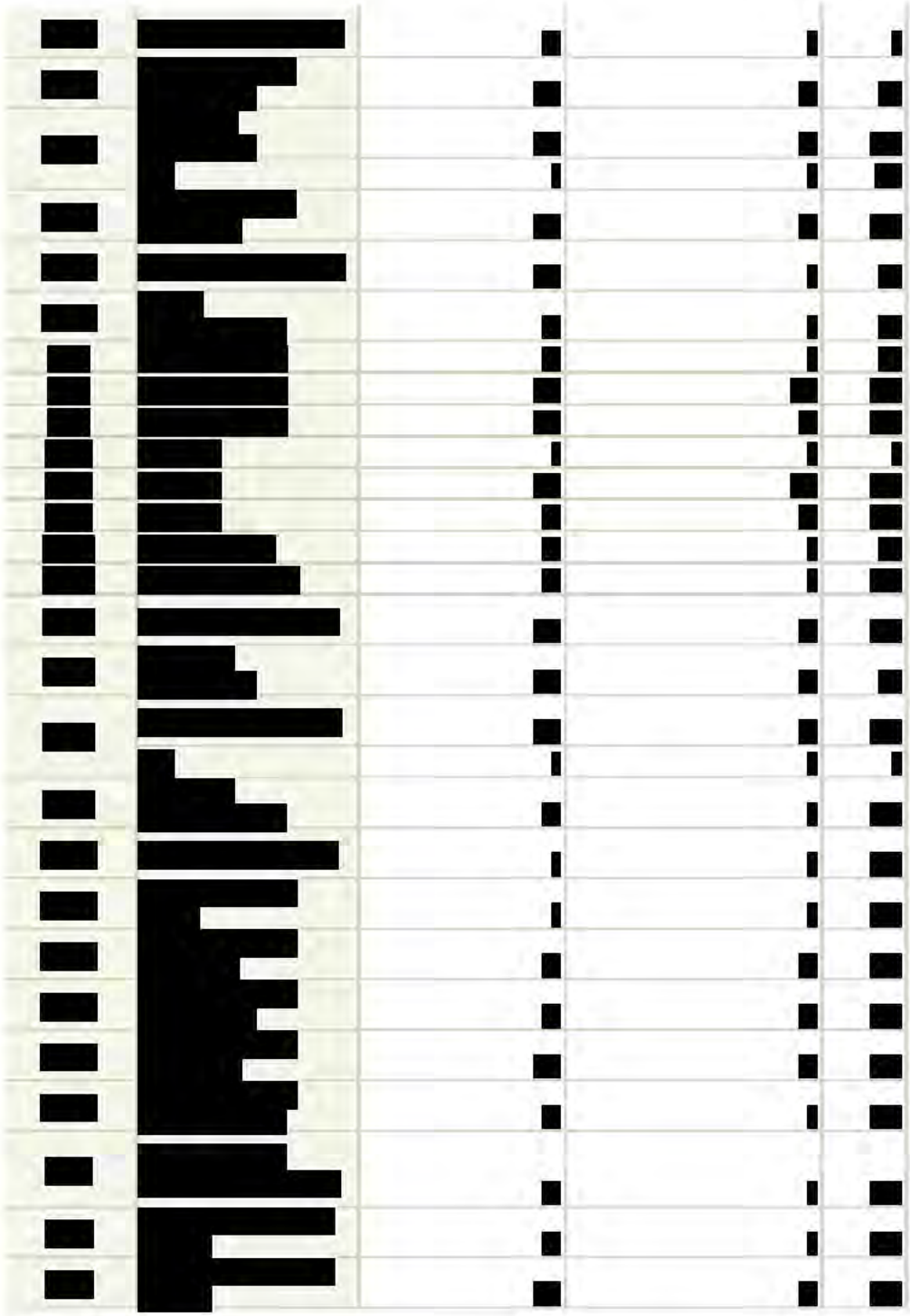


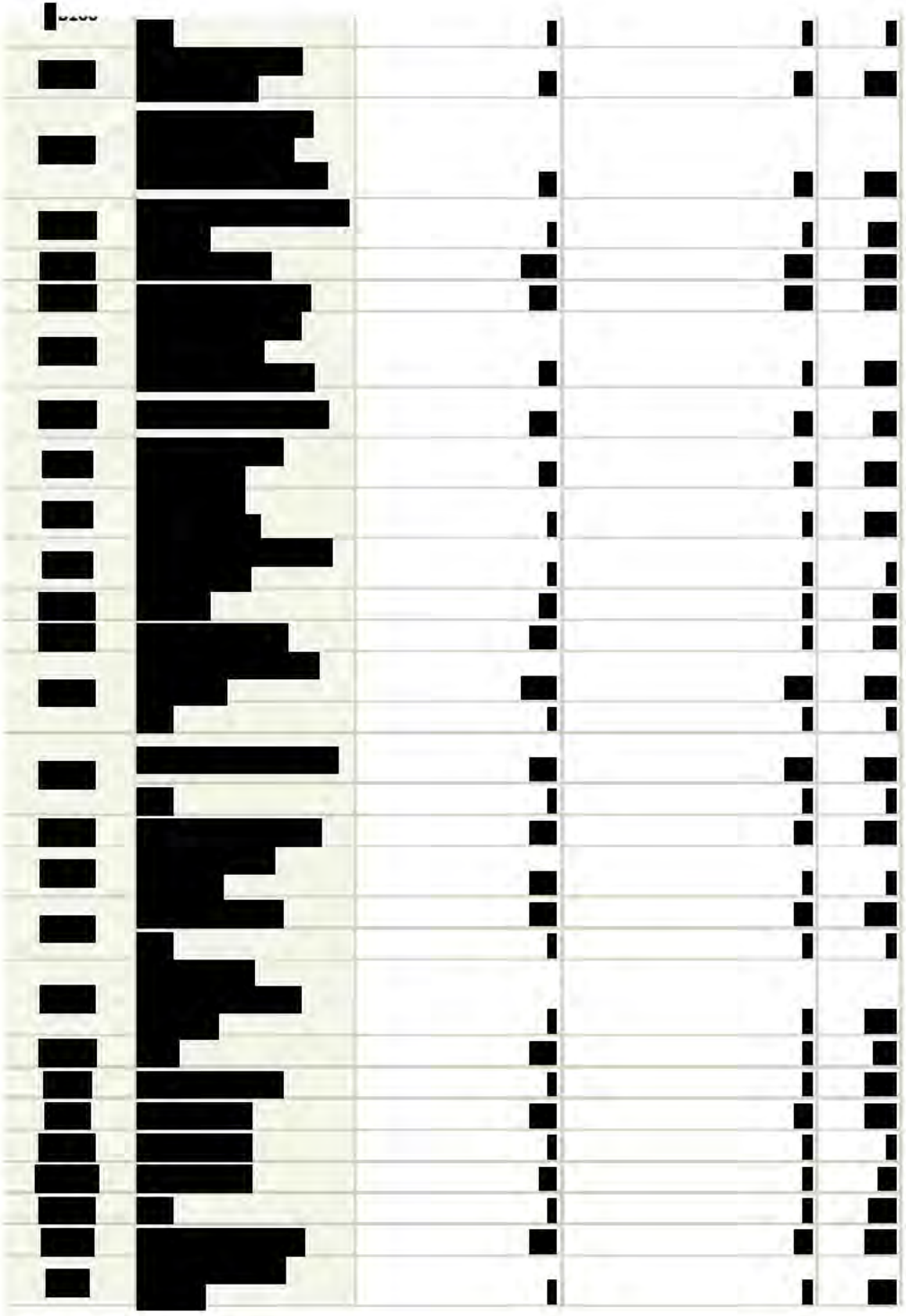


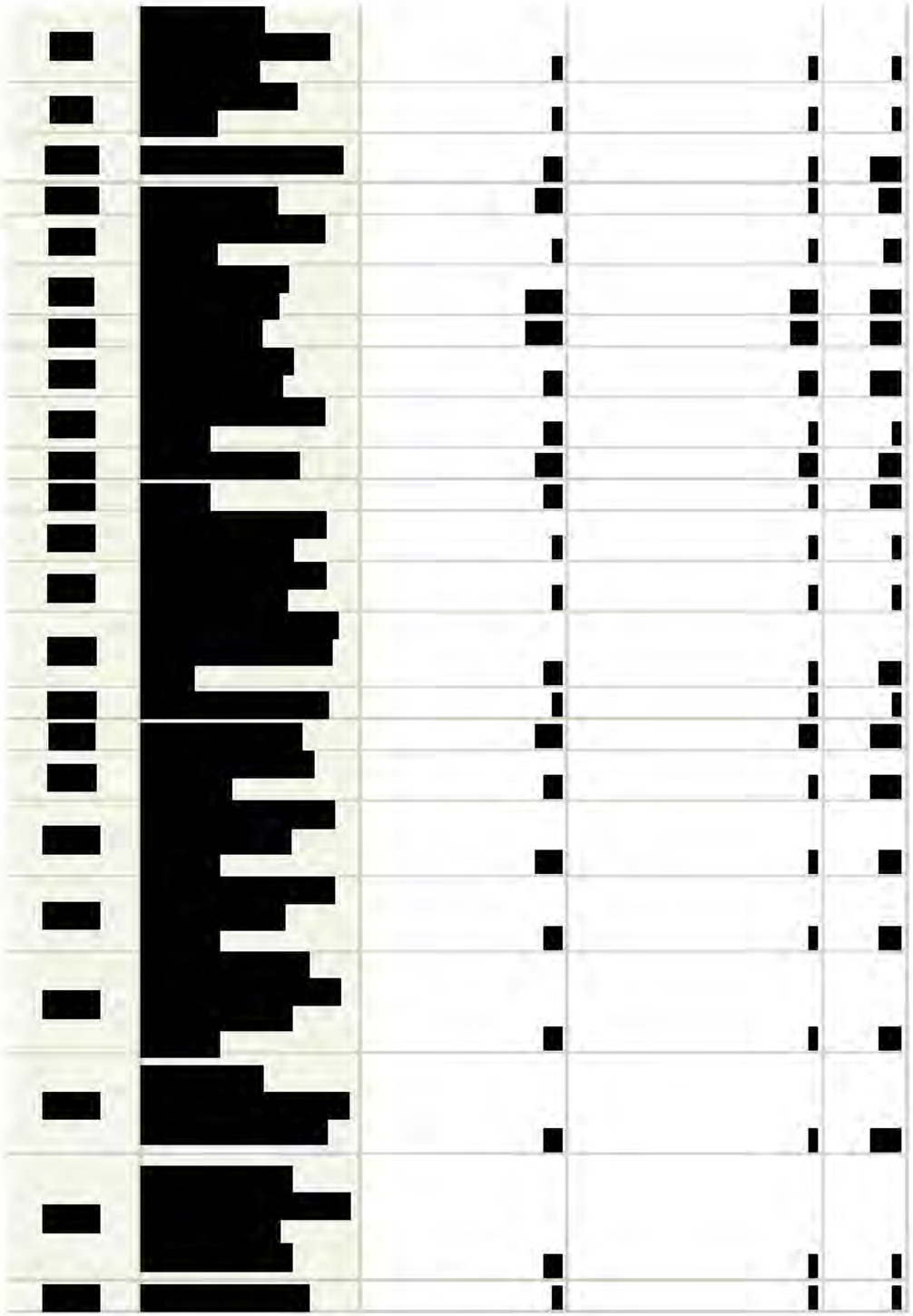


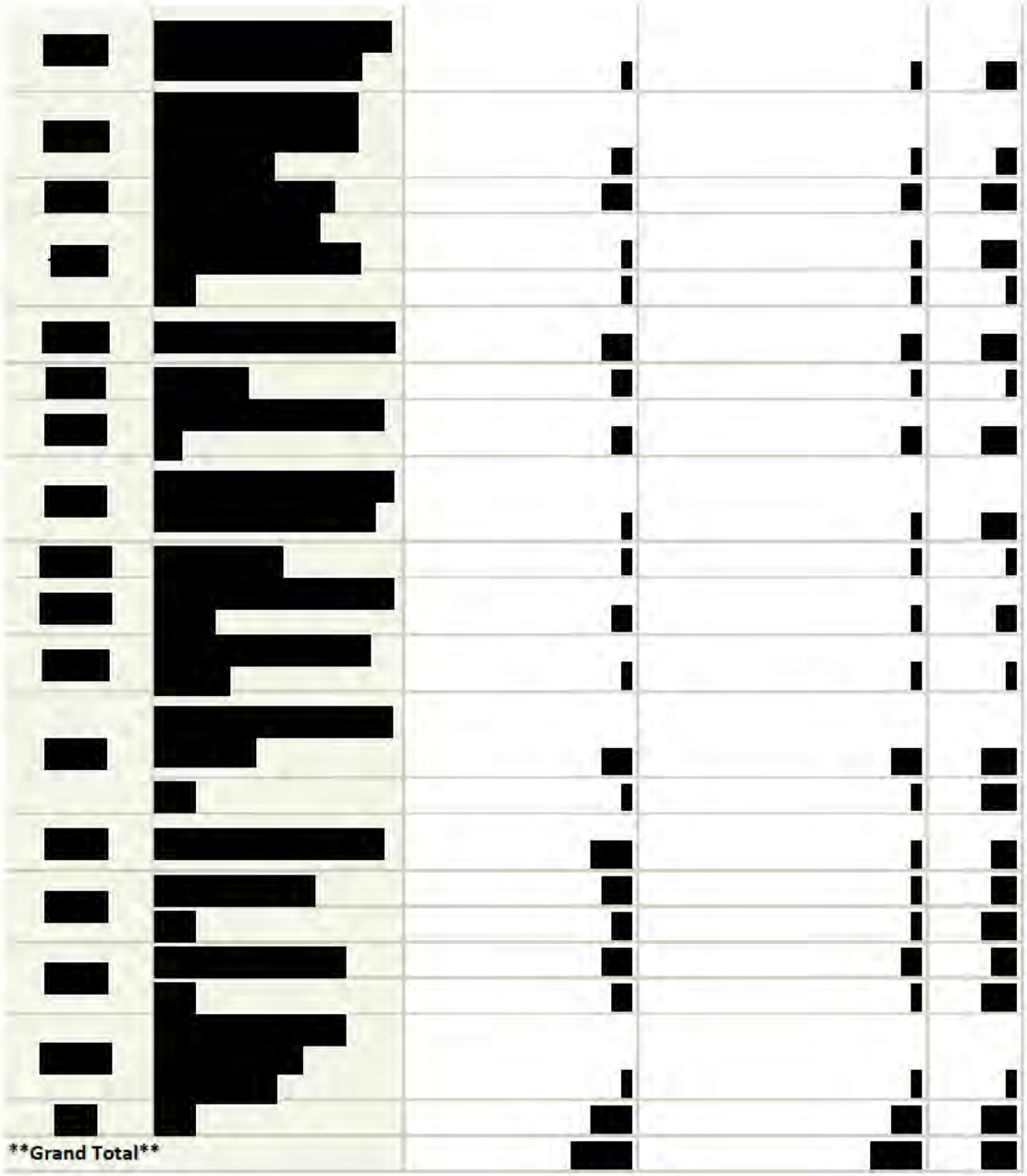








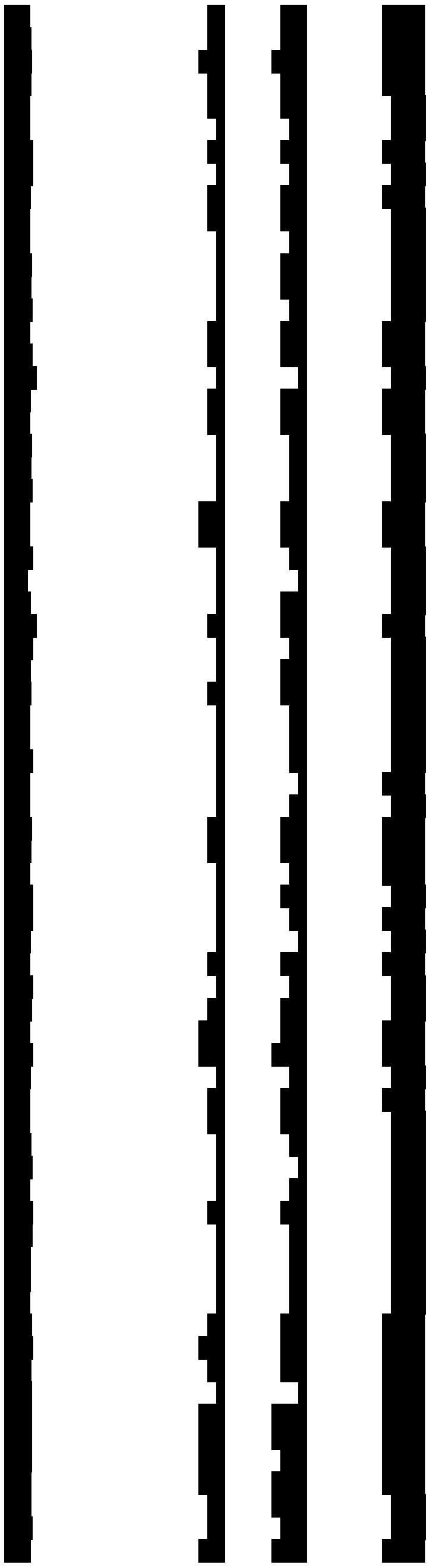



**Grand Total**

**(FOUO) FOR OFFICIAL USE ONLY; Information which must be protected under the Privacy Act and AFI 33-332**

# DEPLOYERS - NUMBERS OF **ACTIVE DUTY** MEMBERS WHO DEPLOYED AT LEAST ONCE FROM FY15-17 BY CONTROL/DUTY AFS (CONTINGENCIES ONLY)
# ASGN - NUMBER OF UNIQUE SOCIALS (**ACTIVE DUTY ONLY**) BY THEIR **LAST** CONTROL/DUTY AFS FROM FY15-17
**Note - If an Airmen deploys and then changes AFS, his ASGN AFS will not match DEPLOYED AFS. Thus, three AFSs (18G, 18E, 86M) show more deployed than assigne*

| CAFS/DAFS | # OF DEPLOYERS | # ASGN | % DEPLOYED |
|---|---|---|---|
| [redacted] | | | |



[redacted]

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| 0004 | Memorandum For SAF/MRBP, Appeal of the Findings of the Formal Physical Evaluation Board, [redacted] | A-00750 |
| 0006 | Memorandum For AFPC/CC, Retention of Airmen with Asymptomatic HIV, [redacted] | A-00752 |
| 0007 | Formal Physical Evaluation Board Contention Slip, [redacted] | A-00753 |
| 0008 | Memorandum for SAFPC, Review of Physical Evaluation Board Proceedings, [redacted] | A-00754 |
| 0009 | Findings and Recommended Disposition of USAF Formal Physical Evaluation Board, [redacted] | A-00755 |
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[redacted]

| | | |
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| 0163 | Entrance Medical Examination, [redacted] | A-00909 |
| 0175 | Veterans Affairs Disability Evaluation System Proposed Rating, [redacted] | A-00921 |
| 0185 | Veterans Affairs Disability Evaluation System Coding Sheet, [redacted] | A-00931 |
| 0188 | Action on Physical Evaluation Board Findings and Recommended Disposition, [redacted] | A-00934 |
| 0189 | Veterans Affairs Benefits Letter, [redacted] | A-00935 |
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**DEPARTMENT OF THE AIR FORCE**
**WASHINGTON, DC**

**Office of the Assistant Secretary**

MEMORANDUM FOR AFPC/DPFDD

FROM: SAF/MRBP

SUBJECT: Physical Evaluation–[redacted]

On behalf of the Secretary of the Air Force, it is directed that [redacted] be discharged and receive severance pay with a disability rating of 10 percent under the provisions of Title 10, United States Code, Section 1203. This disability rating was determined based on the Veterans Affairs Schedule for Rating Disabilities (VASRD) in accordance with the National Defense Authorization Act of 2008.

[redacted]s case was considered by the Air Force Personnel Board (AFPB), which made a recommendation regarding its disposition. The following rationale is provided for the final decision in this case. The Board considered the member's contention that he is fit and should be returned to duty. The Board noted the member has been compliant with all treatment, is currently asymptomatic, and has an undetectable human immunodeficiency virus (HIV) viral load. Additionally, he is able to perform all in garrison duties, has passed his most recent fitness assessment without any component exemptions, and his commander strongly supports his retention. However, the Board noted the member's condition precludes him from being able to deploy world-wide without a waiver and renders him ineligible for deployment to the Central Command (CENTCOM) Area of Responsibility (AOR), where the majority of Air Force members are expected to deploy. Deployability is a key factor in determining fitness for duty and the Board recognized the member belongs to a career field with a comparatively high deployment rate/tempo. Therefore, based on his inability to deploy and considering his current career point, the Board determined he is unfit for continued military service and shall be discharged with severance pay.

Addressing the applicant's disability rating award, the Board is required by law to rate a disability using criteria outlined in the VASRD. The AFPB typically applies the disability ratings proposed by the Department of Veterans Affairs (DVA) under the Integrated Disability Evaluation System (IDES), as these ratings should be in compliance with the VASRD. The Board therefore assigned a rating of 10 percent to the member's HIV infection. This rating warranted discharge with severance pay.





A-00747

This action is taken under the authority delegated by the Secretary of the Air Force.

[redacted]

X John K. Vallario

JOHN K. VALLARIO
Deputy Director, SAF Personnel Council
Signed by: VALLARIO.JOHN.K.[redacted]

Attachment:
Additional Information Sheet

## Additional Information Sheet

Your case was reviewed by the Air Force Personnel Board (AFPB) of the Secretary of the Air Force Personnel Council (SAFPC) under authority delegated by the Secretary of the Air Force. The board reviewed all facts and evidence in the case, to include the testimony presented before the Formal Physical Evaluation Board (FPEB) and the remarks of the FPEB (if applicable), the remarks of the Informal Physical Evaluation Board (IPEB), the service medical record (including electronic entries contained in the Armed Forces Health Longitudinal Technology Application, or AHLTA), the Narrative Summary of the Medical Evaluation Board (MEB), the Department of Veterans Affairs (DVA) medical examination, information provided by you and your counsel, and any additional information that was provided.

If you are on extended active duty and have between 15 and 19+ years of active duty service (but less than 20 years), have an essentially stable condition, and wish to return to duty, you ***may*** be eligible to apply for the Limited Assignment Status (LAS) program. Please see Chapter 6 of AFI 36-3212 for more information or discuss your options with your Office of Airmen's Counsel (OAC) representative. Note: you are normally **not** eligible to apply for LAS if you are being placed on the Temporary Disability Retired List (TDRL).

The board is sensitive to your potential need for continuing medical care. Therefore, the board encourages you to utilize the resources of the DVA to the extent that you may be entitled. The DVA is the agency chartered by Congress to provide assistance to all eligible veterans. A full complement of medical services is available at any tertiary-level DVA health care facility. The DVA's Vocational Rehabilitation and Employment Program's mission is to assist veterans with a service-connected disability to prepare for and find suitable employment. Additional information regarding this program can be obtained at the following website: http://www.benefits.va.gov/vocrehab/index.asp. The Military Disability Evaluation System (MDES) is responsible for maintaining a fit and vital fighting force. While the MDES considers all of the service member's medical conditions, compensation can only be offered for those medical conditions that cut short a service member's career, and then only to the degree of severity present at the time of final disposition. However, the DVA, operating under a different set of laws (Title 38, United States Code), is empowered to periodically re-evaluate veterans for the purpose of adjusting their disability ratings should their degree of impairment vary over time.

You are also advised of your right to pursue further appeal through application to the Air Force Board for Correction of Military Records (AFBCMR) should you find reason that brings into question the decision of the board. The AFBCMR is an independent body chartered by Congress to redress any Air Force personnel action without influence of previous boards or their respective decisions. You may obtain information on appeal procedures from the AFBCMR website at: http://www.afpc.af.mil/Board-for-Correction-of-Military-Records.

[redacted]

MEMORANDUM FOR SAF/MRBP

FROM: [redacted]

SUBJECT: Appeal of the Findings of the Formal Physical Evaluation Board (FPEB)

1. On [redacted] I had my FPEB hearing. The FPEB determined me to be unfit for continued military service and recommended discharge with severance pay with a disability rating of 10%. ***I disagree with the FPEB's findings and ask that you find me fit for duty.***

2. I am [redacted] I am currently stationed at [redacted], working as a [redacted]. My duties [redacted] Despite the diagnosis of my condition, I have continued to excel in my job.

3. My medical condition does not affect my ability to perform my assigned duties either physically or mentally. The only restriction I am under is my ability to deploy to any AFCENT location strictly due to a ban on the condition, not my ability to perform my work. [redacted] My ability to perform any of the components of the physical fitness assessment is also unaffected by my condition. In my latest official physical fitness assessment, I scored [redacted] I also have consistently passed every fitness assessment throughout my military career.

4. While yes, I am currently not allowed to deploy to AFCENT locations, my AFSC is always in need of personnel for TDY's to multiple locations across MAJCOMs including PACAF and USAFE, all of which I am fully qualified to fill. Along with that, I am [redacted]

5. The informal and formal medical evaluation boards (IPEB and FPEB) highlighted a potential issue. They indicated concern with my inability to deploy to AFCENT as potentially having an impact on the high tempo of my AFSC. [redacted]

[redacted]

6. In regards to availability of medication to maintain my health, there are no issues. I am currently prescribed 3 months' worth of medication at a time for both Tivicay and Descovy with multiple methods of filling the prescription. I have the ability to have them mailed to my residence, pick them up at a local pharmacy or even an on-base pharmacy.

4. I am continuing to gather information in support of my case. I understand the appeals process can be lengthy, and I respectfully request you contact my appointed counsel, Capt Charles Grotewohl, 210-565-0739 prior to a final decision being made. This will allow me the opportunity to submit updated information regarding my case.

[redacted]

DEPARTMENT OF THE AIR FORCE
WASHINGTON DC

11 Oct 17

MEMORANDUM FOR AFPC/CC

FROM: HQ USAF/A1P

SUBJECT: Retention of Airmen with Asymptomatic HIV

Airmen with asymptomatic HIV infection, defined as laboratory evidence of Human Immunodeficiency Virus (HIV) infection without the presence of progressive clinical illness or immunological deficiency, shall be referred to Air Force Personnel Center (AFPC) Medical Standards Branch in the Medical Service Officer Management Division (DP2NP) for a case review.

AFPC/DP2NP will determine if the Airman may be returned to duty with an Assignment Limitation Code (ALC-C) or if medically necessary, be referred to the Integrated Disability Evaluation System (IDES). Asymptomatic HIV alone is not unfitting for continued service.

Airmen with laboratory evidence of HIV infection and with the presence of progressive clinical illness or immunological deficiency shall be referred into the IDES.

Our points of contact are Lt Col Matthew Huibregtse, AF/A1PPP (703-571-0827, matthew.j.huibregtse.mil@mail.mil) and Col Patrick Danaher, AFMOA/SGHM, (210-395-9140, patrick.j.danaher6.mil@mail.mil).

ROBERT D. LABRUTTA
Major General, USAF
Director, Military Force Management Policy

cc:
AFMOA/CC

**DEPARTMENT OF THE AIR FORCE**
HEADQUARTERS AIR FORCE LEGAL OPERATIONS AGENCY
JBSA RANDOLPH TX 78150

## Formal Physical Evaluation Board Contention Slip

[redacted]
**Board Date:** [redacted]

**Attorney:** Capt Charles Grotewohl

**Contention:** [redacted] **contends he is fit and should be returned to duty.**

**Witnesses:** [redacted]

**Board Exhibits:**

I Contention Slip

**Administrative Errors or Irregularities:** None

**Observers:** None

**AF FPEB Board Exhibit I**
**1 of 1 Pages**

0007

A-00753

**DEPARTMENT OF THE AIR FORCE**
**HEADQUARTERS AIR FORCE PERSONNEL CENTER**
**JOINT BASE SAN ANTONIO-RANDOLPH TEXAS**

[redacted]

MEMORANDUM FOR SAFPC

FROM: AFPC/DPFDD
550 C Street West Ste 6
JBSA Randolph AFB TX 78150-4708

SUBJECT: Review of Physical [redacted] ion Board Proceedings - [redacted]

REQUESTED ACTION: APPEAL

BASIS FOR REQUEST: The attached Physical Evaluation Board proceedings and allied documents are forwarded for necessary action under paragraph a, Secretary of the Air Force Personnel Memorandum, 10 February 2014.

FACTS: Member contends that he is fit and should be returned to duty.
*****Member does not request a VA Recon.*****

RECOMMENDATION: N/A

POC is Pedro Encina, DSN 665-2880.

Ramona L. Scott
TSGT RAMONA L. SCOTT, USAF
Disability Operations Branch
USAF Physical Disability Division
Directorate of Airman & Family Care

Attachments:
1. Disability Case

| FORMAL | FINDINGS AND RECOMMENDED DISPOSITION OF USAF PHYSICAL EVALUATION BOARD | DATE: [redacted] |
|---|---|---|

*PRIVACY ACT STATEMENT*

*AUTHORITY 10 U.S.C. 8013, Secretary of the Air Force (AF); as implemented by AF Instruction 36-2608 and Executive Orders 9397 (SSN) and 13478.*
*PRINCIPAL PURPOSE Military personnel records are used at all levels of AF personnel management for actions/processes related to disability evaluation for separation/retirement or retention.*
*ROUTINE USES Records may be disclosed to the Department of Veterans Affairs for research, processing, and adjudication of claims, and providing medical care.*
*DISCLOSURE Voluntary. SSN is necessary to ensure positive identification. Refusal to divulge information may delay or halt further processing and may jeopardize entitlement to disability benefits.*

| 1. BOARD CONVENED AT JBSA Randolph AFB TX 78150-4708 | 2. EXHIBITS ATTACHED: A-C; G-I | |
|---|---|---|
| 3. MEMBER'S NAME (Last, First, MI) [redacted] | 4. GRADE [redacted] | 5. SSN [redacted] |
| 6. COMPONENT: **Regular AF** | 7. 10 USC 1208 SERVICE **05** | 8. APPROVED RETIREMENT/HYT: |

**9. FINDINGS CONCERNING INDIVIDUAL CONDITIONS DESCRIBED IN THE RECORDS**

A. DIAGNOSIS
B. INCURRED WHILE ENTITLED TO RECEIVE BASIC PAY (Enter "Yes", "No", or "NA" for Not Applicable.)
C. LINE OF DUTY OR PROXIMATE RESULT OF PERFORMING DUTY (Enter "Yes" for in line of duty or proximate result, "No" for not proximate result of performing duty (ARC only), "M" for Not LOD - intentional misconduct, "N" for Not LOD - willful neglect, "A" for Not LOD - incurred during a period of unauthorized absence, or "NA" for not applicable)
D. DISABILITY COMPENSATION RATING
E. VETERANS ADMINISTRATION SCHEDULE FOR RATING DISABILITIES (VASRD) CODE
F. COMBAT RELATED DETERMINATION AS DEFINED IN 26 USC 104 (Enter "A" for direct result of armed conflict, "I" for direct result of instrumentality of war, "S" for duty under conditions simulating war, or "H" for while engaged in hazardous service, or "No" if not combat related.)

| A. DIAGNOSIS | B. | C. | D. | E. | F. |
|---|---|---|---|---|---|
| **CATEGORY I - UNFITTING CONDITIONS:**<br>HIV | Yes | Yes | 10 | 6351 | No |
| **CATEGORY II - CONDITIONS THAT CAN BE UNFITTING BUT ARE NOT CURRENTLY UNFITTING:**<br>See NOTE in Block 15 | | | | | |
| **CATEGORY III - CONDITIONS THAT ARE NOT UNFITTING AND NOT COMPENSABLE OR RATABLE:**<br>NONE | | | | | |

| 10. ADDITIONAL FINDINGS | |
|---|---|
| A. MEMBER IS UNFIT BECAUSE OF PHYSICAL DISABILITY | YES |
| B. OVERCOMES THE PRESUMPTION OF FITNESS | N/A |
| C. CONDITION IS PERMANENT/STABLE | YES |
| D DISABILITY WAS INCURRED IN LINE OF DUTY IN TIME OF WAR OR NATIONAL EMERGENCY OR AFTER 14 SEP 1978 | YES |
| E. DISABILITY WAS INCURRED IN A COMBAT ZONE OR INCURRED DURING THE PERFORMANCE OF DUTY IN COMBAT-RELATED OPERATIONS AS DESIGNATED BY THE SECRETARY OF DEFENSE (NDAA 2008, Sec 1646) | NO |

| 11. COMBINED COMPENSABLE PERCENTAGE | 12. RECOMMENDED DISPOSITION |
|---|---|
| **10** | **Discharge With Severance Pay (DWSP)** |
| 13. NAME OF PEB PRESIDENT OR REPRESENTATIVE<br>**JEFFERY A. TOWNS, Lt Col, USAF** | 14. SIGNATURE Jeffery A. Towns |

**CLINICS FOR TDRL EVALUATIONS**

| | | | |
|---|---|---|---|
| N/A | N/A | N/A | N/A |

FINDINGS AND RECOMMENDED DISPOSITION OF USAF PHYSICAL EVALUATION BOARD

| GRADE/NAME: [redacted] / [redacted] | SSN: [redacted] | DATE: [redacted] |
|---|---|---|

Continuation of Item 9, FINDINGS CONCERNING INDIVIDUAL CONDITIONS DESCRIBED IN THE RECORDS

| A. DIAGNOSIS | B. | C. | D. | E. | F. |
|---|---|---|---|---|---|
| | | | | | |

**15. REMARKS:**

**Contention:** [redacted] contends he is fit for duty.

[redacted] His initial viral load was 14,000. After initiation of treatment which included daily Tivicay and Descovy, subsequent testing revealed a reduction in viral load and [redacted] testified his viral load is currently "0". [redacted] has undergone routine follow-up since his diagnosis and has exhibited no evidence of infection related to his HIV diagnosis. As of [redacted], [redacted] is considered to be stage 2 by CDC case definition and nadir values and he does not have evidence of immune compromise. [redacted] testified he is aware his condition is associated with deployment limitations, but he noted he is able to perform his in-garrison duties and he has no fitness restrictions. The AF FORM 469, *Duty Limiting Condition Report*, indicates [redacted] has the following mobility/duty/fitness restrictions: no PCS/TDY/mobility. [redacted] commander commented [redacted] is able to function in his primary AFSC garrison duties but is limited to deploy; however, she recommends retention. The Board acknowledges the commander's recommendation for retention. The Board also notes [redacted] HIV condition is welled controlled and he is currently asymptomatic. However, as a result of his chronic medical condition, [redacted] requires frequent follow-up with a specialist and he is a non-deployable asset in a high ops-tempo career field. For these reasons, the Board finds [redacted] HIV condition *unfitting* for continued military service

[redacted] HIV medical condition prevents him from reasonably performing the duties of his office, grade, rank, or rating. The Formal Physical Evaluation Board finds SrA [redacted] *unfit* and recommends discharge with severance pay with a disability rating of 10% IAW Veterans Administration Schedule for Rating Disabilities guidelines.

**NOTE:** The FPEB has considered all other medical conditions rated by the Department of Veterans Affairs related to SrA [redacted] military service as required under the Integrated Disability Evaluation System. The Board finds these conditions are currently not unfitting for duty separately or collectively.

| INFORMAL | FINDINGS AND RECOMMENDED DISPOSITION OF USAF PHYSICAL EVALUATION BOARD | DATE: [redacted] |
|---|---|---|

*PRIVACY ACT STATEMENT*

*AUTHORITY 10 U.S.C. 8013, Secretary of the Air Force (AF); as implemented by AF Instruction 36-2608 and Executive Orders 9397 (SSN) and 13478.*
*PRINCIPAL PURPOSE Military personnel records are used at all levels of AF personnel management for actions/processes related to disability evaluation for separation/retirement or retention.*
*ROUTINE USES Records may be disclosed to the Department of Veterans Affairs for research, processing, and adjudication of claims, and providing medical care.*
*DISCLOSURE Voluntary. SSN is necessary to ensure positive identification. Refusal to divulge information may delay or halt further processing and may jeopardize entitlement to disability benefits.*

| 1. BOARD CONVENED AT JBSA Randolph AFB TX 78150-4708 | 2. EXHIBITS ATTACHED: A | |
|---|---|---|
| 3. MEMBER'S NAME (Last, First, MI) [redacted] | 4. GRADE [redacted] | 5. SSN [redacted] |
| 6. COMPONENT: **Regular AF** | 7. 10 USC 1208 SERVICE **05** | 8. APPROVED RETIREMENT/HYT: |

**9. FINDINGS CONCERNING INDIVIDUAL CONDITIONS DESCRIBED IN THE RECORDS**

A. DIAGNOSIS
B. INCURRED WHILE ENTITLED TO RECEIVE BASIC PAY (Enter "Yes", "No", or "NA" for Not Applicable.)
C. LINE OF DUTY OR PROXIMATE RESULT OF PERFORMING DUTY (Enter "Yes" for in line of duty or proximate result, "No" for not proximate result of performing duty (ARC only), "M" for Not LOD - intentional misconduct, "N" for Not LOD - willful neglect, "A" for Not LOD - incurred during a period of unauthorized absence, or "NA" for not applicable)
D. DISABILITY COMPENSATION RATING
E. VETERANS ADMINISTRATION SCHEDULE FOR RATING DISABILITIES (VASRD) CODE
F. COMBAT RELATED DETERMINATION AS DEFINED IN 26 USC 104 (Enter "A" for direct result of armed conflict, "I" for direct result of instrumentality of war, "S" for duty under conditions simulating war, or "H" for while engaged in hazardous service, or "No" if not combat related.)

| A. DIAGNOSIS | B. | C. | D. | E. | F. |
|---|---|---|---|---|---|
| **CATEGORY I - UNFITTING CONDITIONS:**<br>HIV | Yes | Yes | 10 | 6351 | No |
| **CATEGORY II - CONDITIONS THAT CAN BE UNFITTING BUT ARE NOT CURRENTLY UNFITTING:**<br>See NOTE in Block 15 | | | | | |
| **CATEGORY III - CONDITIONS THAT ARE NOT UNFITTING AND NOT COMPENSABLE OR RATABLE:**<br>NONE | | | | | |

| 10. ADDITIONAL FINDINGS | |
|---|---|
| A. MEMBER IS UNFIT BECAUSE OF PHYSICAL DISABILITY | YES |
| B. OVERCOMES THE PRESUMPTION OF FITNESS | N/A |
| C. CONDITION IS PERMANENT/STABLE | YES |
| D DISABILITY WAS INCURRED IN LINE OF DUTY IN TIME OF WAR OR NATIONAL EMERGENCY OR AFTER 14 SEP 1978 | YES |
| E. DISABILITY WAS INCURRED IN A COMBAT ZONE OR INCURRED DURING THE PERFORMANCE OF DUTY IN COMBAT-RELATED OPERATIONS AS DESIGNATED BY THE SECRETARY OF DEFENSE (NDAA 2008, Sec 1646) | NO |

| 11. COMBINED COMPENSABLE PERCENTAGE | 12. RECOMMENDED DISPOSITION |
|---|---|
| **10** | **Discharge With Severance Pay (DWSP)** |
| 13. NAME OF PEB PRESIDENT OR REPRESENTATIVE<br>**RICHARD S. BINGER, DAFC** | 14. SIGNATURE [signature] |

**CLINICS FOR TDRL EVALUATIONS**

| | | | |
|---|---|---|---|
| N/A | N/A | N/A | N/A |

AF Form 356, Dec 14 PREVIOUS VERSION IS OBSOLETE

FINDINGS AND RECOMMENDED DISPOSITION OF USAF PHYSICAL EVALUATION BOARD

| GRADE/NAME: | SSN: | DATE: |
|---|---|---|
| [redacted] | [redacted] | [redacted] |

Continuation of Item 9, FINDINGS CONCERNING INDIVIDUAL CONDITIONS DESCRIBED IN THE RECORDS

| A. DIAGNOSIS | B. | C. | D. | E. | F. |
|---|---|---|---|---|---|
| | | | | | |

**15. REMARKS:** The Informal Physical Evaluation Board (IPEB) has reviewed the available evidence and finds the service member's (SM) medical condition incompatible with continued military service; accordingly, the IPEB recommends the SM be discharged with severance pay with a disability rating of 10% IAW the Veterans Administration Schedule for Rating Disabilities (VASRD) guidelines. The SM is a [redacted] ([redacted] submitted for HIV. He has undergone HIV treatment protocols since [redacted] without any additional sequelae but due to this lifelong condition, he will require quarterly evaluations and restrictions for deploying. The AF FORM 469, Duty Limiting Condition Report, indicated the SM has the following mobility/duty/fitness restrictions: no PCS/TDY/mobility. The SM's commander has indicated the SM is able to function in his primary AFSC garrison duties but is limited to deploy; however, she recommends retention. The IPEB acknowledges the commander's recommendation for retention; however, the IPEB finds the SM's medical condition prevents him from reasonably performing the duties of his office, grade, rank or rating; represents a medical risk to the health of the SM or the health/safety of others with continued service; is subject to progression; requires frequent follow-up with a medical specialist; and limits the SM's ability to meet mobility requirements. Thus, the IPEB finds the SM's condition is incompatible with the rigors of military service and unfitting. NOTE: The IPEB has considered all other medical conditions rated by the Department of Veterans Affairs related to the SM's military service as required under the Integrated Disability Evaluation System. The Board finds these conditions are currently not unfitting for duty separately or collectively.

[redacted]

PERSONAL DATA - PRIVACY ACT OF 1974 (USC 552a)

[redacted] 4674 RS: 20 FUNC-CAT: A EE0VFDX6
DOR: [redacted] DLOC: [redacted] DUTY [redacted]
MPF: [redacted] OFF-SYM: [redacted]
DAS: [redacted] ANG-STATE: *** SEPARATION DATA ***
REQUESTED APPROVED
****AFSC**** ***SERVICE DATES*** RET/SEP DATE: 26 DEC 2017
CAF: [redacted] DOB: [redacted]
PAF: [redacted] PAY DT: [redacted] RSN/SPD: / MBK
2AF: TAFMSD: [redacted] SP-PROG/WVR:
1405 DT: TRACER: / A
EAD: [redacted] LAW/RET-GR:
**PROMOTION** DOS: 26[redacted] FORCE ADJ:
GR PRJ/NR: DOS PREV: RSN: ORDER/DATE:
SVC-COMP: R DIEMS: [redacted] APPL-DT:
REG DT: TOE: [redacted] HYT/RSN: [redacted]
COMP-CAT: DOE: [redacted] CE/RE/ETS: [redacted]
BTZ: ADMIN-HLD:NO MED-HLD:NO MEMO-DT:
SOC: VSI/ER:
MSO: 8 SEPIND:
ADV_DT: STAT-ID:
ADV-GRD/CD: / DEROS/RSN: SEP-ID: Q
ELIG-STAT: X ELIG - ELIGIBLE FOR SELE CHG/CANX/FLAG:
** PRJ RES/GUARD PAS ** APR-LVL/CHAR: 3 / 1
PAS: S73IFLX5 OVER-4/SPEC-PAY:
AFR SEC ID: RMK:
****** RESTRICTIONS ****** ***** PRJ ASGMT *****
ADSCD-1: [redacted] RNLTD: [redacted]
ADSCD-2: [redacted] ASG/NOTIF:
ADSCD-3: [redacted] PROJ PAS: [redacted]
AAC-1: [redacted] ALC-1: ADN: 015
AAC-2: ALC-2: PPC1:
AAC-3: ALC-3: PPC2:
AEFI: YR AEFI VULNERABILITY PERIOD:
EXCLUSIONS:
UIF: WMP:
PME LAST/YR: / EPR: AC VC 5B 5B 5B
EDUC: [redacted] COM [redacted]
LOST DAYS: 0 ACF: *** DUTY STATUS ***
00-PRESENT FOR DUTY
********** DUTY INFO ********** EFF: 15 APR 2017
[redacted] END:
DAFSC: [redacted] SPD TRACER PREV:
DTY-EFF-DT: [redacted]

AQE SCORES: [redacted]

********** PERSONAL DATA **********
MARITAL STATUS: [redacted]
# DEPENDENTS IN HHLD: 0

Loss_Management__RSLOSS_[redacted]txt[redacted]]

## CHECKLIST FOR MEDICAL EVALUATION BOARD CASES REFERRED TO PHYSICAL EVALUATION

**Complete all items and include checklist with MEB package. Call AFPC/DPFDD at for assistance. (Privacy Act of 1974 applies)**

| Last/First Name | Rank | SSAN | Date | VTA: |
|---|---|---|---|---|
| [redacted] | [redacted] | [redacted] | [redacted] | [redacted] |

**PEBLO INFORMATION**

NAME: [redacted]

DSN PHONE NUMBER: [redacted]

EMAIL: [redacted]

MTF/BASE: [redacted]

| | YES or N/A |
|---|---|
| AAC 37 UPDATED | |
| Tech School Student | |
| Basic Trainee | |
| Cadets | |
| DEROS <6 months | |
| Expedite Request Memo (MTF/CC or designee) | |
| (Please insert Expedite memo behind checklist) | |
| Referral Date: | |
| MEB End Date: (required for all IET & legacy cases) | |

| | YES | NA | REMARKS |
|---|---|---|---|
| 1. AF 618 - MEB Report, per AFI41-210, para 4.62.5 | X | | |
| AF 618 – Item 2 Date Convened | X | | |
| AF 618 – Item 23 B –Date of Origin noted for each condition | X | | |
| AF 618 – Item 26 Psychiatrist Indicated (if applicable) | X | | |
| Administrative LOD | X | | |
| DA Form 3947 or NAVMED Form 6100/1-2 TriService MEB | | X | |
| 2. Commander's Letter, dated & signed---Bookmark | X | | NOT NEEDED FOR BMTS |
| 3. Impartial Review Election | X | | |
| Impartial Review | | X | |
| MEB rebuttal letter | | X | |
| MEB convening authority response | | X | |
| 4. Letter of Exception | | X | |
| 5. DES Fact Sheet Acknowledgement Page | X | | |
| 6. Letter of Intent for Med Hold (Enlisted only & within 6 mos/DOS) | X | | |
| 7. DD Form 2499, Health Care Provider Action Report | | X | |
| 8. Waiver Ltr from DPANM (med persons boarded at their own MTF) | | X | |
| 9. Post Deployment Assessment Worksheet | | X | |
| 10. AF Form 469 - Duty Limiting Condition Report ---Bookmark | X | | |
| 11. SF Form 502/AHLTA NARSUM ---Bookmark (dated & signed or cosigned by MD, DO, MC) | X | | |
| DBQ Reconciliation Statement (following the NARSUM) (dated & signed or cosigned by MD, DO, MC ) ---Bookmark | X | | |
| 12. DoD/VA Referral Form 21-0819 (provide all pages of signed form & (required for all cases EXCEPT IET and legacy) | X | | |
| 13. DBQ or C&P ---Bookmark | X | | |
| Asthma - current PFTs ---Bookmark | | X | |
| Mental Health case – Psychiatry consult ---Bookmark | | X | |
| Orthopedic Case – Range of Motion ---Bookmark | | X | |
| 14. Consultations | | X | |
| Special studies relevant to case (put in order by date) | | X | |
| Supporting civ med docs for ARC members (put in order by date) | | X | |
| 15. Previous AF 618s (within one year of current MEB) | | X | |
| 16. Copy of DD Form 2808, Report of Medical Examination <8 yrs. | X | | |
| 17. Copy of DD Form 2807-1, Report of Medical History < 8 yrs. | X | | |
| 18. AF Form 348 or DD Form 261 Line of Duty --Bookmark | | X | |
| 19. Orders showing ARC mbr duty status (UTA, etc), current AGR orders and/or DD Form 214 @ time of the origin date of illness, injury, disease ---Bookmark | | X | |
| 20. Additional Documentation | | X | |
| Grade determination documentation – Bookmark | | X | |
| Next of Kin Information VRAD | | X | |
| | | | |

October 2015

# MEDICAL BOARD REPORT

*(This form is subject to the Privacy Act of 1974 - Use Blanket PAS - DD Form 2005)*

| 1. INSTALLATION AT WHICH CONVENED | 2. DATE CONVENED |
|---|---|
| [redacted] | [redacted] |

| 3. NAME (Last, First, Middle Initial) | 4. GRADE | 5. SSN | 6. COMPONENT |
|---|---|---|---|
| [redacted] | [redacted] | [redacted] | Reg AF |

| 7. DEPT OR SERVICE | 8. ORGANIZATION | 9. SEX | 10. DATE OF BIRTH (Yr, Mo, day) | 11. AGE |
|---|---|---|---|---|
| DOD/USAF | [redacted] | [redacted] | [redacted] | [redacted] |

| 12. SEPARATION/ RETIREMENT DATE | 13. HOSPITAL INITIALLY ADMITTED | 14. TRANSFERRED FROM | 15. HOME ADDRESS |
|---|---|---|---|
| [redacted] | N/A | N/A | [redacted] |

| 16. MILITARY OCCUPATIONAL SPECIALTIES | | 17. TOTAL YEARS MILITARY SERVICE | | 18. DATE ENTERED AD CURRENT TOUR 20151229 |
|---|---|---|---|---|
| TITLE | CODE | | | 19. AERO RATING N/A |
| Training Instructor | 2W0X1 | ACTIVE [redacted] | INACTIVE N/A | 20. ON FLYING STATUS ON ADMISSION ☐ YES ☑ NO |
| | | | | 21. DATE RELIEVED FROM FLYING STATUS |

22. BY DIRECTION OF THE APPOINTING AUTHORITY, THE BOARD CONVENED TO CONSIDER THE CASE OF THE ABOVE NAMED MEMBER.

| A. UNDER PROVISIONS OF THE FOLLOWING DIRECTIVES: | | B. FOR THE PURPOSE OF: | |
|---|---|---|---|
| ☑ AFI 44-113 AND 48-123 | ☐ MANUAL FOR COURTS-MARTIAL | ☑ CONTINUED ACTIVE DUTY | ☐ EPTS DEFECTS |
| ☑ OTHER (Specify) AFI 10-203, 36-3212, 41-210 | | ☐ SEPARATION/RETIREMENT | ☐ OTHER (Specify) |

23. DIAGNOSIS AND FINDINGS

| AFTER CONSIDERATION OF CLINICAL RECORDS, LABORATORY FINDINGS, AND PHYSICAL EXAMINATION, THE BOARD ESTABLISHES THE FOLLOWING DIAGNOSIS: *(List all diagnoses, in accordance with applicable directives, which contribute or may contribute to make the qualifications of the individual for worldwide duty questionable. Include any competency determinations. (DFAS-DE MANUAL 177-173).* | APPROXIMATE DATE OF ORIGIN | INCURRED WHILE ENTITLED TO BASIC PAY | | EXISTED PRIOR TO SERVICE | | PERMANENTLY AGGRAVATED BY SERVICE | |
|---|---|---|---|---|---|---|---|
| | | YES | NO | YES | NO | YES | NO |
| A | B | C | D | E | F | G | H |
| 1. HIV | 20170201 | X | | | X | | |
| ADMINISTRATIVE LOD: YES | | | | | | | |

| 24. SANITY DETERMINATION *(To be completed for sanity board cases only.) (Manual for Courts-Martial,* | YES | NO |
|---|---|---|
| A. IS THIS A DISEASE OR DEFECT OF THE MIND AS DISTINGUISHED FROM A CHARACTER DEFECT? | ☐ | ☐ |
| B. DID THE ACCUSED, AT THE TIME OF THE ALLEGED OFFENSE AND AS A RESULT OF MENTAL DISEASE OR DEFECT, LACK SUBSTANTIAL CAPACITY TO APPRECIATE THE CRIMINALITY OF THIS CONDUCT? | ☐ | ☐ |
| C. DID THE ACCUSED, AT THE TIME OF THE ALLEGED OFFENSE AND AS A RESULT OF MENTAL DISEASE OR DEFECT, LACK SUBSTANTIAL CAPACITY TO CONFORM HIS/HER CONDUCT TO THE REQUIREMENTS OF THE LAW? | ☐ | ☐ |
| D. DID THE ACCUSED HAVE THE MENTAL CAPACITY TO FORM THE SPECIFIC INTENT OR REQUIRED STATE OF MIND? | ☐ | ☐ |

25. ACTION RECOMMENDED BY BOARD *(or directed by higher authority)*

Refer to Informal PEB

26. BOARD MEMBERS

| TYPED NAME, GRADE, ARM OF SERVICE | SIGNATURE *(Place check after signature of psychiatrist)* | 27. MINORITY REPORT ON REVERSE |
|---|---|---|
| PRESIDENT ~~TILTON, PAUL A., LT COL~~ USAF, MC, SFS | Duffy Tilton, Elizabeth Maj MD | ☐ |
| MEMBER OLSEN, LYNN A., CIV USAF, ~~MC, FS~~ | [signature] MD | ☐ |
| MEMBER ~~MARTIN, BRYANT R., LT COL~~ USAF, MC, SFS | [signature] | ☐ YES ☐ NO |

28. HOSPITAL COMMANDER OR DESIGNEE

| A. DATE REVIEWED | B. BOARD RECOMMENDATION † | C. TYPED NAME, GRADE, SERVICE | D. SIGNATURE |
|---|---|---|---|
| | ☐ APPROVED<br>☐ DISAPPROVED | Not Required Per AFI 41-210 | |

29. I HAVE BEEN INFO[redacted]

| A. DATE | C. LETTER OF EXCEPTION ATTACHED |
|---|---|
| [redacted] | ☐ YES ☒ NO ☐ N/A |

† If applicable indicate reason for disapproval on reverse.

AF IMT 618, 19951001, V2 PREVIOUS EDITION IS OBSOLETE.



A-00761

AF IMT 618 CONTINUATION SHEET

V2

## COMMANDER'S IMPACT STATEMENT FOR MEDICAL EVALUATION BOARD

**PRIVACY ACT STATEMENT**

**AUTHORITY:** 10 U.S.C. 8013, Secretary of the Air Force and 10 U.S.C. Chapter 61, Retirement or Separation for Physical Disability; as implemented by AFI 36-2608.
**PURPOSE:** Military personnel records are used at all levels of AF personnel management for actions/processes related to disability evaluation for separation/retirement or retention.
**ROUTINE USES:** May specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. 552a(b)(3). DoD Blanket Routine Uses apply.
**DISCLOSURE:** Voluntary, refusal to divulge information may delay or halt further processing jeopardizing entitlement to disability benefits.
**SORN:** F036 AFPC E, Temporary Disability Retirement List (TDRL) Case Files are searchable by number and title, and are available at: http://dpclo.defense.gov/Privacy/SORNs/.aspx (if applicable).

**Please visit the following website:** https://kx.afms.mil/kj/kx8/AFPCMedicalRetentionStandards/Pages/home.aspx **for information about the Disability Evaluation System process and instructions for completing this form.**

**I. PERSONNEL DATA**

| (Last, First, Middle Initial) | RANK/GRADE | AFSC |
|---|---|---|
| [redacted] | [redacted] | [redacted] |

**II. EFFECT ON UNIT MISSION** ***(Answer the following questions below.)***

1. Can Airman satisfactorily perform all primary AFSC in-garrison duties? ☒ YES ☐ NO

If no, explain how Airman's medical condition(s) impacts his/her ability to perform all duties related to their primary AFSC and ability to perform their full scope of duties in future assignments and in OCONUS deployed environments?

2. Describe the specific duties Airman is unable to perform because of his/her medical condition. Also, detail any duty-related restrictions, limitations, "work-arounds" or schedule modifications that are in effect and for how long they have been in effect. Also, if Airman is currently assigned to desk or administrative duties, was the medical condition a factor in selecting this duty? ☐ YES ☒ NO

Applicable limiting factor is the AFCENT restriction for members with this condition. Member is fully capable of performing any activity/function that applies to [redacted] career field.

3. How many days of work has Airman missed over the past 12 months due to their condition(s)? Specify how many days were for medical appointments, formal quarters, convalescent leave or other days off due to Airman's condition:

Member has missed approximately [redacted] days of work due to medical appointments concerning his condition.

4. You are encouraged to speak with the Primary Care Manager (PCM) or military provider (for ANG) regarding the Airman's medical condition (including profile recommendation/restrictions, if required).
Have you spoken with the PCM and do you agree with the PCM's assessment of the Airman's conditions? ☒ YES ☐ NO If not, why?

Attempts to reach the member's PCM were unsuccessful.

**III. ADMINISTRATIVE ACTIONS** ***(For Sections III, IV, and V check appropriate Yes or No box and if required, provide additional comments.)***

| | |
|---|---|
| 1. Is Airmen pending administrative action or judicial/nonjudicial punishment that could result in demotion/separation/punitive discharge or dismissal? If yes, provide status:<br>NOTE: If status changes after submitting your impact statement, inform PEBLO immediately. | ☒ NO<br>☐ YES |
| 2. Has Airman had administrative action in the past resulting in a demotion in rank? If yes, provide administrative action/demotion package. | ☒ NO<br>☐ YES |
| 3. Does Airman have an approved retirement/separation date in the system or a high year tenure (HYT) date?<br>If yes, provide date: | ☒ NO<br>☐ YES |

20170615 PREVIOUS EDITIONS ARE OBSOLETE

**IV. DEPLOYMENT RELATED ILLNESSES/INJURIES** ***(If applicable)***

| | |
|---|---|
| 1. Was Airman deployed when the medical condition(s) originated or was incurred? If yes, provide date(s) and location: | ☒ NO ☐ YES |
| 2. If yes for Section IV, Question 1, briefly describe the circumstances based on your knowledge. If you have documentation to support the circumstances (an evaluation, decoration, or letter from a witness), please provide it. Also, annotate source of the information. (Airman reports, personally or coworker witnessed, etc.) | |

**V. AIR RESERVE COMPONENT INPUT** ***(Complete the questions below if your Airman is a Guard/Reserve member)***

| | |
|---|---|
| 1. Was Airman in military status when the medical condition originated or was incurred? If yes, what type of orders/military status at the time and for how long: | ☐ NO ☐ YES |
| 2. Was Airman in military status when the medical condition was first diagnosed? | ☐ NO ☐ YES |
| 3. Did Airman have this medical condition prior to the beginning of their duty status or prior to joining the Guard/Reserve? (If yes, provide copy of DD 214 if applicable) | ☐ NO ☐ YES |
| 4. Is Airman receiving treatment and/or compensation from the Department of Veterans Affairs for his/her referred condition(s)? | ☐ NO ☐ YES |
| 5. Has Airman been placed on extended military status/orders for the purpose of medical treatment and/or MEB processing? If yes, what type of orders/military status: | ☐ NO ☐ YES |
| 6. Has Airman been placed on No Points/No Pay status? If yes, how long: | ☐ NO ☐ YES |

**VI. COMMANDER RETENTION RECOMMENDATION** ***(Check appropriate box and if required, provide comments.)***

☒ RETAIN ☐ DO NOT RETAIN

Additional Comments:
Member superiorly performs all primary duties and has also volunteered with enthusiasm for several on/off base organizations/ function. He is overall a valuable AF asset. Retain.

| | |
|---|---|
| 1. Would your recommendation change if you knew the member would be assigned an Assignment Limitation Code – C, and hence, may have deployment limitations and can affect Mobility Reporting Data? | ☒ NO ☐ YES |

| DATE | Commander's Signature Block: | Signature |
|---|---|---|
| [redacted] | [redacted] | [redacted] |

Please provide a point of contact (name, rank, DSN and email address) if further information is required.

**VII. AIRMAN ACKNOWLEDGEMENT**

Comments:

| DATE | Airman's Signature |
|---|---|
| [redacted] | [redacted] |

NOTE: If Airman is found unfit for further military service, the date of separation/retirement will be approximately 90 days from the finalization of the DES/MEB case.

# IMPARTIAL REVIEW ELECTION

Service Member [redacted] SSN (PA of 1974 applies): [redacted]

Refer DoDI 1332.18, Encl 3, Operational Standards for the IDES, para 2 MEB, (4) Impartial [redacted]views

I have reviewed the contents of the MEB and narrative summary. The PEBLO has counseled me regarding the impartial review process, and I understand it is designed to provide me with an impartial review of my medical board findings and recommendation to ensure that the MEB adequately reflects the complete spectrum of my injuries and/or illnesses. I understand I have five (5) calendar days in which to decide whether to request an impartial review. I understand that this request form will become a part of my MEB package.

Section I. Please circle and initial your selection below:

[redacted]No, I do not elect an impartial review of my MEB. ☐ I do / ☒ do not wish to submit a rebuttal letter. (Sect II not req)

_____ Yes, I elect an impartial review of my MEB ☐ I do / ☐ do not wish to provide a letter detailing my concerns.

I understand that if I have elected to submit a rebuttal letter, I have five (5) calendar days to do so, with a due date of _____. I understand that if the rebuttal letter is not submitted by the due date, the MEB case will be forwarded to the Medical Evaluation Board for review without my letter. After assignment, the reviewer will have five (5) calendar days to review my case and provide me feedback.

An impartial health care professional (not associated with my MEB) will be assigned to review my MEB to ensure the complete spectrum of my injuries and/or illnesses have been addressed. After assignment, the reviewer will have five (5) calendar days to review my case and provide me feedback.

SIGNATURE [redacted] DATE: [redacted]

PEBLO [redacted] DATE: [redacted]

**********[redacted]**********

Section II [redacted] five (5) calendar days.

I have reviewed the narrative summary and MEB package for the named Service Member and:

_____ Concur. The narrative summary and MEB package adequately reflect the complete spectrum of injuries or illness of the Service Member.

_____ Nonconcur. The narrative summary and MEB package do not adequately reflect the complete spectrum of injuries or illness of the Service Member. The following issues should be addressed on a separate memo.

I have informed the above member on this date_____

_____
Signature and Stamp of Impartial Reviewer

For Service Member:

_____ I have been informed of the results of the impartial review. ☐ I do / ☐ do not wish to submit a rebuttal letter.

I understand that if I have elected to submit a rebuttal letter, I have (5) calendar days with a due date of _____ I understand that if the rebuttal letter is not submitted by the due date, the MEB case will be forwarded to the Medical Evaluation Board for review without my letter.

Member Signature:_____ Date: _____

(Signature only required if IMR was completed)

October 2015

**DES COUNSELING ACKNOWLEDGEMENT SHEET**

***PEBLO: PLEASE INCLUDE THIS ACKNOWLEDGEMENT MEMO TO THE MEB FILE FORWARDED TO AFPC/DPFDD***

[redacted] (initial) I have been briefed on the Integrated Disability Evaluation System (IDES) and Legacy DES (LDES) process and have been provided a copy of the IDES Fact Sheet. I understand the Physical Evaluation Board Liaison Officer (PEBLO) is my point of contact throughout this process and I will contact him or her with any questions or concerns regarding the status of my case. Also, I understand that my commander/First Sergeant will be kept informed of my DES process and that I must be available throughout the complete process.

[redacted] (initial) I understand that if I elect to undergo LDES processing, I will have until [redacted] (7 duty days from the date of IDES briefing) to contact the Office of Airman's Counsel (OAC) at DSN 665-0739 or Commercial [redacted]) 565-0739 to receive my legal counsel concerning the differences between LDES and IDES process. If I fail to make contact with the OAC or have not returned the completed and signed Legacy DES Election Statement memo back to the PEBLO, I will have forfeited my option to undergo the LDES process and the PEBLO will refer you into the IDES process instead.

[redacted] (initial) I understand that I have five (5) calendar days to request an Air Force physician or other appropriate health care professional (not involved in my MEB process) to offer an impartial review of the medical evidence presented by the narrative summary or MEB findings. The impartial health professional will have no more than five (5) calendar days to advise me on whether the findings of the MEB adequately reflect the complete spectrum of injuries and illness.

[redacted] (initial) After review of the findings with the assigned impartial health care professional, I shall be afforded an opportunity to provide a rebuttal of the results of the MEB, and I shall be afforded five (5) calendar days to prepare a rebuttal to the convening medical authority. The convening medical board authority shall be afforded five (5) calendar days to consider the rebuttal and return the fully documented decision to me. In the case of an MEB rebuttal, the MEB shall not be forwarded to AFPC/DPFDD until this process is finalized. The fully documented review, rebuttal and convening authority response, will be included with the MEB information and will be sent to AFPC/DPFDD.

[redacted] (initial) I understand it is my sole responsibility to contact the Airman and Family Readiness Center (AFRC) to schedule pre-separation counseling at the earliest possible date following notification of my entry into the Disability Evaluation System. If I am found unfit for continued service, my retirement or separation date will not be extended as a result of my failure to schedule and attend said counseling.

[redacted] (initial) For IDES, I understand that VA determination of service connection for disabilities incurred in or aggravated by military service may be established from the day following date of discharge from the Air Force. Entitlement to payment, however, is not authorized until the first of the month following the month in which service connection is established. VA compensation is paid, like military pay, in arrears. Because of these rules, a separation date other than 3 days from end of month may result in a delay in receipt of VA payments and I must plan accordingly. For LDES, I understand I may be entered into the VA Benefits Delivery at Discharge (BDD) or Quick Start Program after my LDES process is complete. You may visit the VA website to start appropriate process once you receive your approved disability separation or retirement orders at: http://benefits.va.gov/PREDISCHARGE/claims-pre-discharge-quickstart.asp for Quick Start Program or at: http://www.benefits.va.gov/predischarge/claims-pre-discharge-benefits-delivery-at-discharge.asp for the BDD Program. Please review the eligibility requirements for both programs to determine which one applies to you.

[redacted] (initial) I understand that I may bring someone to my MEB/PEB recommendation briefings.

[redacted] (initial) I have received a copy of the OAC Representation Request (ORR) memo during the DES process counseling session and I understand that I have the right to legal counsel and representation from the OAC at no expense to me. I also understand that I must decline legal counsel in writing.

[redacted] (initial) I understand that I may not go on leave, TDY or deploy without obtaining approval through my PEBLO/MEB office. I further understand that I may not have surgery (unless emergency to save life, limb or eyesight) within 6 months of my Date of Separation (DOS), and must coordinate approval through my PEBLO/MEB office.

[redacted] (initial) I understand that it is Mandatory to make the VA compensation and pension exam(s) appointment(s) (IDES only). I also understand that I cannot reschedule or cancel my exams. Any change to exam schedule can only be done by my PEBLO.

[redacted] (initial) I understand that the entire IDES process has a timeline of 295 (AD) /305 (ARC) days and that each phase of the process has its own timeline. I also understand that due to the uniqueness of my case each phase timeline and the overall timeline may change.

RANK/NAME OF SERVICE MEMBER: [redacted]

SIGNATURE OF SERV[redacted] DATE: [redacted]

Member was briefed by [redacted]

May 2016

[redacted]

MEMORANDUM FOR: AFPC/DP2NP, JBSA Randolph, TX 78150

FROM: [redacted]

SUBJECT: Request for Retention Beyond ETS

I hereby request to be retained on active military status beyond the date my term of service expires, for medical treatment or evaluation, and if necessary, for processing for disability separation. I understand I will be subject to the obligations of my military service in the same manner and to the same extent as if my term of enlistment had not expired.

[redacted]

The members original Sep/Ret date is [redacted] (submit med hold memo when within 60 days)

MEB Status: _IDES_____
If there is a FL4 directing Medical Hold, please annotate the MEB Status above.

If a recent IRILO or MEB has not been submitted to AFPC, please have PCM contact AFPC/DP2NP Medical Retention Standards to request Medical Hold.

Note: THIS MEMO MUST BE DIGITALLY SIGNED OR WET SIGNATURE ONLY.

*This form is governed by the Privacy Act of 1974. (Blanket PAS 1974, Routine Uses) Disclosure of requested information is mandatory. AFI 33-332*

# DUTY LIMITING CONDITION REPORT

| | | |
|---|---|---|
| Name (Last, First MI) [redacted] | RANK [redacted] | DATE [redacted] |
| SSAN [redacted] | MAJCOM / INSTALLATION [redacted] | Squadron / Unit Of Assignment [redacted] |
| Squadron E-Mail Address [redacted] | Duty Telephone: ☑ DSN ☐ Commercial [redacted] | |

## HEALTH CARE PROVIDER'S MEDICAL RECOMMENDATION FOR THE SQUADRON COMMANDER

☐ DUTY RESTRICTIONS ☑ MOBILITY RESTRICTIONS ☐ 49 / 81

### PHYSICAL LIMITATIONS / RESTRICTIONS (DO NOT include medical condition or diagnosis)

These limitations expire [redacted]

Member is undergoing an MEB and must be available for testing at the request of the board. Further, TDY and crosstraining at this time is prohibited without express consent of the MEB coordinator. The member's retention is in question, and such training would not be productive if the member is separated from the USAF.

This member is undergoing an MEB to determine medical fitness for continued worldwide duty and retention. No PCS, deploy, or mobility assignment until disposition is made and reported on an AF Form 422. This member should not depart home station for TDY or Leave without consulting the medical treatment facility Physical Evaluation Board Liaison Officer (PEBLO). Commanders may inquire about member's status by contacting PEBLO. Specific information about this member's diagnosis and care cannot be released to anyone

IAW AFI 10-203, member is required to report any change in medical condition to the Primary Care Manager

**Release Dates: 31** **37** [redacted] **81** **MR** [redacted] **DR** **FR**

| | |
|---|---|
| Name and Grade of Health Care Provider [redacted] | Signature [redacted] Today's Date |
| ☐ 31 (ILLNESS OR INJURY WILL BE RESOLVED WITHIN 31-365 DAYS) | ☑ 37 (MEDICAL DEFECT/CONDITION REQUIRES MEB OR PEB PROCESSING IAW AFI 41-210) |
| Force Health Manager [redacted] | Signature [redacted] Today's Date |
| Profile Officer Review [redacted] | Signature [redacted] Today's Date |

### SQUADRON COMMANDER'S REVIEW - MOBILITY RESTRICTIONS NOT VALID WITHOUT SIGNATURE

Squadron Commander Signature Today's Date

DUTY LIMITING CONDITION REPORT AF FORM 469 Computer Generated (ASIMS)



A-00768

# iRILO-MEB NARRATIVE SUMMARY

**(18 September 2017)**

## (1) Demographics:

[redacted] *is a* [redacted] *y.o. ADAF caucasian male with SSN:* [redacted] *and DOD ID #:* [redacted] *that has been ADAF x* [redacted] *years (USAF since* [redacted] *and has a Duty AFSC* [redacted] *working for* [redacted] *since* [redacted] *He is not due to separate, be HYT, nor re-enlist at this time or this year; and there are no administrative actions pending. His CC is* [redacted] *at the* [redacted]

## (2) History:

### (a) Pertinent Past Medical History:

[redacted]

Positive HIV w/o AIDS (Dx Feb 2017 despite TRUVADA; now on Triple Antiviral Therapy): ACTIVE

[redacted]

### (b) Pertinent Past Surgical History:

[redacted]

### (c) Pertinent Family History:

[redacted]

## (3) Current Medications:

Tivicay and Descovy (combo 2 NRTIs) (DTG 50 mg and TAF/FTC 200/25 mg po daily) since March 2017.

[redacted]

## (4) HPI – Potentially Unfitting Diagnos(es): *For each potentially unfitting diagnosis as per AFI 48-123, Chapter 5 (or any other diagnosis which affects the member's ability to perform duties, deploy and/or places a significant burden on the government to either protect or maintain the member), include the following:*

[redacted] *was diagnosed with HIV positive screening test when assessed for or while in the process of* [redacted]

[redacted]

*Confirmation Panel testing confirmed HIV-1 diagnosis on* [redacted]

[redacted]

*The member has been deployed in the past and stationed OCONUS (Lakenheath and Kunsan AB) but this has never treated and/or impacted upon a deployment except* [redacted]

*He was diagnosed in* [redacted] *and referred to* [redacted] *SAMMC (HIV program) for full formal evaluation per standard protocols in place and initiation of therapies.* **Otherwise, he has mainly been seeing** [redacted] **for routine visits: for HIV Dx and** [redacted]

*(g) Current medications and/or other treatment modalities* ***used to treat this or related conditions*****:**
Meds: Tivicay and Descovy (DTG and TAF/FTC) since March 2017 and started by I.D [redacted]

*He has never required use of Narcotics and his clinical exam has been essentially normal except when* [redacted] *This condition was* [redacted]

## (5) Targeted Physical Exam:

*(a) Vitals Written by* [redacted]

*(b) Physical Exam essentially normal.* [redacted]

## (6) Ancillary Study Summary: *Note the table (attached) for ancillary requirements*

### (a) Pertinent Labs:

(1) HIV Viral loads:

| | | | | | |
|---|---|---|---|---|---|
| HIV-1 Viral Load Ultrasensitive | Site/Specimen | [redacted] | | | Units |
| HIV-1 RNA Ultrasensitive | PLASMA | 21 | to | 14854 | copies/mL |
| HIV-1 RNA Log 10 Ultrasensitive | PLASMA | 1.32 | to | 4.17 | log 10 |

(2) HIV – 1/0/2 Ab testing:

| | | | | |
|---|---|---|---|---|
| HIV-1/O/2 Ab | Site/Specimen | 27 Feb 2017 0932 | Units | Ref Rng |
| HIV-1/O/2 Ab | SERUM SCREEN | REACTIVE - CONFIRMATION TO FOLLOW (H) | | NON-REACTIVE |
| HIV-1/O/2 Ab | Site/Specimen | 15 Aug 2016 1121 | Units | Ref Rng |
| HIV-1/O/2 Ab | SERUM | NON-REACTIVE (Nml) | | NON-REACTIVE |

[redacted]

| | | | | |
|---|---|---|---|---|
| CDC Basic Panel | Site/Specimen | 29 Aug 2017 1026 | Units | Ref Rng |

[redacted]

### (b) Pertinent Rads:

[redacted]

**(c) Pertinent Other:** None

## (7) Consult Summary:

Infectious Disease Specialty Visits [redacted] SAMMC in [redacted] multiple visits, see AHLTA visit notes.

## (8) Current Profile Restrictions:

Member is undergoing an MEB and must be available for testing at the request of the board. Further, TDY and crosstraining at this time is prohibited without express consent of the MEB coordinator. The member's retention is in question, and such training would not be productive if the member is separated from the USAF.
NO Fitness Restrictions nor Duty Restrictions; Only Mobility Restriction associated with Code 37.
"Provider reviewed restrictions and they are deemed accurate and appropriate on [redacted]

## (9) Line of Duty Determination (LOD): YES

## (10) Occupational Impact:

There are no current impacts upon his ability to perform his current AFSC duties except that associated with his medical clinic appointments of various types associated with his HIV diagnosis and [redacted] His current required quarterly recurring appointments/visits with Infectious Disease and h[redacted] may at times impact his ability to deploy. There are No limitations to his fitness training, testing, work and/or leisure activities currently nor expected in the near future.

## (11) Prognosis:

There is no expected recovery from a Positive HIV diagnosis, however with compliance in following with current antiviral regimens he is expected to remain in a stabilized maintenance of chronic condition for his lifetime.
Future medication treatment regimens may change with advancements in medicine, technology and science but duration of expected requirements are likely to be lifetime.
The anticipated annual frequency for Infectious Disease Specialist is quarterly, and expected duration required is lifetime.

[redacted]

HEALTH RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE

Patient: [redacted]
Treatment Facility: [redacted]
Patient Status: Outpatient

Date: [redacted] 30 CDT
Clinic: INFECTIOUS DIS, [redacted]

Appt Type: SPEC
Provider: [redacted]

YES

AutoCites Refreshed by [redacted]

Allergies [redacted]

Active Medications

[redacted]

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

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

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




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

HEALTH RECORD [redacted]

CHRONOLOGICAL RECORD OF MEDICAL CARE

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: [redacted]

Tel H:

Tel W:

CS:

PCM:

Sponsor Name: [redacted]

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]

[redacted]

Name: [redacted]

FMP/SSN: [redacted]

DOB:

PAT CAT: F11 USAF ACTIVE DUTY

MC Status:

Status

CIC:

Sex:

DoD ID: [redacted]

Tel H:

Tel W:

CS:

PCM:

Sponsor Name:

Rank:

Unit:

OutPAT RR:

Insurance:

Tel: PCM:

[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]

[redacted]

AREAS 2 TO 3 TIMES A DAY

Name: [redacted]

FMP/SSN [redacted]

DOB:

PAT CAT

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<br>Provider: [redacted] |

[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: [redacted]

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

[redacted]

Name: [redacted]

FMP/SSN: [redacted]

DOB:

PAT CAT: FH 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 | CHRONOLOGICAL RECORD OF MEDICAL CARE |
|---|---|
| [redacted] | Facility: JB San Antonio Military Treatment Facility, TX 78205 Clinic: Infectious Dis, BAMC/Bo<br>Provider: [redacted] |

[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: [redacted]

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.

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Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505
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HEALTH RECORD [redacted]

CHRONOLOGICAL RECORD OF MEDICAL CARE

Facility: JB San Antonio Military Treatment Facility, TX 78205 Clinic: Infectious Dis, BAMC/Bo

Provider [redacted]

[redacted]

Screening Written by [redacted]

Reason For Appointment: INIT

Allergen information verified by [redacted]

Vitals

[redacted]

EDUCATIONAL NEEDS ASSESSMENT

[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:

[redacted]

Sponsor Name:

Rank:

Unit:

OutPAT RR:

Insurance:

Tel. PCM:

[redacted]

| HEALTH RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE |
|---|---|
| [redacted] | Facility: JB San Antonio Military Treatment Facility, TX 78205 Clinic: Infectious Dis, BAMC/Bo<br>Provider: M[redacted] |

The Chief Complaint is: HIV.

**Reason for Visit**

Visit for: Referred [redacted] Visit for: comprehensive medical evaluation including disease staging, disease specific education, management recommendations and/or treatment as necessary.

**Referred here**

[redacted]

**History of present illness**

The Patient is a [redacted] year old male.

He reported: Past medical history reviewed in [redacted], confirmed with patient and updated in patient problem list and medication list reviewed. Previous history of medication list reviewed.

[redacted]

He was diagnosed as being HIV positive on test drawn [redacted] with last negative test from our system [redacted] He states he had a negative HIV test in [redacted]. Testing was performed during evaluation for [redacted] and high risk exposure. He was found to have [redacted] and early HIV. Neurosyphilis evaluation completed with LP, no pleocytosis and negative VDRL. He may have had an illnesses suggestive of acute antiretroviral syndrome or may have only [redacted]. He has no blood or needle exposures, and no known HIV positive contacts. He has had no illnesses consistent with [redacted] pertinent immunizations include hepatitis A [redacted] He is immunocompromised state [redacted] He was started on trizivir by ID physician [redacted]

He also has a history of recurrent anal fissures, once wi[redacted] hematospermia. He had colonoscopic biopsies, which were benign, and was treated with topical analgesics and vasodilators with resolution of symptoms. He has a supply of those medications and uses them infrequently when he has 'flares' of similar symptoms.

[redacted]

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

| 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:

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

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

[redacted]

Lab Result Cited by [redacted]

| | |
|---|---|
| **Hepatitis A Virus Ab** | **Site/Specimen** |
| Hepatitis A 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 |
| **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 |
| **Glucose-6-Phosphate Dehydrogenase Quant** | |
| Units | Ref Rng |
| Glucose-6-Phosphate Dehydrogenase | BLOOD |
| **Varicella Virus Ab** | **Site/Specimen** |
| Varicella Zoster Virus Ab | SERUM |
| **Treponema pallidum Ab MHA** | **Site/Specimen** |
| Treponema pallidum Ab | SERUM |
| **Chlamydia+Gonococcus DNA Panel NAAT** | **Site/Specimen** |
| Chlamydia trachomatis DNA (NEGATIVE) | URINE |
| Neisseria gonorrhoeae DNA | URINE |

[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:

[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/Ba |
| | Provider: [redacted] |

| | |
|---|---|
| **Chlamydia+Gonococcus DNA Panel NAAT** | **Site/Specimen** |
| Chlamydia trachomatis DNA | THROAT |
| Neisseria gonorrhoeae DNA | THROAT |
| **Chlamydia+Gonococcus DNA Panel NAAT** | **Site/Specimen** |
| Chlamydia trachomatis DNA | RECTUM |
| Neisseria gonorrhoeae DNA | RECTUM |
| **HIV-1 Viral Load Ultrasensitive** | **Site/Specimen** |
| HIV-1 RNA Ultrasensitive | PLASMA |
| HIV-1 RNA Log 10 Ultrasensitive | PLASMA |
| **Rapid Plasma Reagin Panel** | **Site/Specimen** |
| Reagin Ab | SERUM |
| Reagin Ab | SERUM |
| **Fluorescent Treponema Ab** | **Site/Specimen** |
| FTA T. pallidum Ab | SERUM |
| **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 |
| **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 |
| **proBrain Natriuretic Peptide N-Terminal** | **Site/Specimen** |
| Natriuretic Peptide B-Type | SERUM |
| **C-Reactive Protein High Sensitivity** | **Site/Specimen** |
| C-Reactive Protein High Sensitivity | SERUM |
| **Hepatic Function Panel** | **Site/Specimen** |

[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:

| HEALTH RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE |
|---|---|
| [redacted] | Facility: JB San Antonio Military Treatment Facility, TX 78205 Clinic: Infectious Dis, BAMC/Bo |
| | Provider: [redacted] |

| | |
|---|---|
| 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 |
| **Phosphorus** | **Site/Specimen** |
| Phosphate | SERUM |
| **Lipid Panel** | **Site/Specimen** |
| Cholesterol/HDL Cholesterol | SERUM |
| Cholesterol | SERUM |
| HDL Cholesterol | SERUM |
| LDL Cholesterol | SERUM |
| Triglyceride | SERUM |
| Hemolysis Index | SERUM |
| Icteric Index | SERUM |
| Lipemia Index | SERUM |
| **Lactate Dehydrogenase** | **Site/Specimen** |
| Lactate Dehydrogenase | SERUM |
| **Troponin T Cardiac** | **Site/Specimen** |
| Troponin T Cardiac | PLASMA |
| **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 |
| **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 |

[redacted]

| | | | |
|---|---|---|---|
| Name: [redacted] | | Sex: | Sponsor Name: |
| FMP/SSN: [redacted] | | DoD ID | Rank: |
| DOB: | | Tel H: | Unit: |
| PAT CAT: F11 USAF ACTIVE DUTY | | Tel W: | OutPAT RR: |
| MC Status: | | CS: | Insurance: |
| Status | | PCM: [redacted] | Tel. PCM [redacted] |
| CIC: | | | |

| HEALTH RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE |
|---|---|
| [redacted] | Facility: JB San Antonio Military Treatment Facility, TX 78205 Clinic: Infectious Dis, BAMC/Bo |
| | Provider: [redacted] |

| | | |
|---|---|---|
| ABS Neutrophils | BLOOD | [redacted] |
| ABS Lymphocytes | BLOOD | |
| ABS Monocytes | BLOOD | |
| ABS Eosinophils | BLOOD | |
| ABS Basophils | BLOOD | |
| Nucleated RBC/100 WBC | BLOOD | |

[redacted]

Assignment limitations: Code C

[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:

| HEALTH RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE |
|---|---|
| [redacted] | Facility: JB San Antonio Military Treatment Facility, TX 78205 Clinic: Infectious Dis, BAMC/Bo<br>Provider: [redacted] |

[redacted]

Signed By [redacted]

[redacted]

Name: [redacted]
FMP/SSN:
DOB:
PAT CAT: FH 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 | CHRONOLOGICAL RECORD OF MEDICAL CARE |
|---|---|
| [redacted] | Facility: JB San Antonio Military Treatment Facility, TX 78205 Clinic: Infectious Dis, BAMC/Bo<br>Provider [redacted] |

Assignment limitations: Code C

[redacted]

[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: [redacted]

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

[redacted]

MEMORANDUM FOR HQ AFPC/DPANM

FROM: [redacted]

SUBJECT: C&P Exam Review for [redacted] (DODID: [redacted]) Medical Evaluation Board

**MEB ADDENDUM**

1. I have reviewed the C&P results and find the information within the NARSUM to be current and complete (See VA Form 21-0819). [redacted] his recently-discovered positive HIV status. [redacted]

2. Do not hesitate to contact me at [redacted] if there are any questions or concerns.

[redacted]

[redacted]

[redacted]

**MEMORANDUM FOR** HQ AFPC/DPANM/DP2NP

**FROM** [redacted]

**SUBJECT:** [redacted] SSN: [redacted] D.O.B.: [redacted]

**MEB NARSUM ADDENDUM** (MEB NARSUM dated [redacted]

1. Please note that an MEB Narrative Summary Dictation was completed in [redacted] and that there have been no significant interval clinical (symptom and/or signs) changes since that time, [redacted]

2. I have reviewed the C & P "ADDENDUM TO VA FORM 21-526EZ (Claimed Disabilities)" results and find that the information provided within the NARSUM to be current and complete. None of these diagnoses change the patient's medical condition since his iRILO-MEB NARSUM was completed earlier this year.

3. Do not hesitate to contact me at [redacted]

[redacted]

*Any Time...Any Place*

OMB Control No. 2900-0075
Respondent Burden: 15 minutes
Expiration Date: 01/31/2018

Department of Veterans Affairs

# 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. |
|---|---|---|
| | | C/CSS- |

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

NAME: [redacted]
SSN:

ADDENDUM TO VA FORM 21-526EZ (CLAIMED DISABILITIES)

1. HIV (MEB REFERRED CONDITION)

[redacted]

I CERTIFY T[redacted]est of my knowledge and belief.

| SIGNATURE [redacted] | DATE SIGNED [redacted] | |
|---|---|---|
| ADDRESS [redacted] | TELEPHONE NUMBERS *(Include Area Code)* | |
| | DAYTIME | EVENING |

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

VA FORM JAN 2015 **21-4138** SUPERSEDES VA FORM 21-4138, AUG 2011, WHICH WILL NOT BE USED

CONTINUE ON REVERSE

OMB Approved No. 2900-0704
Respondent Burden: 30 minutes
Expiration Date: 03/31/2019

RECEIVED VARO
ST PETERSBURG (317)
(DO NOT WRITE IN THIS SPACE)
[redacted]

Department of Veterans Affairs

# 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 t[redacted]

SIGNA[redacted]

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

COMPONENT
USAF

UNIT ADDRESS
[redacted]

SOCIAL SECURITY NUMBER
[redacted]

DATE OF BIRTH *(MM,DD,YYYY)*
[redacted]

SEX
☒ MALE ☐ FEMALE

NAME AND PHONE NUMBER OF ASSIGNED PHYSICAL EVALUATION BOARD LIAISON OFFICER *(PEBLO)*

| *(First, MI, Last)* | *(Include Area Code)* |
|---|---|
| Rachel L. Ortiz | 8508811616 |

NAME OF REFERRING MILITARY TREATMENT FACILITY *(MTF)*
[redacted]

DATE OF REFERRAL TO MEDICAL EVALUATION BOARD *(MEB) (MM,DD,YYYY)*
[redacted]

MEDICAL CONDITIONS TO BE CONSIDERED AS THE BASIS OF FITNESS FOR DUTY DETERMI[redacted]
1) HIV
[redacted]

PR[redacted]

[redacted] address. If you are on Temporary Duty, please [redacted] available on the internet at www.va.gov/vaforms

1. WHAT IS YOUR ADDRESS?
[redacted]

2. WHAT ARE YOUR TELEPHONE NUMBERS? *(Include Area Code)*
[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

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

8. PLACE OF ENTRY

**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?
☐ YES *(If "Yes," provide date of activation below)*
☐ NO _____

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)*

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)*

12. DO YOU HAVE DEPENDENTS?
☐ YES ☐ NO *(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.

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

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 10 before comp

## SECTION I: IDENTIFICATION AND CLAIM INFORMA

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)*

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)*

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

11. PREFERRED TELEPHONE NUMBER

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

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

VETERANS SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

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. | See Attachments |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |
| 7. | |
| 8. | |
| 9. | |
| 10. | |
| 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 |
|---|---|
| | |
| | |
| | |
| | |

VETERANS SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

**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)
Month ☐☐ – Day ☐☐ – Year ☐☐☐☐

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

16D. PLACE OF LAST OR ANTICIPATED SEPARATION

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
Month / Day / Year
From: ☐☐ – ☐☐ – ☐☐☐☐
To: ☐☐ – ☐☐ – ☐☐☐☐

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. [ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]

## 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)* |
|---|---|
| USAA | [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. [redacted] SIGNER SIGNATURE (REQUIRED) | 27B. DATE SIGNED [redacted] |
|---|---|

## 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.

OMB Control No. 2900-0075
Respondent Burden: 15 minutes
Expiration Date: 01/31/2018

Department of Veterans Affairs

# 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 |
|---|---|---|
| | | C/CSS - |

The following statement is made in connection with a claim for benefits in the case of the above-named veteran. KILO - MEB [redacted]

NAME: [redacted]
SSN:

ADDENDUM TO VA FORM 21-526EZ (CLAIMED DISABILITIES)

1. HIV (MEB REFERRED CONDITION)

[redacted]

I CERTIFY [redacted] to the best of my knowledge and belief.

| SIGNATURE [redacted] | DATE SIGNED [redacted] | |
|---|---|---|
| ADDRESS [redacted] | TELEPHONE NUMBERS *(Include Area Code)* | |
| | DAYTIME | EVENING |

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

VA FORM JAN 2015 **21-4138** SUPERSEDES VA FORM 21-4138, AUG 2011, WHICH WILL NOT BE USED

CONTINUE ON REVERSE

Quality.
Timeliness.
Customer Service.

# DBQ Notification

The Disability Benefits Questionnaire(s) has/have been completed and is/are being submitted for adjudication purposes.

Thank you.

**QTC Medical Services, Inc.**

**Department of Veterans Affairs** [redacted]

**IMPORTANT** – THE DEPARTMENT OF VETERANS AFFAIRS (VA) ***WILL NOT PAY OR REIMBURSE*** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION ON REVERSE BEFORE COMPLETING FORM.

| NAME OF PATIENT/VETERAN | PATIENT/VETERAN'S SOCIAL SECURITY NUMBER |
|---|---|
| [redacted] | [redacted] |

NOTE: This examination must be conducted by a licensed ophthalmologist or by a licensed optometrist. The examiner must identify the disease, injury or other pathologic process responsible for any decrease in visual acuity or other visual impairment found. Examinations of visual fields or muscle function should be conducted ONLY when there is a medical indication of disease or injury that may be associated with visual field defect or impaired muscle function. If indicated to address requested claim, and not medically indicated, dilated fundus exam required.

IS THIS DBQ BEING COMPLETED IN CONJUNCTION WITH A VA21-2507 C&P EXAMINATION REQUEST?

[redacted]

**ACCEPTABLE CLINICAL EVIDENCE (ACE)**

INDICATE METHOD USED TO OBTAIN MEDICAL INFORMATION TO COMPLETE THIS DOCUMENT:

[redacted]

[redacted]

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination [redacted]

**SECTION I - DIAGNOSIS**

**NOTE: The diagnosis section should be filled out AFTER the clinician has completed the examination.**

[redacted]

**SECTION II – MEDICAL HISTORY**

[redacted]

**SECTION III – PHYSICAL EXAMINATION**

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

**SECTION III – PHYSICAL EXAMINATION**

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

SECTION III – PHYSICAL EXAMINATION

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination [redacted]

SECTION III – PHYSICAL EXAMINATION

[redacted]

SECTION IV – EYE CONDITIONS

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination [redacted]

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

[redacted]

Claimant name [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

Claimant name [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

**SECTION IX – OPTOMETRIST/PHYSICIAN'S CERTIFICATION AND SIGNATURE**

**CERTIFICATION** - To the best of my knowledge, the information contained herein is accurate, complete and current.

| | 9B. OPTOMETRIST/PHYSICIAN'S PRINTED NAME | 9C. DATE SIGNED |
|---|---|---|
| [redacted] | [redacted] | [redacted] |

| 9D. OPTOMETRIST/PHYSICIAN'S PHONE NUMBER | 9E. OPTOMETRIST/NATIONAL PROVIDER IDENTIFIER (NPI) | 9F. OPTOMETRIST/PHYSICIAN'S ADDRESS |
|---|---|---|
| [redacted] | [redacted] | [redacted] |

**NOTE:** VA may request additional medical information, including additional examinations, if necessary to complete VA's review of the Veteran's application.

**PRIVACY ACT NOTICE:** VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is 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. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a 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 determine entitlement to benefits (38 U.S.C. 501). 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 the 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.

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

Quality.
Timeliness.
Customer Service.

# DBQ Notification

The Disability Benefits Questionnaire(s) has/have been completed and is/are being submitted for adjudication purposes.

Thank you.

**QTC Medical Services, Inc.**

**Department of Veterans Affairs** [redacted]

**IMPORTANT** – THE DEPARTMENT OF VETERANS AFFAIRS (VA) ***WILL NOT PAY OR REIMBURSE*** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION BEFORE COMPLETING FORM

| NAME OF PATIENT/VETERAN | PATIENT/VETERAN'S SOCIAL SECURITY NUMBER |
|---|---|
| [redacted] | [redacted] |

[redacted]

[redacted]

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

SECTION II – MEDICAL HISTORY

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination [redacted]

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination [redacted]

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

Claimant nam[redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

Claimant name [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

*NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the application.*

**SECTION VI – PHYSICIAN'S CERTIFICATION AND SIGNATURE**

**CERTIFICATION** - To the best of my knowledge, the information contained herein is accurate, complete and current.

| 6A. PHYSICIAN'S SIGNATURE | 6B. PHYSICIAN'S PRINTED NAME | 6C. DATE SIGNED |
|---|---|---|
| [redacted] | [redacted] | [redacted] |

| 6D. PHYSICIAN'S PHONE AND FAX NUMBERS | 6E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER | 6F. PHYSICIAN'S ADDRESS |
|---|---|---|
| [redacted] | [redacted] | [redacted] |

NOTE: VA may request additional medical information, including additional examinations, if necessary to complete VA's review of the veteran's application.

**PRIVACY ACT NOTICE:** VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a 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 determine entitlement to benefits (38 U.S.C. 501). 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 the 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.

Claimant name [redacted] Account # [redacted] Date of Examination [redacted]

**Department of Veterans Affairs**

INTERNAL VETERANS AFFAIRS USE [redacted]

**IMPORTANT** - THE DEPARTMENT OF VETERANS AFFAIRS (VA) ***WILL NOT PAY*** OR ***REIMBURSE*** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION BEFORE COMPLETING FORM.

| NAME OF PATIENT/VETERAN | PATIENT/VETERAN'S SOCIAL SECURITY NUMBER |
|---|---|
| [redacted] | [redacted] |

[redacted]

**ACCEPTABLE CLINICAL EVIDENCE (ACE)**

[redacted]

**EVIDENCE REVIEW**

[redacted]

[redacted]

Claimant name [redacted] Account #: [redacted] Date of Examination: [redacted]

I - DIAGNOSIS

[redacted]

underlying soft tissue damage.

[redacted]

Claimant name [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

Claimant name [redacted] Account #: [redacted] Date of Examination [redacted]

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

**SECTION IV – PHYSICIAN'S CERTIFICATION AND SIGNATURE**

**CERTIFICATION** – To the best of my knowledge, the information contained herein is accurate, complete and current.

| 4A. PHYSICIAN'S SIGNATURE | 4B. PHYSICIAN'S PRINTED NAME | 4C. DATE SIGNED |
|---|---|---|
| [redacted] | [redacted] | [redacted] |

| 4D. PHYSICIAN'S PHONE AND FAX NUMBER | 4E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER | 4F. PHYSICIAN'S ADDRESS |
|---|---|---|
| [redacted] | [redacted] | [redacted] |

**NOTE:** VA may obtain additional medical information, including an examination, if necessary to complete VA's review of the veteran's application.

**PRIVACY ACT NOTICE:** VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a 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 determine entitlement to benefits (38 U.S.C. 501). 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 the 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]

## Disability Benefits Questionnaire

| Name of patient/Veteran: [redacted] | SSN: [redacted] |
|---|---|

**Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.**

[redacted]

Other skin condition

Claimant name [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

## Disability Benefits Questionnaire

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

## Disability Benefits Questionnaire

[redacted]

Claimant name[redacted] Account #: [redacted] Date of Examination [redacted]

[redacted]

## Disability Benefits Questionnaire

[redacted]

Claimant name [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

## Disability Benefits Questionnaire

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

## Disability Benefits Questionnaire

[redacted]

Physician signature: Date: [redacted]

[redacted]

Physician printed name: [redacted]
Medical license #: [redacted] Physician address: [redacted]

Phone [redacted]

**NOTE**: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

# Disability Benefits Questionnaire

| Name of patient/Veteran: [redacted] | SSN: [redacted] |
|---|---|

**Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.**

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

## Disability Benefits Questionnaire

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

## Disability Benefits Questionnaire

[redacted]

Physician signature: Date: [redacted]

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

## Disability Benefits Questionnaire

Physician printed name: [redacted]

Medical license #[redacted] Physician address: [redacted]

Phone [redacted]7334

**NOTE**: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

Claimant name [redacted] Account #: [redacted] Date of Examination: [redacted]

# HIV-Related Illnesses
# Disability Benefits Questionnaire

| Name of patient/Veteran: [redacted] | SSN: [redacted] |
|---|---|

**Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits.**
**VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.**

**1. Diagnosis**

Does the Veteran now have or has he/she ever been diagnosed with HIV or an HIV-related illness?
☒ Yes ☐ No

If yes, provide only diagnoses that pertain to HIV-related illnesses or complications:
Diagnosis #1: HUMAN IMMUNODEFICIENCY VIRUS
ICD code: V08
Date of diagnosis: 07/2017

Diagnosis #2:
ICD code:
Date of diagnosis:

Diagnosis #3:
ICD code:
Date of diagnosis:

If there are additional diagnoses that pertain to HIV-related illness, list using above format:

**2. Medical history**

a. Describe the history (including onset and course) of the Veteran's HIV-related illness(es): SPECIFIC HISTORY FOR: HUMAN IMMUNODEFICIENCY VIRUS (MEB REFERRED CONDITION) The claimant states the above condition began Unknown. The claimant reports being diagnosed with HIV on routine testing. Contracted by anal sex. No secondary manifestations of disease. Treated with anti-retroviral medication. The claimant reports being diagnosed with HIV., [redacted] No symptoms.

b. Is continuous medication required for control of HIV-related illness(es)?
☒ Yes ☐ No
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): TIVICAY, DESCOVY.

c. Does the Veteran have any complications due to current or previous medications taken for HIV-related illness(es)?
☐ Yes ☒ No
If yes, list medication and describe complication(s) due to medication(s):

**3. Signs, symptoms and findings**

Does the Veteran have any signs, symptoms or findings attributable to an HIV-related illness?
☐ Yes ☒ No
If yes, check all that apply:

a. ☐ Constitutional symptoms (fever, weight loss, fatigue, malaise, decreased appetite, etc.) attributable to an HIV-related illness
If checked, indicate frequency and severity:
☐ Refractory ☐ Recurrent
Describe constitutional symptoms:
b. ☐ Diarrhea attributable to an HIV-related illness

# HIV-Related Illnesses
# Disability Benefits Questionnaire

If checked, indicate frequency and severity:
☐ Refractory ☐ Intermittent
Describe:

c. ☐ Weight loss attributable to an HIV-related illness
If checked, provide baseline weight: and current weight:
(For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)

d. ☐ Nausea attributable to an HIV-related illness
If checked, indicate severity:
☐Mild ☐ Transient ☐ Recurrent ☐ Periodic
Indicate frequency of episodes of nausea per year:
☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

e. ☐ Vomiting attributable to an HIV-related illness
If checked, indicate severity:
☐Mild ☐ Transient ☐ Recurrent ☐ Periodic
Indicate frequency of episodes of vomiting per year:
☐ 1 ☐ 2 ☐ 3 ☐ 4 or more
Indicate average duration of episodes of vomiting:
☐ Less than 1 day ☐ 1-9 days ☐ 10 days or more

f. ☐ Anemia of chronic disease attributable to an HIV-related illness
If checked, describe:
Provide hemoglobin/hematocrit in Diagnostic testing section.

g. ☐ Hairy cell leukoplakia
If checked, is Veteran currently affected by hairy cell leukoplakia?
☐ Yes ☐ No
Provide date(s) of onset, treatment and course:

h. ☐ Oral candidiasis
If checked, is Veteran currently affected by oral candidiasis?
☐ Yes ☐ No
Provide date(s) of onset, treatment and course:

i. ☐ Other, describe:

**4. Complications**

a. Does the Veteran have any complications attributable to an HIV-related illness or its treatment?
☐ Yes ☒ No
If yes, check all that apply:
☐ HIV-associated neurocognitive disorder
If checked, a Mental Disorders Questionnaire must also be completed.
☐ HIV-associated neuropathy, radiculopathy or myelopathy
If checked, a Peripheral Nerve Questionnaire must also be completed.
☐ HIV-associated retinopathy
If checked, an Eye Questionnaire must also be completed.
☐ HIV-associated cardiopathy
If checked, a Heart Questionnaire must also be completed.
☐ HIV-associated pulmonary hypertension
If checked, a Respiratory Questionnaire must also be completed.

# HIV-Related Illnesses
# Disability Benefits Questionnaire

☐ HIV-induced enteropathy
If checked, the appropriate gastrointestinal Questionnaire must also be completed.
☐ HIV-associated nephropathy
If checked, a Kidney Questionnaire must also be completed.
☐ HIV-associated impaired lipid and glucose metabolism
☐ HIV-associated wasting
☐ Lipodystrophy
☐ Myopathy
☐ Other, describe:

b. For each checked condition (except those conditions for which an additional DBQ is completed), describe (providing date of onset, and brief summary of symptoms, treatment and course):

**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?
☐ Yes ☒ No
If yes, check all that apply:
☐ Oral candidiasis
☐ Tuberculosis
☐ Hepatitis
☐ Pneumocystosis
☐ Toxoplasmosis
☐ Cryptococcosis
☐ Cerebral toxoplasmosis
☐ Cryptococcal meningoencephalitis
☐ Viral meningoencephalitis
☐ Cytomegalovirus
☐ Herpes simplex virus
☐ Varicella zoster virus
☐ Progressive multifocal leukoencephalopathy
☐ Neurosyphilis
☐ Primary central nervous system lymphoma
☐ Other, describe:

For each checked condition (except those conditions for which an additional DBQ is completed), describe (providing date of onset, and brief summary of symptoms, treatment and course):

b. Does the Veteran have recurrent opportunistic infection(s)?
☐ Yes ☒ No
If yes, describe (providing types of infection(s), date(s) of onset, and brief summary of symptoms, treatment and course).
ALSO complete the appropriate Questionnaire(s), if applicable.

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

a. Does the Veteran have depression, cognitive impairment or dementia, or any other mental health conditions attributable to HIV-related illness or its treatment?
☐ Yes ☒ No

b. Does the Veteran's mental health condition(s), as identified in the question above, result in gross impairment in thought processes or communication?
☐ Yes ☐ No

Claimant name [redacted] Account #: [redacted] Date of Examination [redacted]

# HIV-Related Illnesses
# Disability Benefits Questionnaire

If No, also complete a Mental Disorder Questionnaire (schedule with appropriate provider).
If yes, briefly describe the Veteran's mental health condition:

**7. Summary**

Based on symptoms and findings from this exam, complete the following section to provide a summary of the severity of the Veteran's HIV-related condition. This summary provides useful information for VA purposes.

Select all that apply from each level:

a. Level I
- ☒ Asymptomatic, with or without lymphadenopathy or decreased T4 cell count

b. Level II
- ☐ Symptomatic, with current T4 cell of 200 or more and less than 500, and on approved medication(s) (For VA purposes, approved medications include medications prescribed as part of a research protocol at an accredited medical institution.)
- ☐ Evidence of depression with employment limitations
- ☐ Evidence of memory loss with employment limitations

c. Level III
- ☐ Recurrent constitutional symptoms, intermittent diarrhea, and on approved medications
- ☐ Current T4 cell count less than 200
- ☐ Hairy cell leukoplakia
- ☐ Oral candidiasis

d. Level IV
- ☐ Refractory constitutional symptoms
- ☐ Diarrhea and pathological weight loss
- ☐ Development of AIDS-related opportunistic infection or neoplasm

e. Level V
- ☐ AIDS with recurrent opportunistic infections
- ☐ Secondary diseases afflicting multiple body systems
- ☐ HIV-related illness with debility and progressive weight loss, without remission or few or brief remissions

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

a. 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 ☒ No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?

☐ Yes ☐ No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms related to any conditions listed in the Diagnosis section above?

☐ Yes ☒ No

If yes, describe (brief summary):

**9. Diagnostic testing**

NOTE: If imaging studies, diagnostic procedures or laboratory testing has been performed and reflects the Veteran's current condition, provide most recent results; no further studies or tests are required for this examination.

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

# HIV-Related Illnesses
# Disability Benefits Questionnaire

a. Has laboratory testing been performed?
☒ Yes ☐ No
If yes, check all that apply:
☒ CD4 lymphocyte count: 29 Date: [redacted]
☐ Lowest (nadir) CD4 lymphocyte count, if available: Date, if known:
☒ CBC (if anemia of chronic disease attributable to HIV-related illness is suspected or present).
Date: [redacted] Hemoglobin: 14.2 Hematocrit: 42.1 White blood cell count: 4.7 Platelets: 233
☒ Other test, specify: [redacted] Date of test: REACTIVEResults: RPR (MONITOR) W/REFL TITER: REACTIVE(Abnormal) PleasecontactQuestDiagnosticsifconfirmatory testingisneeded. TheRPRisanon-treponemal-specifictest;therefore, atreponemal-specificconfirmatorytestshouldbe performedunlesspriorsyphilisinfectionhasbeen documentedforthispatient. NON-REACTIVE TP

b. Have imaging studies or diagnostic procedures been performed and are the results available?
☐ Yes ☒ No
If yes, provide type of test or procedure, date and results (brief summary):

c. Has an HIV Dementia Scale been administered (if indicated)?
☐ Yes ☒ No
Results: Date:

d. Has neuropsychiatric testing been performed for cognitive impairment (if indicated)?
☐ Yes ☒ No
Results: Date:

e.Are there any other significant diagnostic test findings and/or results?
☐ Yes ☒ No
If yes, provide type of test or procedure, date and results (brief summary):

**10. Functional impact**
Do any of the Veteran's HIV-related illnesses or complications impact his or her ability to work?
☐ Yes ☒ No
If yes, describe impact of each of the Veteran's HIV-related illnesses, providing one or more examples:

**11. Remarks, if any:** The veteran reports serving in the Air Force. He indicates he served a total of [redacted] year(s). The period(s) of service were from: [redacted]. He was in service during Afghanistan War. He was in service during Iraq War. He reports he did not participate in combat activity. For the claimant's claimed condition of HUMAN IMMUNODEFICIENCY VIRUS (MEB REFERRED CONDITION), the diagnosis is already noted in the diagnosis section.

Physician signature: [redacted] Date: [redacted]

Physician printed name: [redacted]

Medical license #: [redacted] Physician address: [redacted]

Phone: [redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

# HIV-Related Illnesses
# Disability Benefits Questionnaire

**NOTE**: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

# Disability Benefits Questionnaire

Name of patient/Veteran: [redacted] SSN: [redacted]

**Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.**

[redacted]

If there are additional diagnoses that pertain to chronic fatigue syndrome, list using above format:

NOTE: For VA purposes, the diagnosis of chronic fatigue syndrome requires:

a. New onset of debilitating fatigue severe enough to reduce daily activity to less than 50 percent of the usual level for at least 6 months; and

b. The exclusion, by history, physical examination, and laboratory tests, of all other clinical conditions that may produce similar symptoms; and

c. Six or more of the following: acute onset of the condition, low grade fever, non-exudative pharyngitis, palpable or tender cervical or axillary lymph nodes, generalized muscle aches or weakness, fatigue lasting 24 hours or longer after exercise, headaches (of a type, severity or pattern that is different from headaches in the pre-morbid state), migratory joint pains, neuropsychological symptoms, sleep disturbance.

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

# Disability Benefits Questionnaire

[redacted]

Claimant name [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

# Disability Benefits Questionnaire

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

# Disability Benefits Questionnaire

[redacted]

[redacted]

**NOTE**: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

Claimant name: [redacted] Account # [redacted] Date of Examination: [redacted]

**Department of Veterans Affairs** [redacted]

**IMPORTANT** - THE DEPARTMENT OF VETERANS AFFAIRS (VA) ***WILL NOT PAY*** OR ***REIMBURSE*** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION ON REVERSE BEFORE COMPLETING FORM.

| NAME OF PATIENT/VETERAN [redacted] | PATIENT/VETERAN'S SOCIAL SECURITY NUMBER [redacted] |
|---|---|

**NOTE TO PHYSICIAN** - Your patient is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the claim. VA reserves the right to confirm the authenticity of ALL DBQs completed by private health care providers.

**ACCEPTABLE CLINICAL EVIDENCE (ACE) AND EVIDENCE REVIEW**

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination [redacted]

SECTION I - DIAGNOSIS

[redacted]

SECTION II – MEDICAL HISTORY

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

SECTION IX – DIAGNOSTIC TESTING

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

## SECTION XI - REMARKS

[redacted]

## SECTION XII – PHYSICIAN'S CERTIFICATION AND SIGNATURE

**CERTIFICATION** - To the best of my knowledge, the information contained herein is accurate, complete and current.

| 12A. PHYSICIAN'S SIGNATURE | 12B. PHYSICIAN'S PRINTED NAME | 12C. DATE SIGNED |
|---|---|---|
| [redacted] | [redacted] | [redacted] |

| 12D. PHYSICIAN'S PHONE AND FAX NUMBERS | 12E. PHYSICIAN'S MEDICAL LICENSE NUMBER | 12F. PHYSICIAN'S ADDRESS |
|---|---|---|
| [redacted] | [redacted] | [redacted] |

NOTE: VA may request additional medical information, including additional examinations, if necessary to complete VA's review of the veteran's application.

**PRIVACY ACT NOTICE:** VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a 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 determine entitlement to benefits (38 U.S.C. 501). 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 the 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.

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

Department of Veterans Affairs [redacted]

IMPORTANT – THE DEPARTMENT OF VETERANS AFFAIRS (VA) *WILL NOT PAY* OR *REIMBURSE* ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION ON REVERSE BEFORE COMPLETING FORM.

| NAME OF PATIENT/VETERAN | PATIENT/VETERAN'S SOCIAL SECURITY NUMBER |
|---|---|
| [redacted] | [redacted] |

[redacted]

**ACCEPTABLE CLINICAL EVIDENCE (ACE)**

[redacted]

**EVIDENCE REVIEW**

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

Claimant name [redacted] Account #: [redacted] Date of Examination: [redacted]

SECTION I - DIAGNOSIS

[redacted]

SECTION II – MEDICAL HISTORY

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

Claimant name [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

[redacted]

SECTION VII – PHYSICAL EXAM

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

**SECTION VII – PHYSICAL EXAM**

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

## SECTION X – DIAGNOSTIC TESTING

**NOTE:** If imaging studies, diagnostic procedures or laboratory testing has been performed and reflects the veteran's current condition, provide most recent results; no further studies or testing are required for this examination. When appropriate, provide most recent results. No specific studies are required for this examination.

[redacted]

## SECTION XI – FUNCTIONAL IMPACT

[redacted]

## SECTION XII - REMARKS

[redacted]

## SECTION XIII – PHYSICIAN'S CERTIFICATION AND SIGNATURE

**CERTIFICATION** - To the best of my knowledge, the information contained herein is accurate, complete and current.

| 13A. PHYSICIAN'S SIGNATURE | 13B. PHYSICIAN'S PRINTED NAME | 13C. DATE SIGNED |
|---|---|---|
| [redacted] | [redacted] | [redacted] |

| 13D. PHYSICIAN'S PHONE AND FAX NUMBER | 13E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER | 13F. PHYSICIAN'S ADDRESS |
|---|---|---|
| [redacted] | [redacted] | [redacted] |

NOTE - VA may request additional medical information, including additional examinations, if necessary to complete VA's review of the veteran's application.

**PRIVACY ACT NOTICE:** VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a 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 determine entitlement to benefits (38 U.S.C. 501). 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 the 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.

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

Department of Veterans Affairs [redacted]

DISABILITY BENEFITS QUESTIONNAIRE

IMPORTANT – THE DEPARTMENT OF VETERANS AFFAIRS (VA) *WILL NOT PAY OR REIMBURSE* ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION BEFORE COMPLETING FORM.

| NAME OF PATIENT/VETERAN | PATIENT/VETERAN'S SOCIAL SECURITY NUMBER |
|---|---|
| [redacted] | [redacted] |

[redacted]

ACCEPTABLE CLINICAL EVIDENCE (ACE)

[redacted]

EVIDENCE REVIEW

[redacted]

Claimant name [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

Claimant name [redacted] Account #: [redacted] Date of Examination: [redacted]

SECTION I - DIAGNOSIS

[redacted]

SECTION II – MEDICAL HISTORY

[redacted]

SECTION III – SIGNS AND SYMPTOMS

[redacted]

Claimant name [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

SECTION IV – EXAM

[redacted]

SECTION V - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

[redacted]

Claimant name [redacted] Account #: [redacted] Date of Examination: [redacted]

## SECTION V - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

[redacted]

## SECTION VI – DIAGNOSTIC TESTING

**NOTE** - If imaging studies, diagnostic procedures or laboratory testing have been performed and reflect the veteran's current condition, no further testing is required for this examination.

[redacted]

## SECTION VII – FUNCTIONAL IMPACT

[redacted]

Claimant name [redacted] Account #: [redacted] Date of Examination: [redacted]

**SECTION VIII - REMARKS**

[redacted]

**SECTION IX – PHYSICIAN'S CERTIFICATION AND SIGNATURE**

**CERTIFICATION** - To the best of my knowledge, the information contained herein is accurate, complete and current.

| 9A. PHYSICIAN'S SIGNATURE | 9B. PHYSICIAN'S PRINTED NAME | 9C. DATE SIGNED |
|---|---|---|
| [redacted] | [redacted] | [redacted] |

| 9D. PHYSICIAN'S PHONE AND FAX NUMBER | 9E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER | 9F. PHYSICIAN'S ADDRESS |
|---|---|---|
| [redacted] | [redacted] | [redacted] |

NOTE: VA may request additional medical information, including additional examinations, if necessary to complete VA's review of the veteran's application.

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**RESPONDENT BURDEN:** We need this information to determine entitlement to benefits (38 U.S.C. 501). 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 the 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.

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

Department of Veterans Affairs [redacted]

**IMPORTANT** - THE DEPARTMENT OF VETERANS AFFAIRS (VA) ***WILL NOT PAY*** OR ***REIMBURSE*** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION BEFORE COMPLETING FORM.

| [redacted]/VETERAN | PATIENT/VETERAN'S SOCIAL SECURITY NUMBER [redacted] |
|---|---|

**NOTE TO PHYSICIAN** - The veteran or service member is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the claim. VA reserves the right to confirm the authenticity of ALL DBQs completed by private health care providers.

**ACCEPTABLE CLINICAL EVIDENCE (ACE) AND EVIDENCE REVIEW**

[redacted]

Claiment name [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

63

**SECTION I - DIAGNOSIS**

[redacted]

**SECTION II – MEDICAL HISTORY**

[redacted]

**SECTION III – SYMPTOMS**

[redacted]

☐ Other, describe:

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

SECTION III – SYMPTOMS

[redacted]

SECTION V - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

## SECTION VI - DIAGNOSTIC TESTING

[redacted]

## SECTION VII - FUNCTIONAL IMPACT

[redacted]

## SECTION VIII - REMARKS

[redacted]

## SECTION IX - PHYSICIAN'S CERTIFICATION AND SIGNATURE

**CERTIFICATION** - To the best of my knowledge, the information contained herein is accurate, complete and current.

| 9A. PHYSICIAN'S SIGNATURE | 9B. PHYSICIAN'S PRINTED NAME | 9C. DATE SIGNED |
|---|---|---|
| [redacted] | [redacted] | [redacted] |

| 9D. PHYSICIAN'S PHONE NUMBER | 9E. PHYSICIAN'S MEDICAL LICENSE NUMBER | 9F. PHYSICIAN'S ADDRESS |
|---|---|---|
| [redacted] | [redacted] | [redacted] |

**NOTE** - VA may request additional medical information, including additional examinations, if necessary to complete VA's review of the veteran's application.

**PRIVACY ACT NOTICE:** VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records – VA, published in the Federal Register. Your obligation to respond is voluntary. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a 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 determine entitlement to benefits (38 U.S.C. 501). 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.

[redacted]

# Disability Benefits Questionnaire

| Name of patient/Veteran [redacted] | SSN: [redacted] |
|---|---|

**Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.**

[redacted]

[redacted]

[redacted]

Claimant name [redacted] Account # [redacted] Date of Examination [redacted]

[redacted]

## Disability Benefits Questionnaire

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

**Disability Benefits Questionnaire**

[redacted]

[redacted]

[redacted]

Claimant name [redacted] Account #: [redacted] Date of Examination [redacted]

[redacted]

## Disability Benefits Questionnaire

[redacted]

Claimant name [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

**Disability Benefits Questionnaire**

[redacted]

Claimant name: [redacted] Account # [redacted] Date of Examination: [redacted]

[redacted]

## Disability Benefits Questionnaire

[redacted]

Claimant name [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

## Disability Benefits Questionnaire

[redacted]

Claimant name [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

**Disability Benefits Questionnaire**

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

## Disability Benefits Questionnaire

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

## Disability Benefits Questionnaire

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

## Disability Benefits Questionnaire

[redacted]

[redacted]

Physician signature: Date [redacted]

[redacted]

Physician printed name: [redacted]

Medical license #: [redacted] Physician address: [redacted]

Phone: [redacted]

**NOTE:** VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

**QTC NOTE:** The bolded statements in this DBQ form provide additional information pertinent to this evaluation.

Claimant name [redacted] Account #: [redacted] Date of Examination: [redacted]

# Separation Health Assessment
# Disability Benefits Questionnaire
** Internal VA or DoD Use Only**

| Name of patient/Veteran [redacted] | SSN: [redacted] |
|---|---|

**1. Diagnosis**

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

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

[redacted]

Claimant name [redacted] Account #: 4064595.1.2 Date of Examination: [redacted]

[redacted]

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

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

# Separation Health Assessment
# Disability Benefits Questionnaire
** Internal VA or DoD Use Only**

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

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

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

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

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

# Separation Health Assessment
# Disability Benefits Questionnaire
** Internal VA or DoD Use Only**

[redacted]

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

# Separation Health Assessment
# Disability Benefits Questionnaire
** Internal VA or DoD Use Only**

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

# Separation Health Assessment
# Disability Benefits Questionnaire

** Internal VA or DoD Use Only**

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

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

[redacted]

Claimant name: [redacted] Account # [redacted] Date of Examination: [redacted]

[redacted]

# Separation Health Assessment
# Disability Benefits Questionnaire

** Internal VA or DoD Use Only**

[redacted]

Claimant name [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

(Aligns with CAPRI Version: 02/13/15@17:34~v14_4)

# Separation Health Assessment
# Disability Benefits Questionnaire

** Internal VA or DoD Use Only**

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

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

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

# Separation Health Assessment
# Disability Benefits Questionnaire

** Internal VA or DoD Use Only**

[redacted]

**NOTE**: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

**QTC NOTE**: The bolded statements in this DBQ form provide additional information pertinent to this evaluation.

Claimant name: [redacted] Account #: [redacted] Date of Examination [redacted]

Quality.
Timeliness.
Customer Service.

# DBQ Notification

The Disability Benefits Questionnaire(s) has/have been completed and is/are being submitted for adjudication purposes.

Thank you.

**QTC Medical Services, Inc.**

[redacted]

# Disability Benefits Questionnaire

| Name of patient/Veteran [redacted] | SSN: [redacted] |
|---|---|

**Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim. Please note that this questionnaire is for disability evaluation, not for treatment purposes.**

**NOTE: If the Veteran experiences a mental health emergency during the interview, please terminate the interview and obtain help, using local resources as appropriate. You may also contact the Veterans Crisis Line at 1-800-273-TALK (8255). Stay on the Crisis Line until help can link the Veteran to emergency care.**

NOTE: In order to conduct an initial examination for mental disorders, the examiner must meet one of the following criteria: a board-certified or board-eligible psychiatrist; a licensed doctorate-level psychologist; a doctorate-level mental health provider under the close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist; a psychiatry resident under close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist; or a clinical or counseling psychologist completing a one-year internship or residency (for purposes of a doctorate-level degree) under close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist.

In order to conduct a review examination for mental disorders, the examiner must meet one of the criteria from above, OR be a licensed clinical social worker (LCSW), a nurse practitioner, a clinical nurse specialist, or a physician assistant, under close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist.

This Questionnaire is to be completed for both initial and review mental disorder(s) claims.

## SECTION I:

[redacted]

Claimant name: [redacted] Account #: [redacted] Date of Examination [redacted]

[redacted]

**Disability Benefits Questionnaire**

[redacted]

Claimant name [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

Disability Benefits Questionnaire

[redacted]

## SECTION II:

[redacted]

[redacted]

Claimant name [redacted] Account #: [redacted] Date of Examination: [redacted]

[redacted]

## Disability Benefits Questionnaire

[redacted]

Claimant name: [redacted] Account #: 4064595.1.5 Date of Examination: [redacted]

[redacted]

**Disability Benefits Questionnaire**

[redacted]

Psychiatrist/Psychologist signature & title: Date: [redacted]

[redacted]

Psychiatrist/Psychologist printed name: [redacted]

Claimant name [redacted] Account #: 4064595.1.5 Date of Examination: [redacted]

[redacted]

# Disability Benefits Questionnaire

License #: [redacted] Psychiatrist/Psychologist address: [redacted]

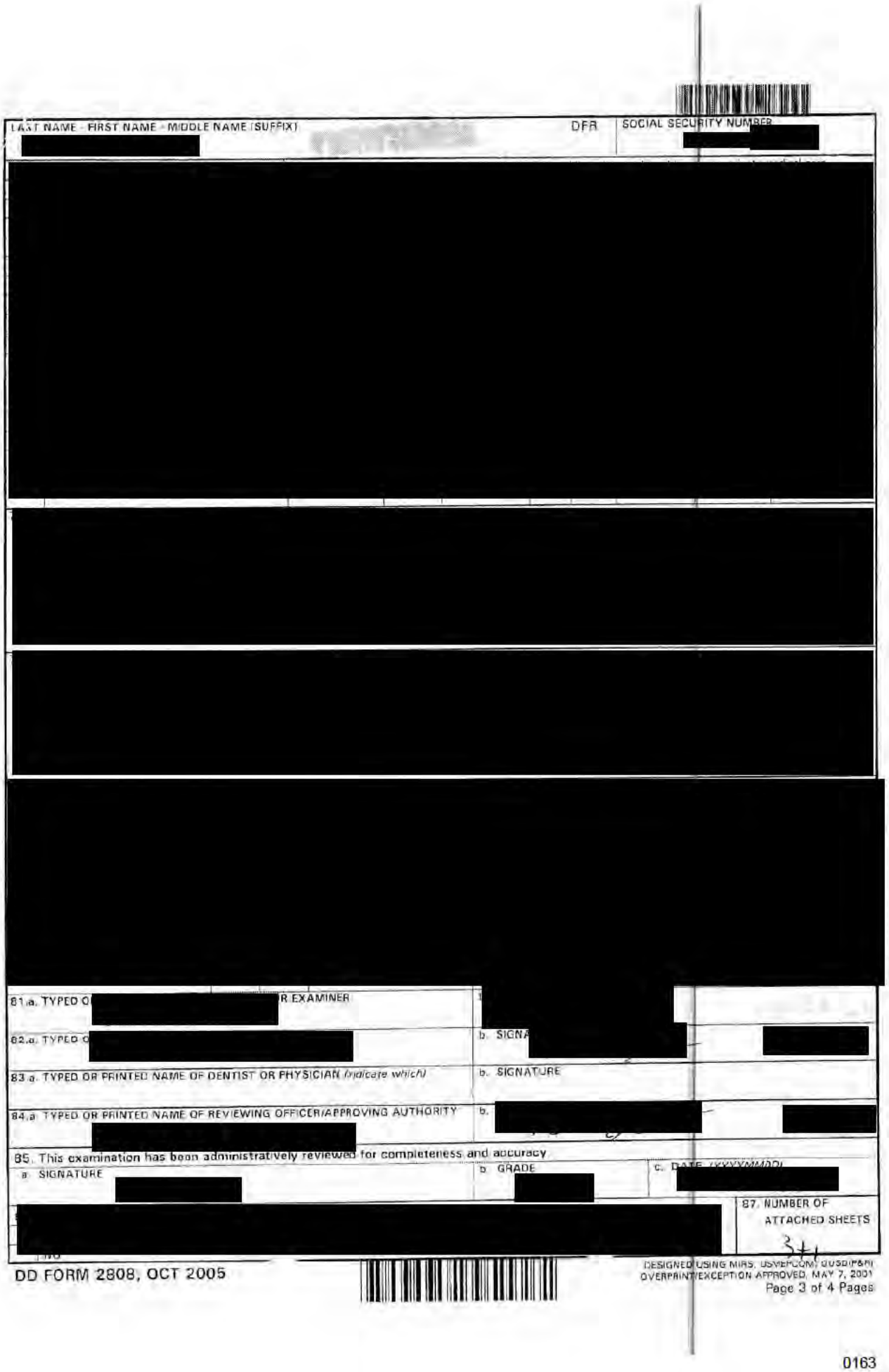
Phone: [redacted] Fax: [redacted]

**NOTE**: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

**Privacy Act Notice:** VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58/VA21/22/28, 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. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a 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.

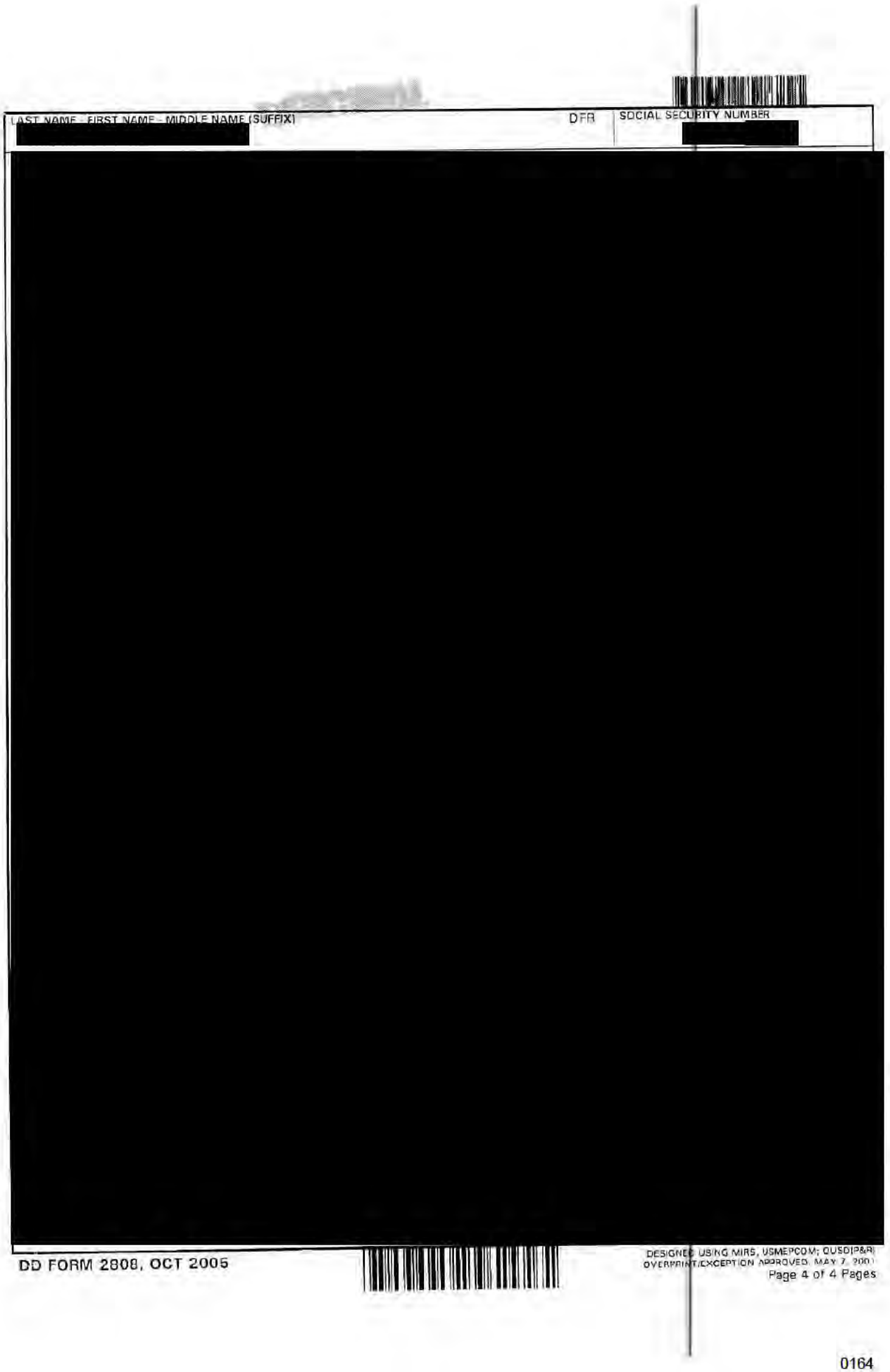
**Respondent Burden:** We need this information to determine entitlement to benefits (38 U.S.C. 501). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 45 minutes to review the instructions, find the information, and complete the form. VA 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.

Claimant name [redacted] Account #: [redacted] Date of Examination [redacted]


LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)
DFR
SOCIAL SECURITY NUMBER
[redacted]
81.a. TYPED O[redacted]R EXAMINER
b. SIGNA[redacted]
82.a. TYPED O[redacted]
b. SIGNA[redacted]
83.a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which)
b. SIGNATURE
84.a. TYPED OR PRINTED NAME OF REVIEWING OFFICER/APPROVING AUTHORITY
b. [redacted]
85. This examination has been administratively reviewed for completeness and accuracy
a. SIGNATURE
b. GRADE
c. DATE (YYYYMMDD)
87. NUMBER OF ATTACHED SHEETS
3+1
DD FORM 2808, OCT 2005
DESIGNED USING MIRS, USAPDC/M, 03SEP04
OVERPRINT/EXCEPTION APPROVED, MAY 7, 2001
Page 3 of 4 Pages

0163

A-00909


LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)
DFR
SOCIAL SECURITY NUMBER
DD FORM 2808, OCT 2005
DESIGNED USING MIRS, USMEPCOM; OUSD(P&R)
OVERPRINT/EXCEPTION APPROVED, MAY 7, 2001
Page 4 of 4 Pages

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

[redacted]

MEASUREMENTS AND C

[redacted]

[redacted]

DD FORM 2808, OCT 2005

DESIGNED USING MIRS, USMEPCOM; OUSD(P&R)
OVERPRINT/EXCEPTION APPROVED, MAY 7, 2001
Page 2 of 4 Pages

0165

A-00911

# 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 | [redacted] | [redacted] |
|---|---|---|---|---|---|
| [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] |

| [redacted] | 12. AGENCY (Non-Service Members Only) | [redacted] |
|---|---|---|
| [redacted] | [redacted] | [redacted] |

| 14. a. RATING OR SPECIALTY (Aviators Only) | b. TOTAL FLYING TIME | c. LAST SIX MONTHS |
|---|---|---|
| [redacted] | [redacted] | [redacted] |

| [redacted] | b. COMPONENT | c. PURPOSE OF EXAMINATION | 16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include ZIP Code) |
|---|---|---|---|
| [redacted] | [redacted] | [redacted] | [redacted] |

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

| [redacted] | Not Acceptable | Class | [redacted] |
|---|---|---|---|
| [redacted] | [redacted] | [redacted] | [redacted] |

# 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) [redacted] |
|---|---|---|---|
| [redacted] | [redacted] | [redacted] | 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".

[redacted]

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) [redacted]

SOCIAL SECURITY NUMBER [redacted]

Mark each item "YES" or "NO". [redacted]

Mark each item "YES" or "NO". For items 19 - 28, every item marked "YES" must be fully explained in Item 29 below. [redacted]

[redacted]

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

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) [redacted]

SOCIAL SECURITY NUMBER [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.)*

[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 D[redacted] complete transcript of my medical record for purposes of processing my application for military service.

X [redacted] EXAMINEE SIGNATURE

[redacted] DATE

b. TYPED OR PRINTED NAME OF EXAMINER [redacted]

c. SIGNATURE [redacted]

d. DATE SIGNED [redacted]



DD FORM 2807-1, OCT 2003

DoD exception to SF 93 approved by ICMR, August 3, 2000

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

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

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

[redacted]

## 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] | [redacted] | [redacted] | [redacted] |

**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 | | 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) - (75) 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]

## 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)* |
|---|---|---|
| [redacted] | [redacted] | [redacted] |

**4. PREVIOUS PRIMARY CARE PHYSICIAN(S)**

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

**5. CURRENT INSURANCE PROVIDER**

| a. NAME | b. ADDRESS *(Include ZIP Code)* | c. INSURANCE ID NUMBER |
|---|---|---|
| [redacted] | | |

**6. PREVIOUS INSURANCE PROVIDER(S)**

| a. NAME(S) | b. ADDRESS *(Include ZIP Code)* | c. INSURANCE ID NUMBER |
|---|---|---|
| [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 |
|---|---|---|
| | | [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]

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

DD FORM 2807-2, MAR 2007

**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

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

5. For purposes of entitlement to Department of Veterans Affairs (VA) benefits, entitlement to service connection for [redacted]

6. For purposes of entitlement to Department of Veterans Affairs (VA) benefits, entitlement to service connection for [redacted]

7. For purposes of entitlement to Department of Veterans Affairs (VA) benefits, entitlement to service connection for [redacted]

8. For purposes of entitlement to Department of Veterans Affairs (VA) benefits, entitlement to service connection for [redacted].

9. For purposes of entitlement to Department of Veterans Affairs (VA) benefits, entitlement to service connection for [redacted]

10. For purposes of entitlement to Department of Veterans Affairs (VA) benefits, entitlement to service connection for [redacted]

11. For purposes of entitlement to Department of Veterans Affairs (VA) benefits, entitlement to service connection for [redacted].

12. For purposes of entitlement to Department of Veterans Affairs (VA) benefits, entitlement to service connection for [redacted].

13. For purposes of entitlement to Department of Veterans Affairs (VA) benefits, entitlement to service connection for [redacted]

[redacted]
3 of

14. For purposes of entitlement to Department of Veterans Affairs (VA) benefits, entitlement to service connection for [redacted]

15. For purposes of entitlement to Department of Veterans Affairs (VA) benefits, entitlement to service connection for [redacted]

16. For purposes of entitlement to Department of Veterans Affairs (VA) benefits, entitlement to service connection for [redacted]

17. For purposes of entitlement to Department of Veterans Affairs (VA) benefits, entitlement to service connection for [redacted].

18. For purposes of entitlement to Department of Veterans Affairs (VA) benefits, entitlement to service connection for [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 Form 21-4138, Statement in Support of Claim, received [redacted], listing additional claimed conditions
- Service Treatment Records, f[redacted]
- VA Contract (QTC) General Medical Exam dated [redacted]
- VA Contract (QTC) Mental Disorders Exam dated [redacted]
- VA Contract (QTC) Eye Conditions Exam dated [redacted]
- Physical Evaluation Board Case File, received [redacted]

## REASONS FOR DECISION

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

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

We have assigned a 10 percent evaluation for your human immunodeficiency virus (HIV) based on:
• On approved medication(s)

Additional symptom(s) include:

[redacted]
4 of

• 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.

**2. 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.

We have assigned a [redacted]:
• A[redacted]

Note: In every instance where the schedule does not provide a zero percent evaluation for a diagnostic code, a zero percent evaluation shall be assigned when the requirements for a compensable evaluation are not met. {38 CFR §4.31}

[redacted]:

• [redacted]

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

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

We have assigned a [redacted]

Note: In every instance where the schedule does not provide a zero percent evaluation for a diagnostic code, a zero percent evaluation shall be assigned when the requirements for a compensable evaluation are not met. {38 CFR §4.31}

[redacted]

[redacted]

[redacted]

[redacted]
5 of

[redacted]

[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.

We have assigned a [redacted]

[redacted]

**5. Proposed entitlement to service connection of [redacted] or Department of Veterans Affairs (VA) benefits.**

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

[redacted]

[redacted]
6 of

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

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

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

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

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

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

[redacted]

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

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

[redacted]

**10. Proposed entitlement to service connection of [redacted] wart with hemangioma for Department of Veterans Affairs (VA) benefits.**

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

[redacted]

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

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

[redacted]

[redacted]

[redacted]
8 of

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

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

[redacted]

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

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

[redacted]

**14. Proposed entitlement to service connection of [redacted] with dermatitis for Department of Veterans Affairs (VA) benefits.**

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

[redacted]

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

[redacted]
9 of

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

[redacted]

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

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

[redacted]

**17. Proposed entitlement to service connection of [redacted] with dysuria for Department of Veterans Affairs (VA) benefits.**

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

[redacted]

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

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

[redacted]
10 of

[redacted]

**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*<br>*Veterans Benefits Administration* | Page 1 of 3 [redacted] |
|---|---|---|

| NAME OF VETERAN | VA FILE NUMBER | | POA | COPY TO |
|---|---|---|---|---|
| [redacted] | [redacted] | [redacted] | | |

| ACTIVE DUTY | | | |
|---|---|---|---|
| EOD | RAD | BRANCH | CHARACTER OF DISCHARGE |
| [redacted] | | [redacted] | |

| LEGACY CODES | | | |
|---|---|---|---|
| ADD'L SVC CODE | COMBAT CODE | SPECIAL PROV CDE | FUTURE EXAM DATE |
| | [redacted] | | [redacted] |

**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)
Proposed DES Service Connected, Gulf War, Incurred
10%

[redacted]

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

10%

*Proposed DES Not Service Connected Disabilities*

6310

| **Disability Evaluation System Proposed Rating** | *Department of Veterans Affairs*<br>*Veterans Benefits Administration* | Page 2 of 3 [redacted] |
|---|---|---|

| NAME OF VETERAN | VA FILE NUMBER | | POA | COPY TO |
|---|---|---|---|---|
| [redacted] | [redacted] | [redacted] | | |

[redacted]

| **Disability Evaluation System Proposed Rating** | ***Department of Veterans Affairs*** ***Veterans Benefits Administration*** | Page 3 of 3 [redacted] | | |
|---|---|---|---|---|
| NAME OF VETERAN [redacted] | VA FILE NUMBER [redacted] | [redacted] | POA | COPY TO |

[redacted]

REVIEWER: [redacted]

eSign: [redacted]

# ACTION ON PHYSICAL EVALUATION BOARD FINDINGS AND RECOMMENDED DISPOSITION

**PRIVACY ACT STATEMENT**

*Authority: 10 U.S.C. 801, Executive Orders 9397and 13478 (SSN).*
*Purpose: To process disability cases. SSN is necessary to ensure positive identification.*
*Routine Uses: May specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. 552a (b) (3).*
*Disclosure is Voluntary: Refusal to divulge information may jeopardize entitlement to disability benefits.*

**I. PERSONNEL DATA**

| MEMBER (Last, First, Middle Initial) | SSN | GRADE |
|---|---|---|
| [redacted] | [redacted] | [redacted] |

**II. NEXT OF KIN OR GUARDIAN DATA**

| NEXT OF KIN (*or guardian*) | ADDRESS | RELATIONSHIP |
|---|---|---|
| | | |

**III. COUNSELING ACTION**

I have fully explained to the member *(or next of kin or guardian indicated in Section II, above)*, in person or by letter, the findings and recommended disposition of the PEB and applicable case processing procedures and appeal rights. I have counseled the member that regardless of their election as indicated below, upon review by a Special Assistant to the Secretary of the Air Force Personnel Council (SAFPC), the member's case ***MAY*** be referred to the SAFPC for further review and final decision.

| DATE | SIGNATURE OF COUNSEL, PEB REPRESENTATIVE, OR PEBLO |
|---|---|
| [redacted] | [redacted] Digitally signed by TWOMEY.SARA.CHRISTINE.[redacted] DN: c=US, o=U.S. Government, ou=DoD, ou=PKI, ou=USAF, cn=TWOMEY.SARA.CHRISTINE.1162752541 Date: 2017.12.27 09:25:09 -06'00' |

**IV. IPEB ACTION BY THE MEMBER, NEXT OF KIN, OR GUARDIAN**

HAVING BEEN ADVISED OF THE FINDINGS AND RECOMMENDED DISPOSITION OF THE PEB *(as indicated on AF Form 356)* AND APPLICABLE CASE PROCESSING PROCEDURES AND APPEAL RIGHTS: *(Check applicable blocks)*

| | |
|---|---|
| | I agree with the findings and recommended disposition of the Informal PEB and am waiving the right to a Formal PEB hearing. |
| | ☐ **(IDES only)** I do not request a one-time reconsideration of the disability ratings for the conditions found unfitting by the PEB.<br>☐ **(IDES only)** I request a one-time reconsideration of the disability ratings for the conditions found unfitting by the IPEB. I understand I **MUST** submitdocumentation in support of my request to my PEBLO or attorney NLT COB CST ***within ten calendar days from my briefing*** or my reconsideration request will not be granted. The request is due NLT COB _____ CST. |
| | I do not agree with the findings and recommended disposition of the Informal PEB and request a formal hearing of my case. *(If the IPEB recommended return to duty, I understand I must provide justification for my request and that my request for a formal hearing may be denied.)* |

**V. FPEB ACTION BY THE MEMBER, NEXT OF KIN, OR GUARDIAN**

HAVING BEEN ADVISED OF THE FINDINGS AND RECOMMENDED DISPOSITION OF THE PEB *(as indicated on AF Form 356)* AND APPLICABLE CASE PROCESSING PROCEDURES AND APPEAL RIGHTS:

| | |
|---|---|
| | **I agree with the findings and recommended disposition of the Formal PEB.** I also elect the following – [Check one below]<br>☐ **(IDES only)** I do not request a one-time reconsideration of the disability ratings for the conditions found unfitting by the PEB.<br>☐ **(IDES only)** I request a one-time reconsideration of the disability ratings for the conditions found unfitting by the PEB. I understand that I **MUST** submit documentation in support of my request to either my attorney, or my PEBLO, or directly to **AFPC/DPFDF, 555 E. Street West, (Bldg 663), JBSA-Randolph AFB, TX 78150** and that it is due NLT COB _____ CST. |
| MBB | **I do not agree with the findings and recommended disposition of the Formal PEB** and request my case be referred to SAFPC for review and final decision. I understand I may submit a rebuttal/additional evidence to my attorney, or to my PEBLO, or directly to **HQ AFPC/DPFDF, 555 E Street W, (Bldg 663), JBSA-Randolph AFB, TX 78150.** I understand my rebuttal is due NLT COB _____ CST. I also elect the following - [Check one below]<br>☒ **(IDES only)** I do not request a one-time reconsideration of the disability ratings for the conditions found unfitting by the PEB.<br>☐ **(IDES only)** I request a one-time reconsideration of disability ratings for unfitting conditions. I understand that my rating reconsideration request will be held until after receipt of the SAFPC decision. I understand I ***MUST*** submit documentation in support of my reconsideration to my attorney, or my PEBLO, or directly to **AFPC/DPFDF, 555 E Street W, (Bldg 663), JBSA Randolph AFB, TX 78150, *within ten calendar days after receipt of the SAFPC decision,*** or my reconsideration request will not be granted. |

**VI. REMARKS**

| LEAVE BALANCE | REQUESTED SEPARATION DATE IF REQUESTING SHORTER DOS (MPS Must concur if <30 days) |
|---|---|
| | |

**VII. SIGNATURE OF MEMBER**

| DATE | SIGNATURE OF MEMBER, NEXT OF KIN, OR GUARDIAN |
|---|---|
| [redacted] | [redacted] |

**AF FORM 1180, February 2015** PREVIOUS EDITIONS ARE OBSOLETE Attaachment 21

**DEPARTMENT OF VETERANS AFFAIRS**
**Evidence Intake Center**
**P.O. Box 4444**
**Newnan, GA 30271-0020**

1[redacted]

**In Reply Refer To: 304/2127/DRAS**

**Claim number:** [redacted]

Dear [redacted]

Thank you for your service to our country. This letter provides a proposed estimate of your Department of Veterans Affairs (VA) benefits to assist you with your financial planning following your discharge from active duty.

## Overview

Your military Service Department requested a disability assessment from VA because you were found unfit for continued military service. We provided the attached proposed VA Rating Decision to your Service Department.

The determination of entitlement to VA benefits is contingent upon the Member's discharge from Service and upon the Member having the requisite character of service. In the event that the Member is not separated from service as a result of the IDES process or, upon discharge, lacks the requisite character of discharge, this rating is null and void for purposes of entitlement to VA benefits.

## Purpose

The purpose of this estimate is to provide you information for transition planning purposes. It does not constitute a final decision by VA. This letter includes what disabilities VA is proposing for service connection, your estimated VA entitlement amount, and approximate VA payment start date. We also included information about additional VA and State benefits and who to contact if you have questions or need assistance.

## What VA Is Proposing

We are proposing that the following disabilities are related to your military service, i.e., service connected:

**Proposed Rating Decision: MICHAEL BELL**

| Medical Description of Claimed Disabilities | Proposed Percent (%) Assigned |
|---|---|
| HUMAN IMMUNODEFICIENCY VIRUS (HIV) | 10% |
| [redacted] | |

We are proposing that the following claimed disabilities are not related to your military service:

| Medical Description |
|---|
| [redacted] |

**Proposed Rating Decision:** [redacted]

[redacted]

We are proposing that your total combined rating for service-connected disabilities is 10%. We do not add the individual percentages of each condition to determine your combined rating. We use a combined rating table that considers the effect from the most serious to the least serious disabilities.

We provided a copy of your proposed Rating Decision to your Service Department Physical Evaluation Board Liaison Officer (PEBLO). Your proposed Rating Decision and this letter are based on your claim received on [redacted]. It represents all claims we understood to be specifically made, implied, or inferred in that claim. It does not include any conditions that were claimed after you completed VA Form 21-0819, VA/DoD Joint Disability Evaluation Board Claim, during your initial meeting with the VA Military Service Coordinator shortly after entering the IDES program.

## What You May Be Entitled to Receive If the IDES Process Results in Your Separation from Service and the Proposed VA Disability Decisions are Finalized

We estimate that if the proposed ratings are implemented, you may be entitled after discharge from service to monthly VA compensation in the amount of $133.57 based on the current statutory rates of disability compensation. This estimate is based on paying you as a single veteran with no dependents. Veterans having a 30% or more service-connected condition may be entitled to additional compensation for eligible dependents. If you receive disability severance pay from the Service Department, your monthly VA compensation may be reduced by the amount of disability severance pay for the percentage(s) of the unfitting disabilities only. However, your monthly VA compensation will not be reduced for any unfitting disabilities the PEB determines were incurred in combat. If you would like more information on Combat-Related Special Compensation (CRSC) and Concurrent Retirement Disability Pay (CRDP), call Defense Finance and Accounting Service toll free at either 1-888-332-7411 or 1-800-321-1080.

## What Happens Next

The following section applies to you only if you are subsequently separated or retired from service and you accept your PEB findings.

1. Your VA Military Services Coordinator (MSC) will contact you to set up an exit interview. At this interview, the MSC will gather dependency and other pertinent information, as well as provide you with additional information on VA benefits.
2. Unless we receive additional medical evidence, we will implement the proposed Rating Decision when the Service Department notifies us that you have separated as a result of the IDES process.

**Proposed Rating Decision:** [redacted]

3. Once separated, generally, your effective date of eligibility for VA benefits is the first day of the month after the month of your separation. VA payments are made at the beginning of each month for the prior month. For example, if you were discharged on May 15, you would be service-connected as of May 16. Your benefits are effective June 1 and your first payment will be made approximately July 1 for June.

## Are You Entitled To Additional Benefits?

You should contact your state's office for Veterans Affairs to obtain information about any tax, license, or fee-related benefits for which you may be eligible after separation from service. A link to each state's web site can be found at http://www.va.gov/statedva.htm.

In addition, you may be eligible for VA Insurance, Education, Home Loan Guaranty, and Vocational Rehabilitation and Employment as described below. Certain benefits may be available while you are still on active duty.

## Insurance

You may be eligible for Service-Disabled Veterans Insurance (S-DVI) if you are in good health (except for any service-connected disabilities), and apply within two years of your final disability rating notification. If you are totally disabled, you may be eligible to have your S-DVI premiums waived and receive up to $20,000 of Supplemental S-DVI coverage. You should receive a package within two weeks after your Rating Decision is finalized. This package will contain information about the insurance and an application. If you do not receive an S-DVI package, please contact the Insurance Center to request additional information at 1-800-669-8477 or go to the VA Insurance web site at http://www.insurance.va.gov.

Your Servicemembers' Group Life Insurance (SGLI) will terminate 120 days after separation or release from military service. However, if you are totally disabled, you are eligible to continue to receive SGLI for another two years under current law. After you are discharged, you will receive information about how to apply for the SGLI extension of coverage based on total disability. Also, you are eligible to convert your SGLI to Veterans' Group Life Insurance (VGLI) within 120 days after discharge without proof of good health or one year after the 120-day period expires upon proof of good health. You will receive a VGLI application within 60 days after separation from service. If you do not receive information about the SGLI extension or VGLI, please contact the Office of Servicemembers' Group Life Insurance at 1-800-419-1473 or visit the VA Insurance web site at http://www.insurance.va.gov.

## VA Education Benefits

VA pays benefits to eligible Veterans and Servicemembers while they are in an approved education or training program. Based on the type of military service, primary benefit programs are for active duty Servicemembers, Veterans, and Reserve or Guard members. Individuals with 90 days or more of active duty on or after September 11, 2001, are generally eligible under the Post-9/11 GI Bill (Chapter 33). However, in the case of a Servicemember who, on or after September 11, 2001, serves at least

30 continuous days on active duty and upon completion of such service is discharged or separated for a service-connected disability, the Servicemember is entitled to full benefits under that program. Those who first entered active duty after June 30, 1985, are generally eligible under the Montgomery GI Bill (MGIB) (Chapter 30). Reserve and Guard members may be eligible for MGIB -Selected Reserve (Chapter 1606). MGIB may be available for those who signed a six-year commitment after June 30, 1985, are actively drilling, and in good standing with their unit. The Reserve Educational Assistance Program (Chapter 1607) is for those who were activated under Federal authority for a contingency operation and served 90 continuous days or more after September 10, 2001. Time limits vary from 10-15 years from either the date of release from active duty or the date eligibility was established, depending upon the benefit. Each program has unique eligibility specified by law, and only one program can be used at any given time. If you need help with your VA education benefits, you can call toll free, 1-888-442-4551, or visit the VA's education web site at http://www.gibill.va.gov.

## VA Home Loan Guaranty

VA offers a number of home loan services to eligible Veterans, some military personnel, and certain surviving spouses. VA can guarantee a portion of a loan made by a private lender to help you buy a home, a manufactured home, a lot for a manufactured home, a condominium unit, or a unit in a cooperative dwelling. VA may waive your mortgage funding fee if you are rated by VA as eligible to receive compensation as a result of your DES disability examination and proposed rating. VA also guarantees loans for building, repairing, and improving homes. If you have a VA mortgage, VA can help you refinance your loan at a lower interest rate. You may also refinance a non-VA loan. There is no time limit for a VA home loan. For more information, visit our web site at http://www.homeloans.va.gov/.

## VA Vocational Rehabilitation and Employment

VA provides assistance to Servicemembers and Veterans with service-connected disabilities to prepare for, obtain, and maintain suitable employment. Assistance may be provided in the form of job search, vocational evaluation, career exploration, vocational training, educational training, and supportive rehabilitation services. Visit the Vocational Rehabilitation and Employment web site at http://www.vba.va.gov/bln/vre/index.htm for additional information. Veterans generally are eligible for the program for 12 years from the date VA informs them that they have at least a 10% rating for a service-connected disability.

## Medical Care

VA provides a variety of health care services including hospital, outpatient medical, dental, pharmacy, and prosthetic services; domiciliary, nursing home, and community-based residential care; sexual trauma counseling; specialized health care for women Veterans; health and rehabilitation programs for homeless Veterans; readjustment counseling; and alcohol and drug dependency treatment. Veterans who have one or more service-connected disabilities as determined by VA are eligible for most medical services through the VA health care system. VA provides cost-free health care for Veterans who served in combat operations after November 11, 1998, for any illness associated with

their service in that theater. If you are a recently discharged combat Veteran, you have five years to access this cost-free care from the date of your discharge from active duty on or after January 28, 2008. If you are interested in obtaining VA medical care, contact your nearest VA health care facility or the VA Enrollment Service Center at 1-877-222-VETS (8387). For additional information, visit http://www.oefoif.va.gov/.

## Clothing Allowance

VA offers an annual clothing allowance to Veterans who have a service-connected disability for which he or she uses prosthetic or orthopedic appliances. This allowance is also available to any veteran whose service-connected skin condition requires prescribed medication that irreparably damages outer garments. To apply, contact the prosthetic representative at the nearest VA Medical Center.

## Dependents' Education Assistance

VA offers education assistance for dependents of veterans that are determined to be permanently and totally disabled due to service-connected disabilities. For more information, you can visit our website at http://www.benefits.va.gov/gibill/survivor_dependent_assistance.asp.

## Automobile Allowance

VA offers qualified Veterans and Servicemembers a one-time payment of not more than $20,114.34 toward the purchase of an automobile or other conveyance if they have service-connected loss or permanent loss of use of one or both hands or feet, permanent impairment of vision of both eyes to a certain degree, severe burn injuries (deep partial thickness or full thickness burns resulting in scar formation that cause contractures and limit motion of one or more extremities or the trunk and preclude effective operation of an automobile), or ankylosis (immobility) of one or both knees or one or both hips. They may also be eligible for adaptive equipment, and for repair, replacement, or reinstallation required because of disability or for the safe operation of a vehicle purchased with VA assistance. To apply, contact a VA regional office at 1-800-827-1000 or the nearest VA medical center.

## Specially Adapted Housing Grants

To qualify for an SAH grant, the Veteran or Servicemember must be found eligible to receive compensation for permanent and total service-connected disability due to one of the following: (1) Loss or loss of use of both lower extremities, such as to preclude locomotion without the aid of braces, crutches, canes, or a wheelchair; (2) Loss or loss of use of both upper extremities at or above the elbow; (3) Blindness in both eyes, having only light perception, plus loss or loss of use of one lower extremity; (4) Loss or loss of use of one lower extremity together with (a) residuals of organic disease or injury, or (b) the loss or loss of use of one upper extremity which so affects the functions of balance or propulsion as to preclude locomotion without the use of braces, canes, crutches or a wheelchair; or (5) Severe burn injuries.

Supplemental Financing: Veterans and Servicemembers with available loan guaranty entitlement may also obtain a guaranteed loan or a direct loan from VA to supplement the grant to acquire a specially

adapted home. Amounts with a guaranteed loan from a private lender will vary, but the maximum direct loan from VA is $33,000. Additional information about the Specially Adapted Housing Program is available at the following web site: http://www.homeloans.va.gov/sah.htm.

## Special Home Adaptation Grants

VA may approve a grant not to exceed the maximum allowable for necessary adaptations to a Veteran's or Servicemember's residence or to help them acquire a residence already adapted with special features for their disability, to purchase and adapt a home, or for adaptations to a family member's home in which they will reside. To be eligible for this grant, Veterans and Servicemembers must be entitled to compensation for permanent and total service-connected disability due to one of the following: (1) Blindness in both eyes with 5/200 visual acuity or less; (2) Anatomical loss or loss of use of both hands; (3) Severe burn injuries; or (4) Residuals of an inhalation injury (including, but not limited to, pulmonary fibrosis, asthma, and chronic obstructive pulmonary disease).

Supplemental Financing: Veterans and Servicemembers with available loan guaranty entitlement may also obtain a guaranteed loan or a direct loan from VA to supplement the grant to acquire a specially adapted home. Amounts with a guaranteed loan from a private lender will vary, but the maximum direct loan from VA is $33,000. Additional information about the Specially Adapted Housing Program is available at the following web site: http://www.homeloans.va.gov/sah.htm.

## Direct Deposit

The Department of Treasury mandated that new recurring benefit payments must be made via EFT or prepaid debit card. You must contact the U.S. Treasury at 1-888-224-2950 to discuss options available for receiving your future payments that are in compliance with U.S. Treasury regulations. Before you call the Treasury, we can help! If compensation or pension is awarded, you can receive your payments through electronic funds transfer (EFT). To have your federal benefits electronically transferred to your designated financial institution (e.g. bank) call VA at 1-800-827-1000 with your banking information or go online to www.ebenefits.va.gov.

Sincerely yours,

*K. Gareau*

Regional Office Director
Regional Office Director

Contact us at: https://iris.va.gov

# 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 |
|---|---|---|---|
| [redacted] | | NO | [redacted] |

| 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://GUM-CRM.CSD.DISA.MIL/APP/ANSWERS/DETAIL/A_ID/8557/P/8,10/C/790.

| 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-032259 | [redacted] |
| AFPC RANDOLPH AFB TX 78150-0000 | 32. TDN FOR THE COMMANDER | | |

| 33. DISTRIBUTION | 34. SIGNATURE ELEMENT OF ORDERS AUTHENTICATING OFFICIAL |
|---|---|
| AA | [redacted] |

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

0196

A-00942

**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). It must be protected or Privacy Act information removed prior to further disclosure.

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

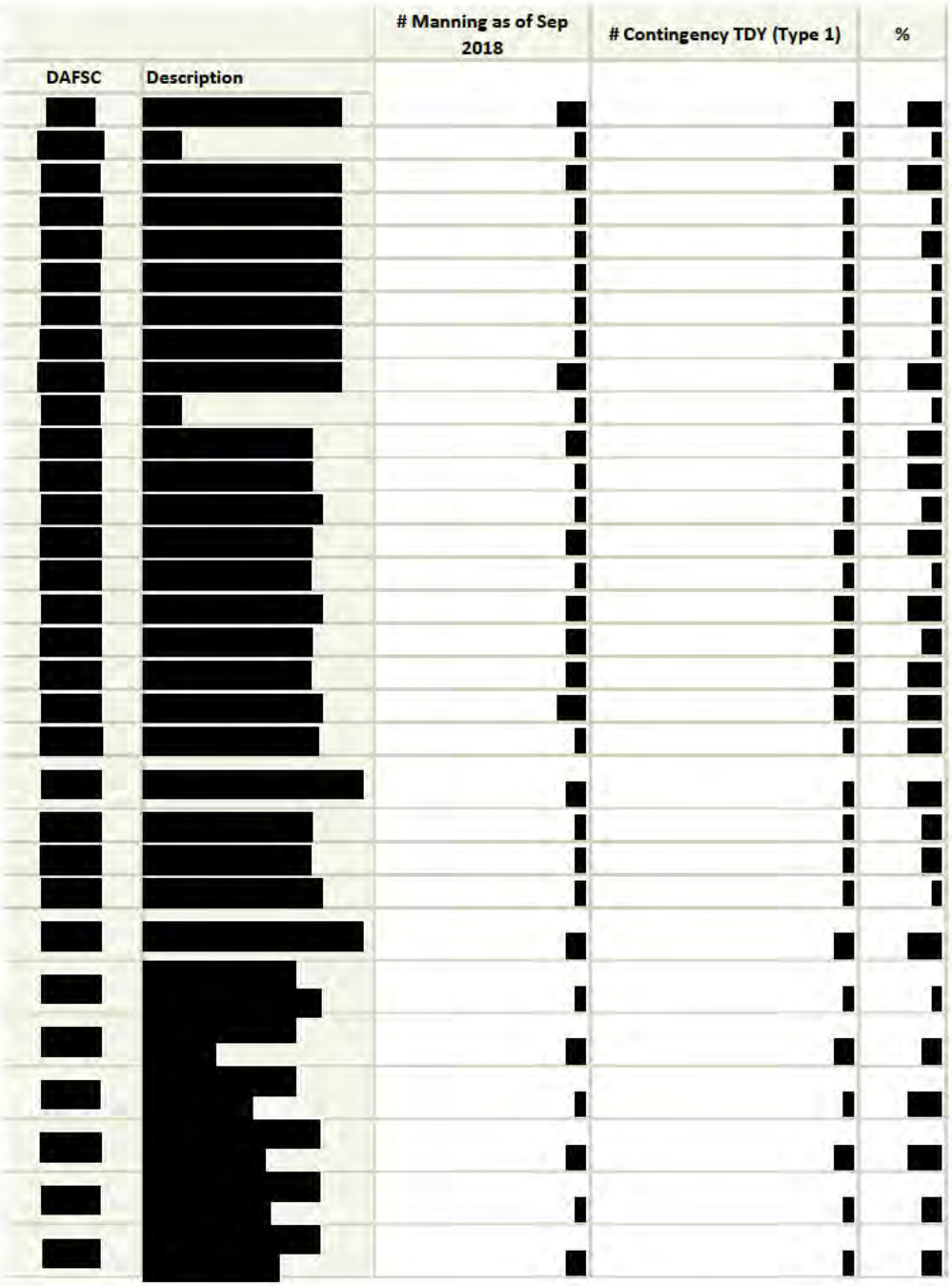
35. CONTINUATION OF DEPENDENTS AND REMARKS

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 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 AIRMAN IS A NON-CARD HOLDER THE CENTRALLY BILLED ACCOUNT WILL BE UTILIZED FOR ALL COMMERCIAL TRANSPORTATION ARRANGEMENTS.

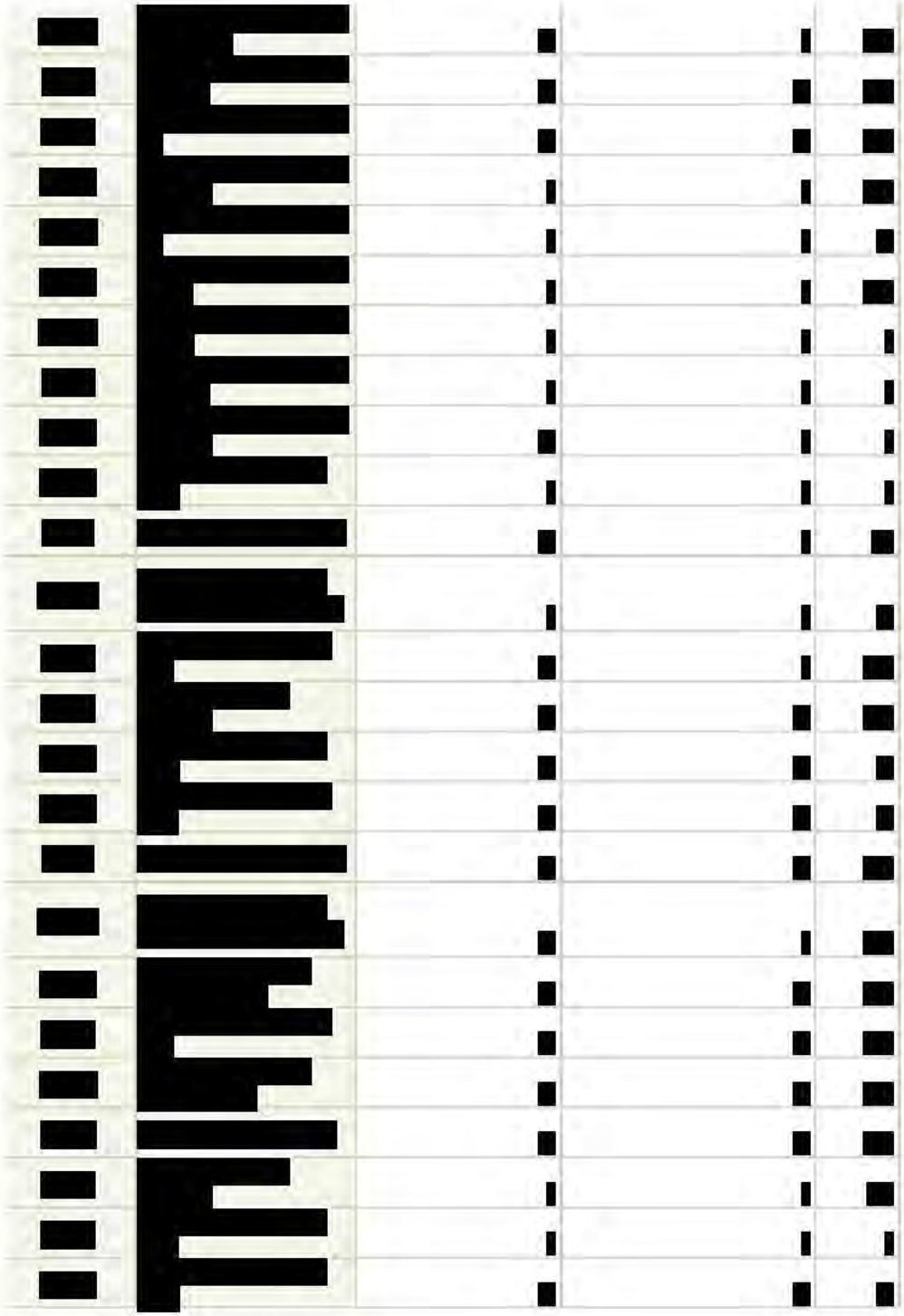
04. MEMBER IS AUTHORIZED PERMISSIVE TDY LEAVE IN CONJUNCTION WITH SEPARATION. YOU MAY BE ELIGIBLE FOR VALUABLE TRANSITION BENEFITS (ID CARD FOR AN ADDITIONAL 2-YEARS, EXTENDED MEDICAL COVERAGE, ETC.). CONTACT THE LOCAL AIRMAN AND FAMILY READINESS CENTER FOR DETAILS CONCERNING THESE BENEFITS.

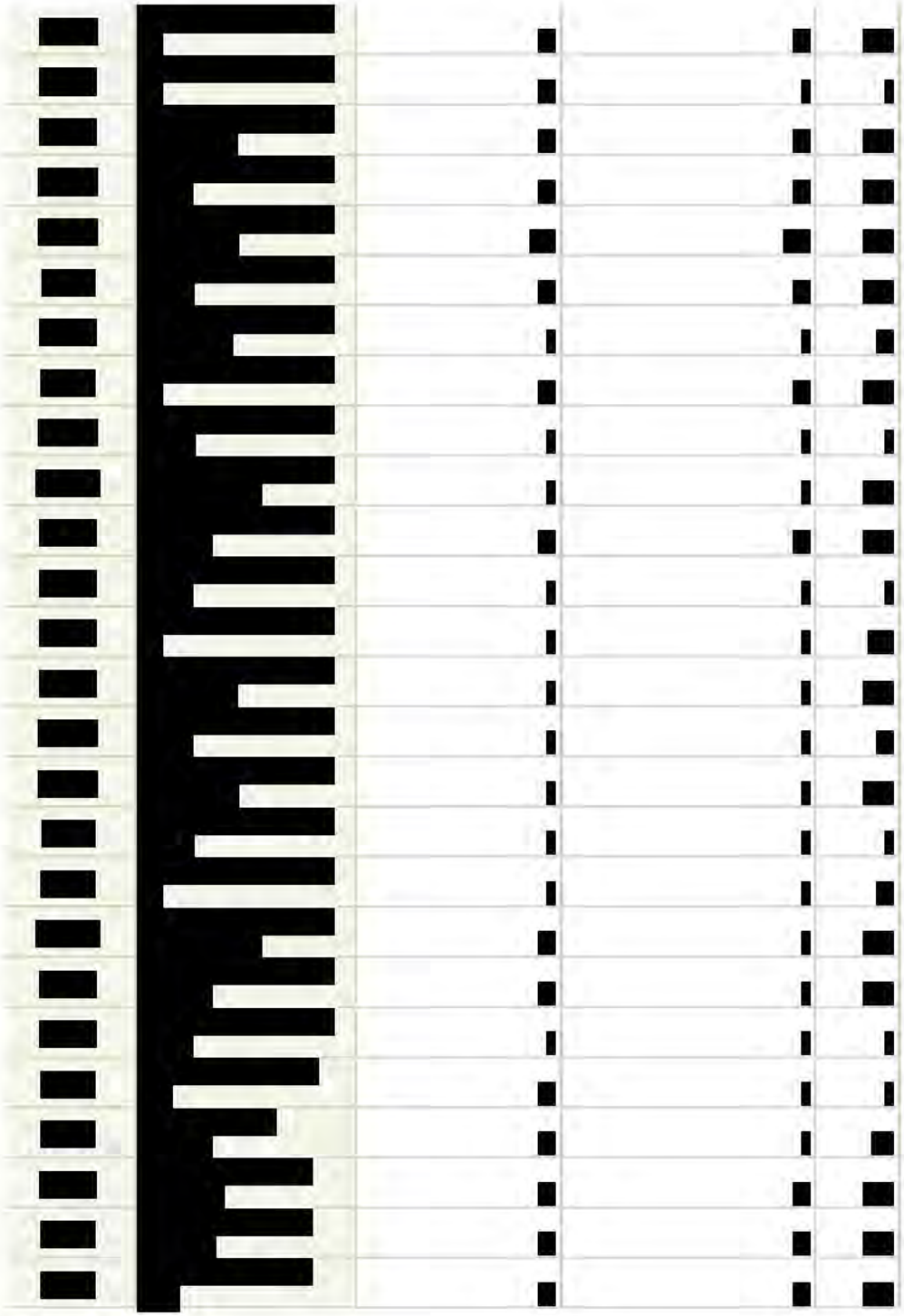
**Active Duty Deployment TDY Rate for Fiscal Year 2018**

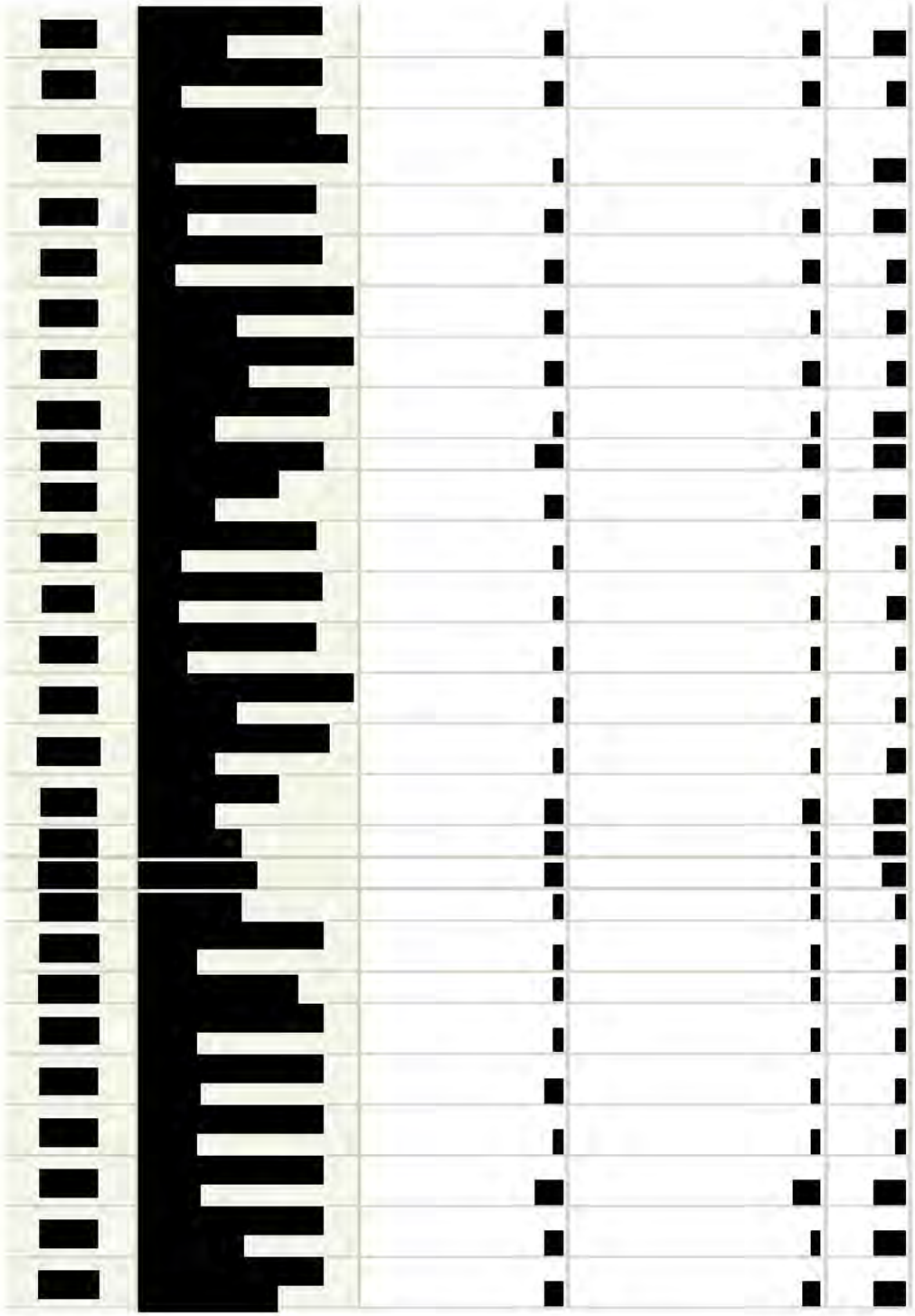
[redacted]

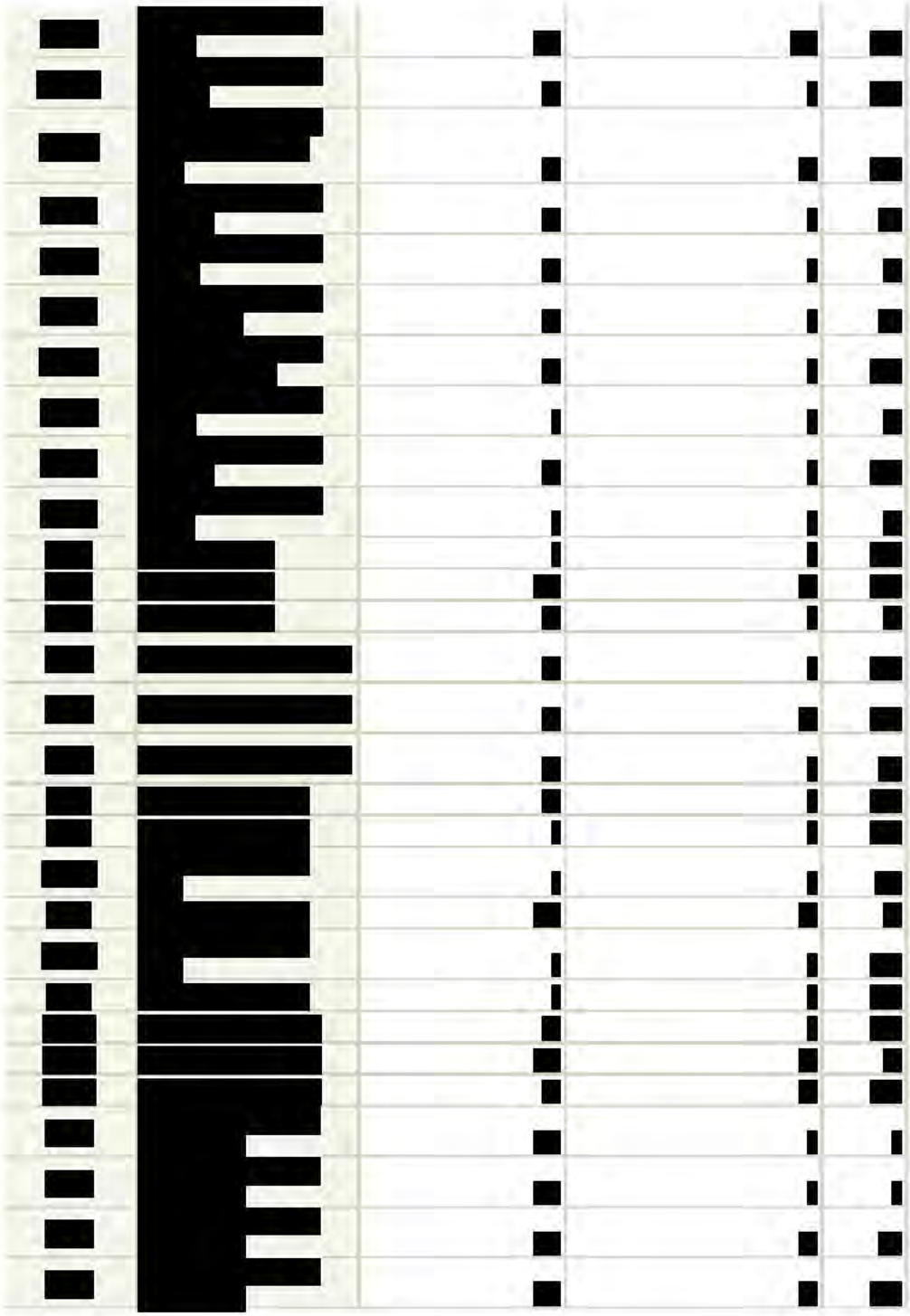


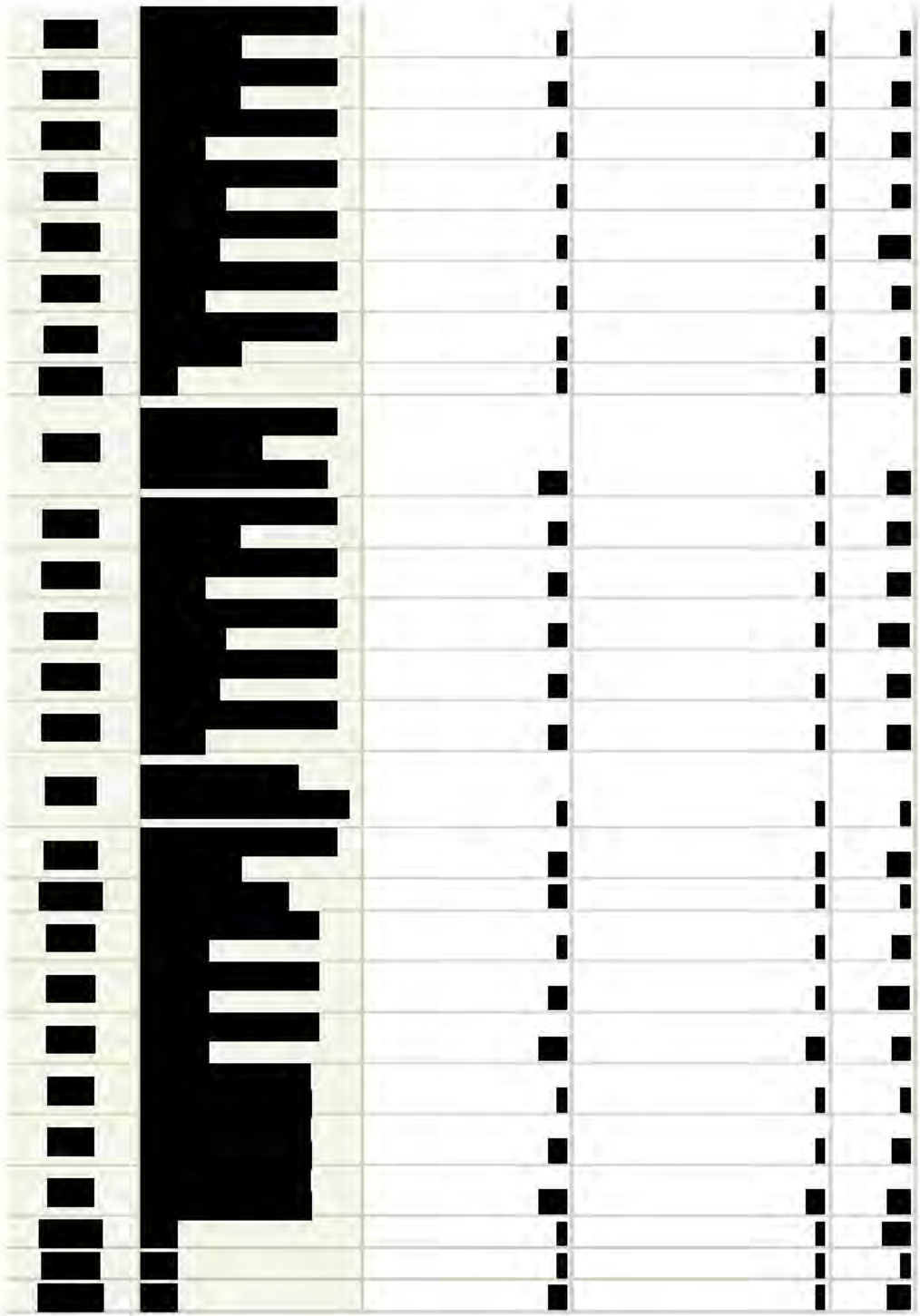
| DAFSC | Description | # Manning as of Sep 2018 | # Contingency TDY (Type 1) | % |
|---|---|---|---|---|

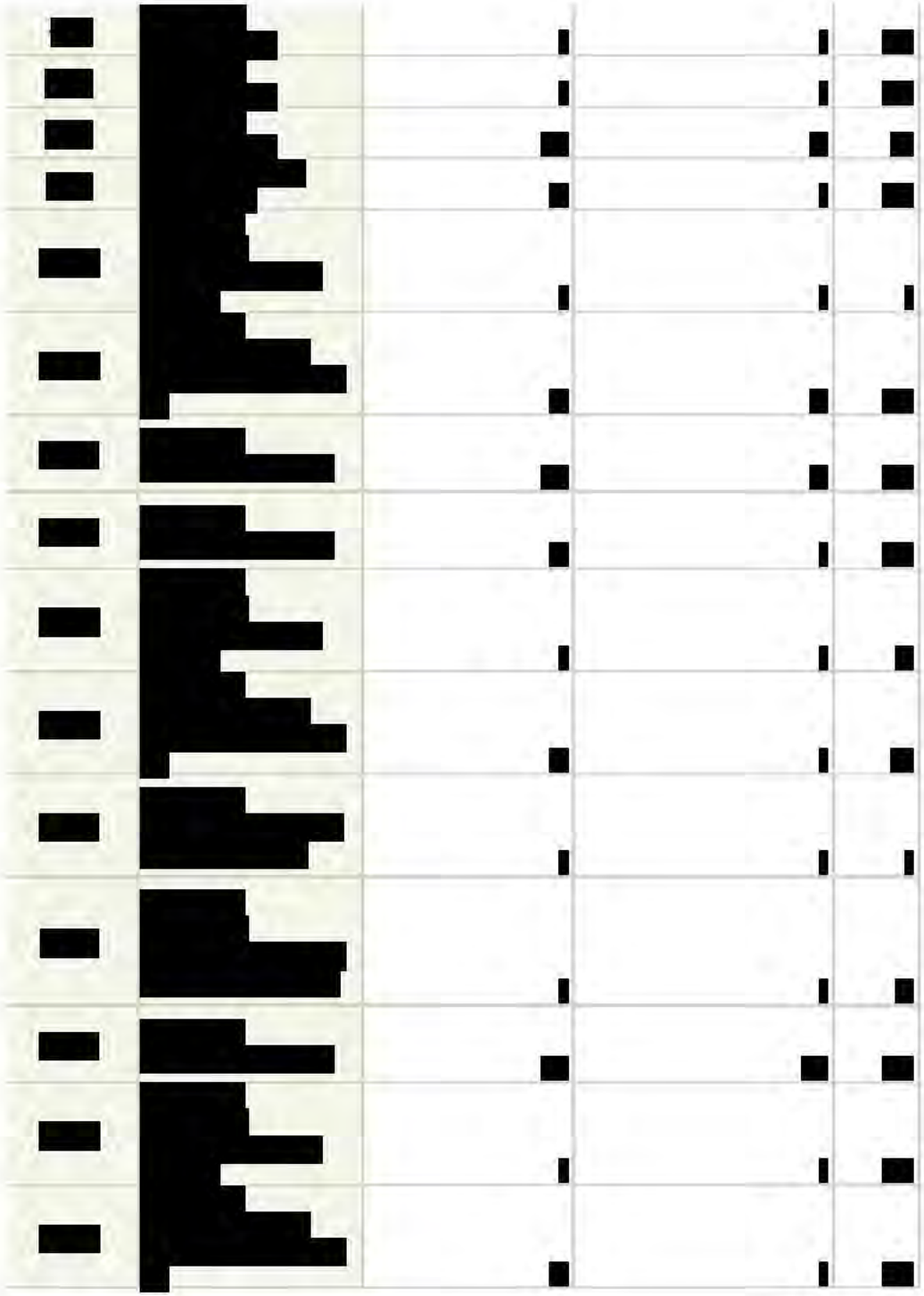


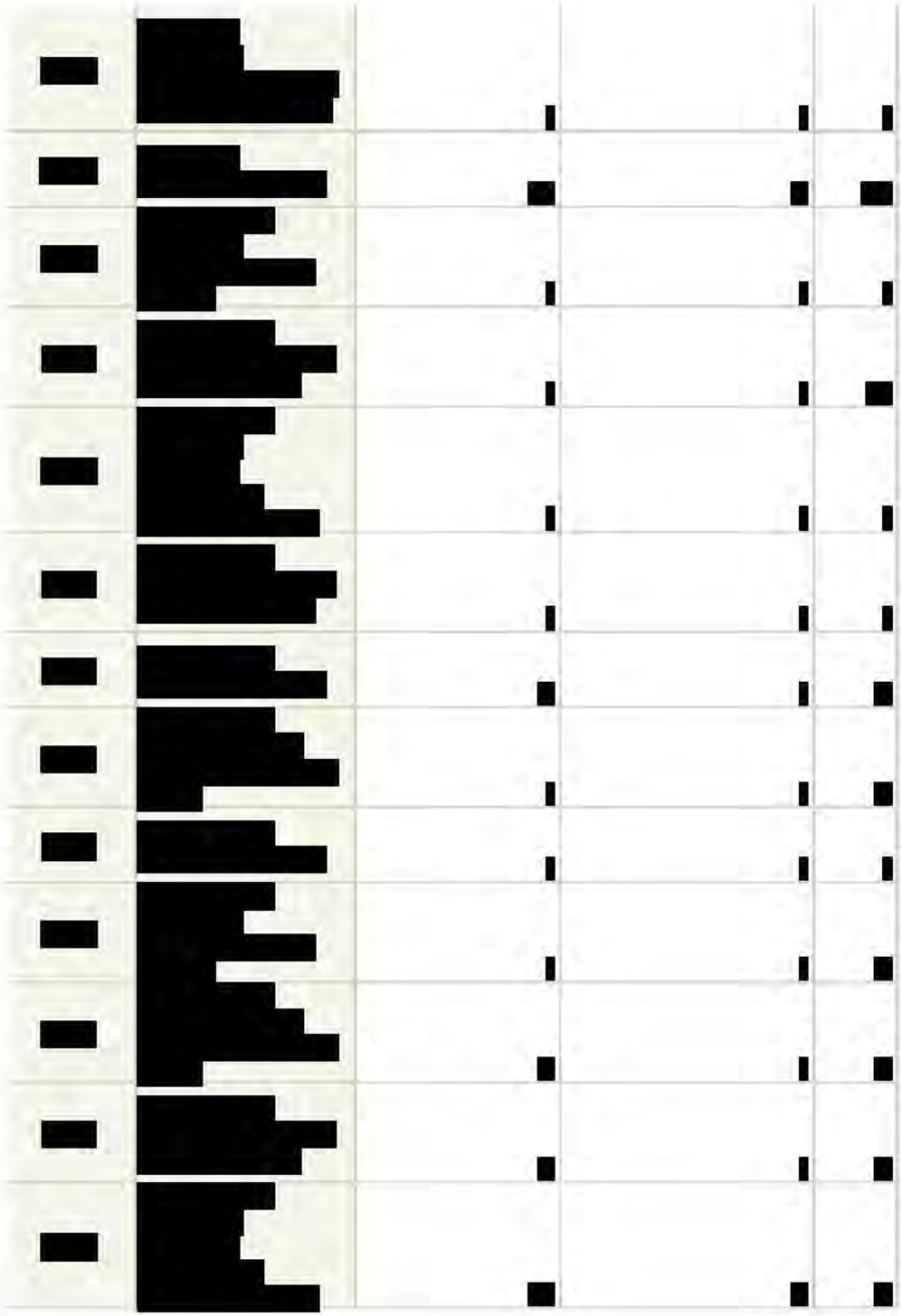


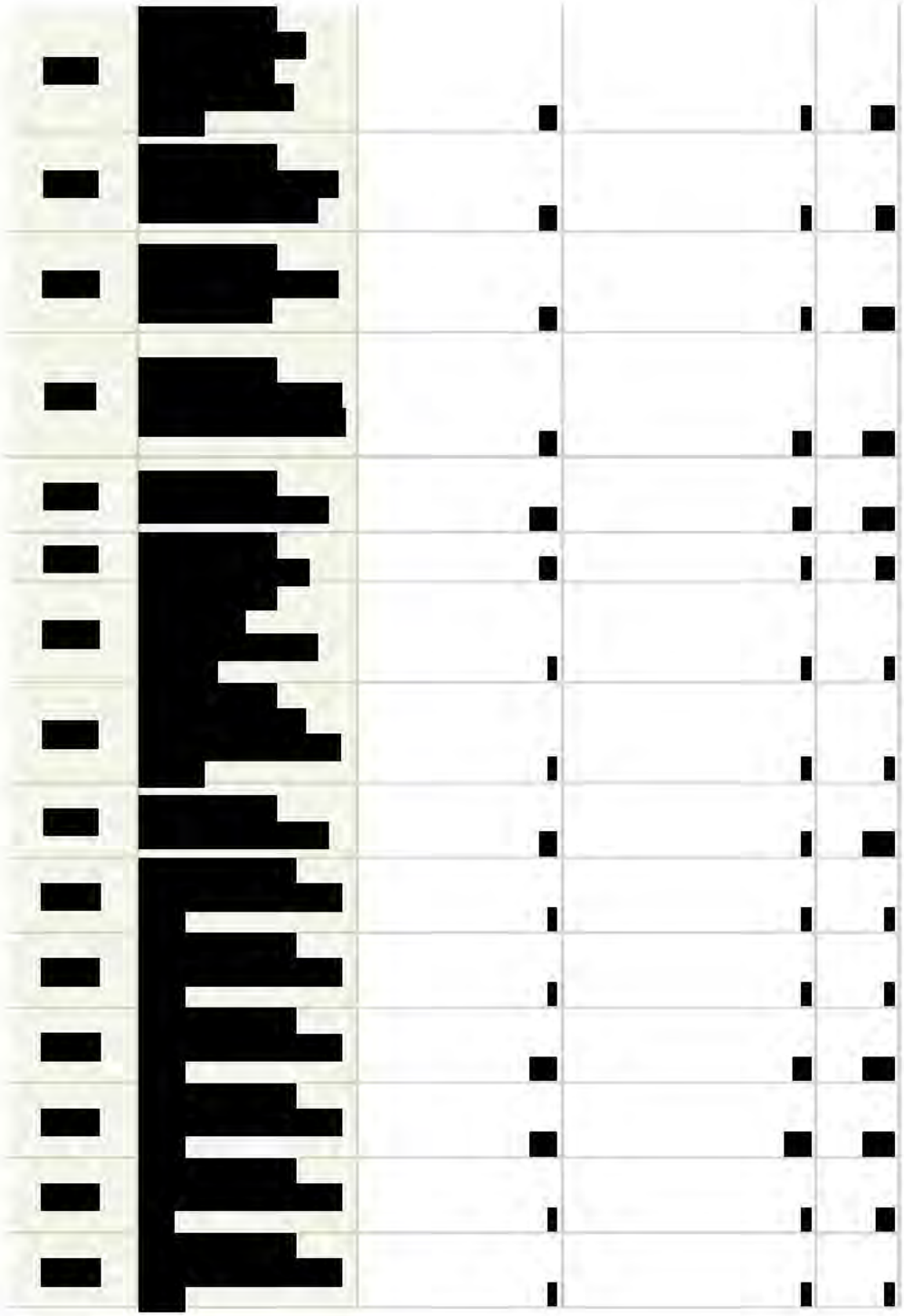


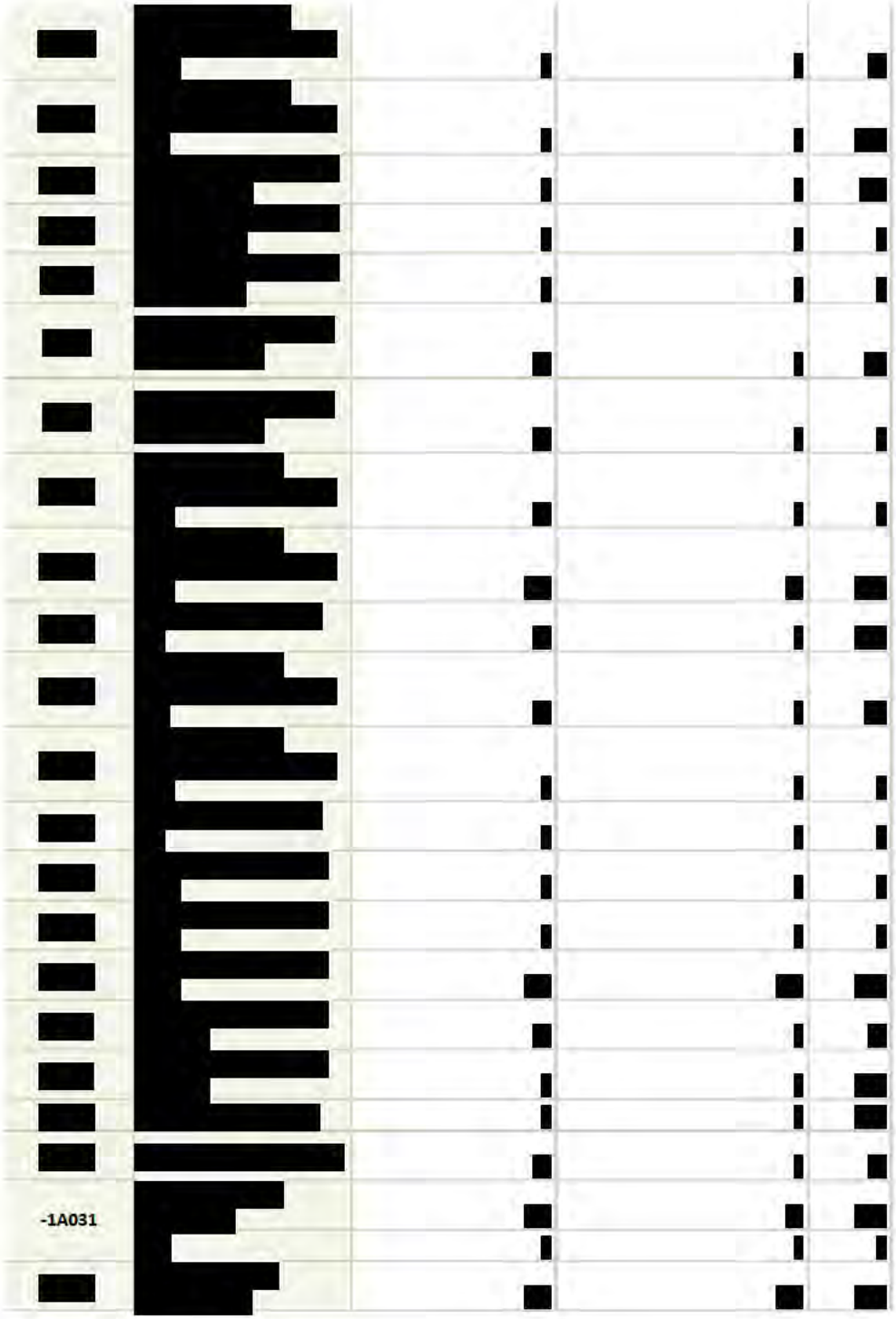








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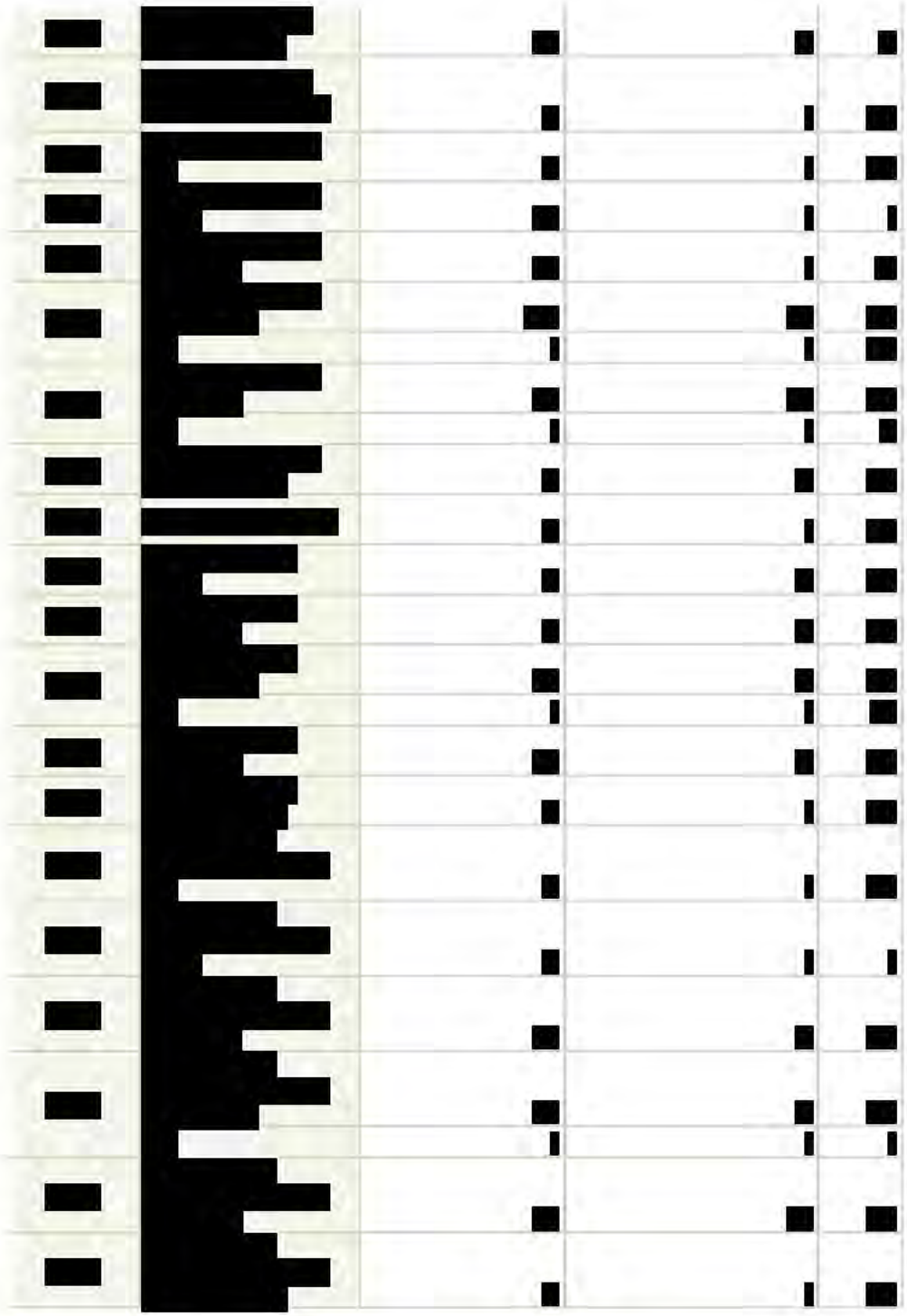
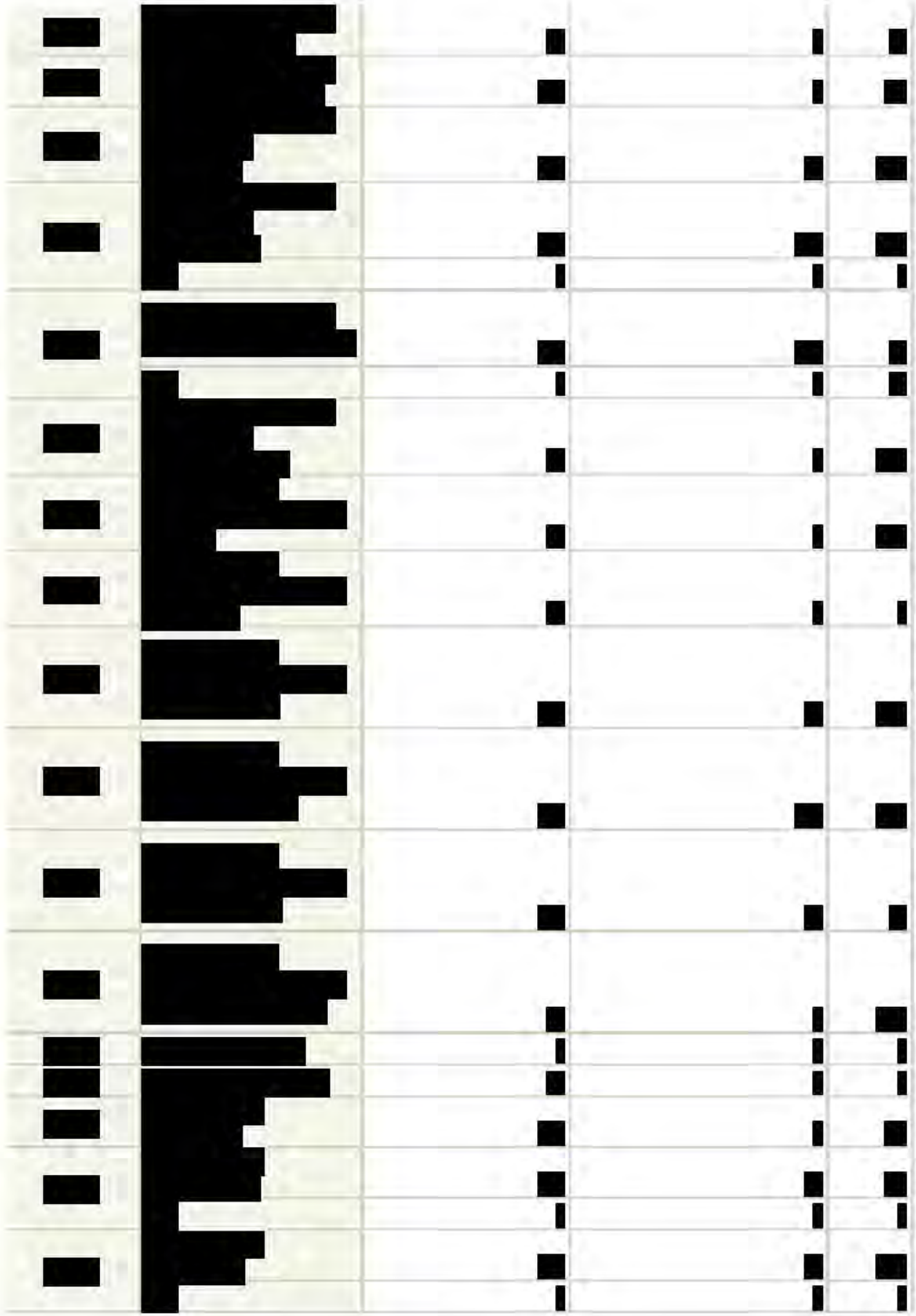
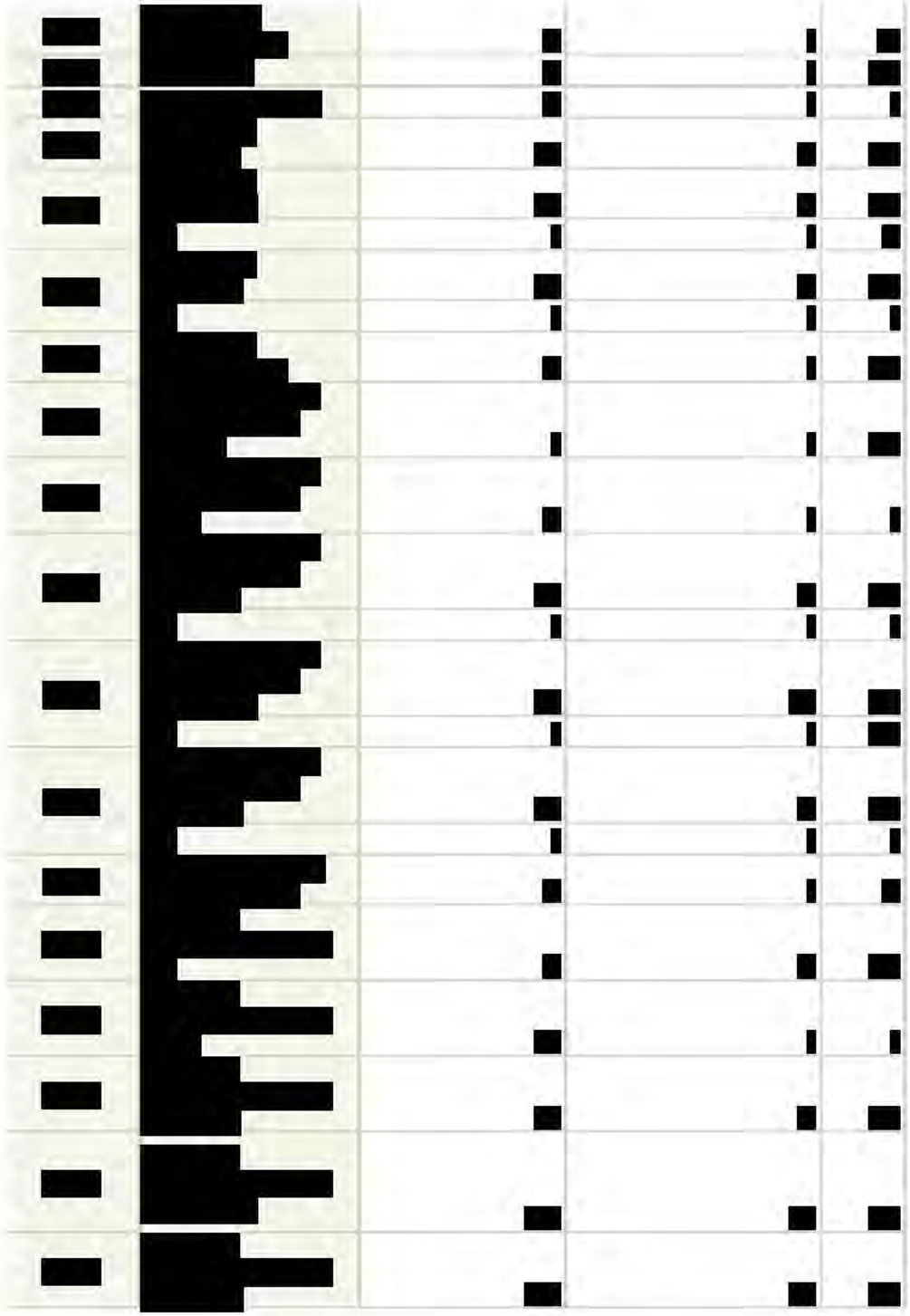
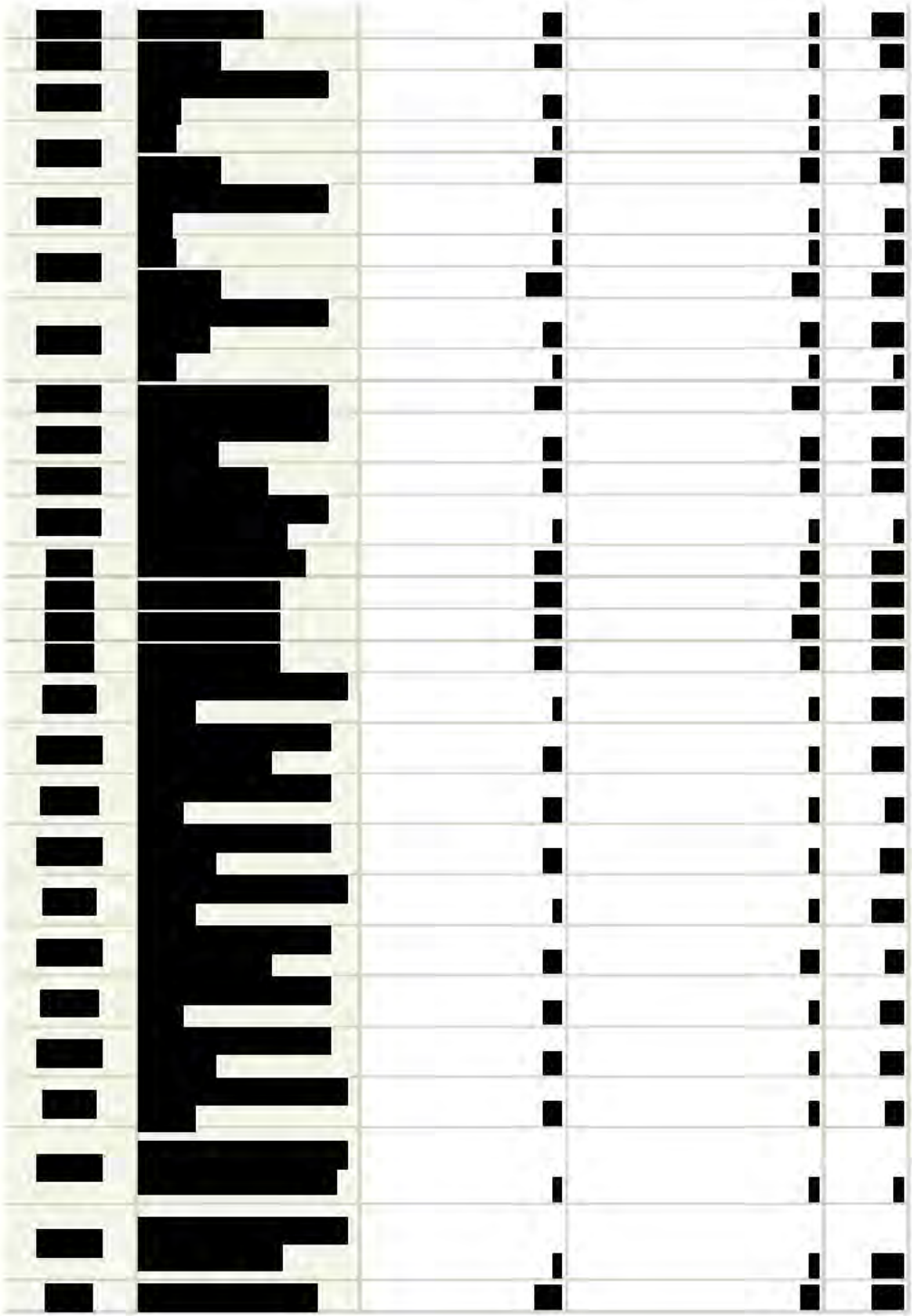
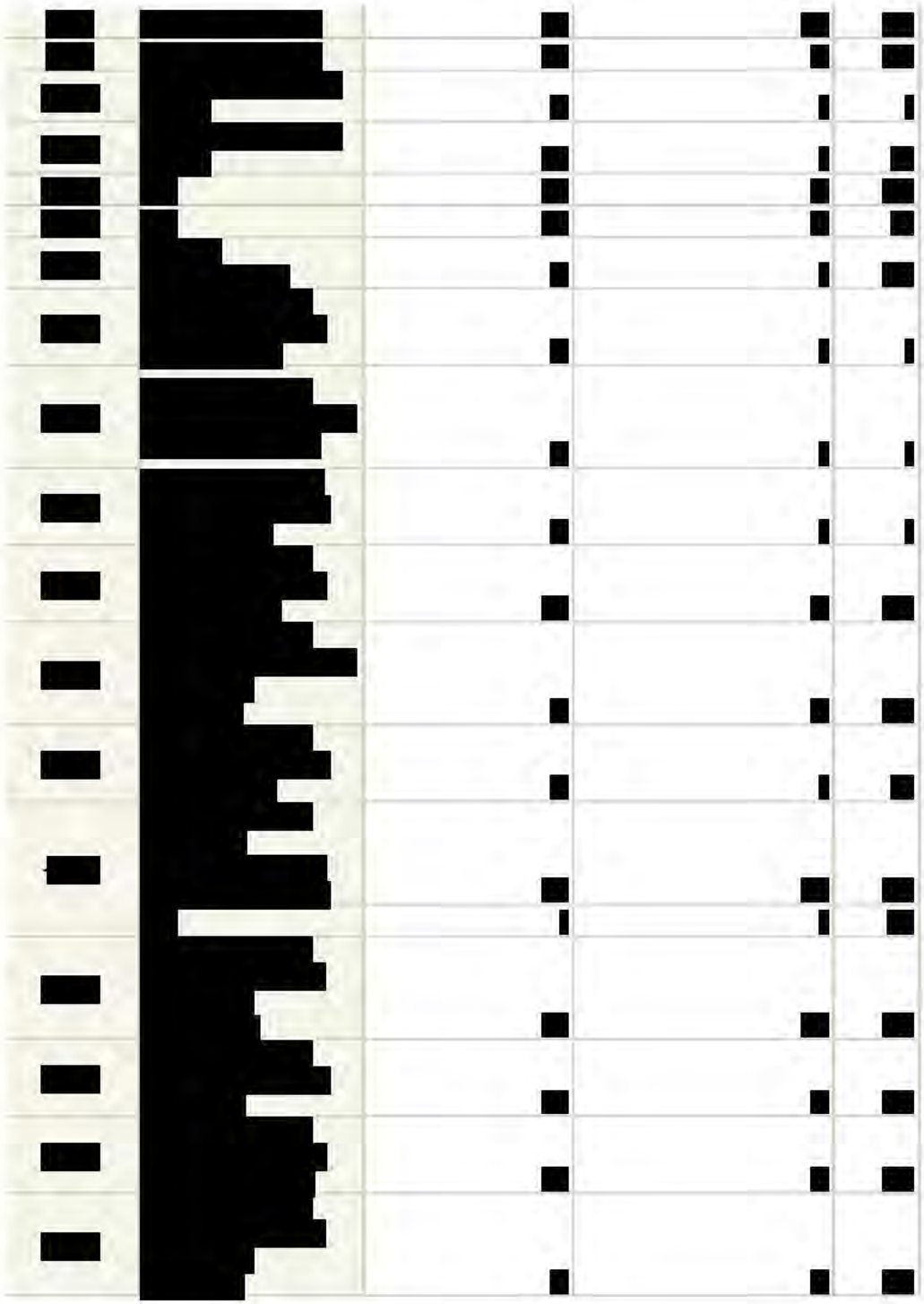
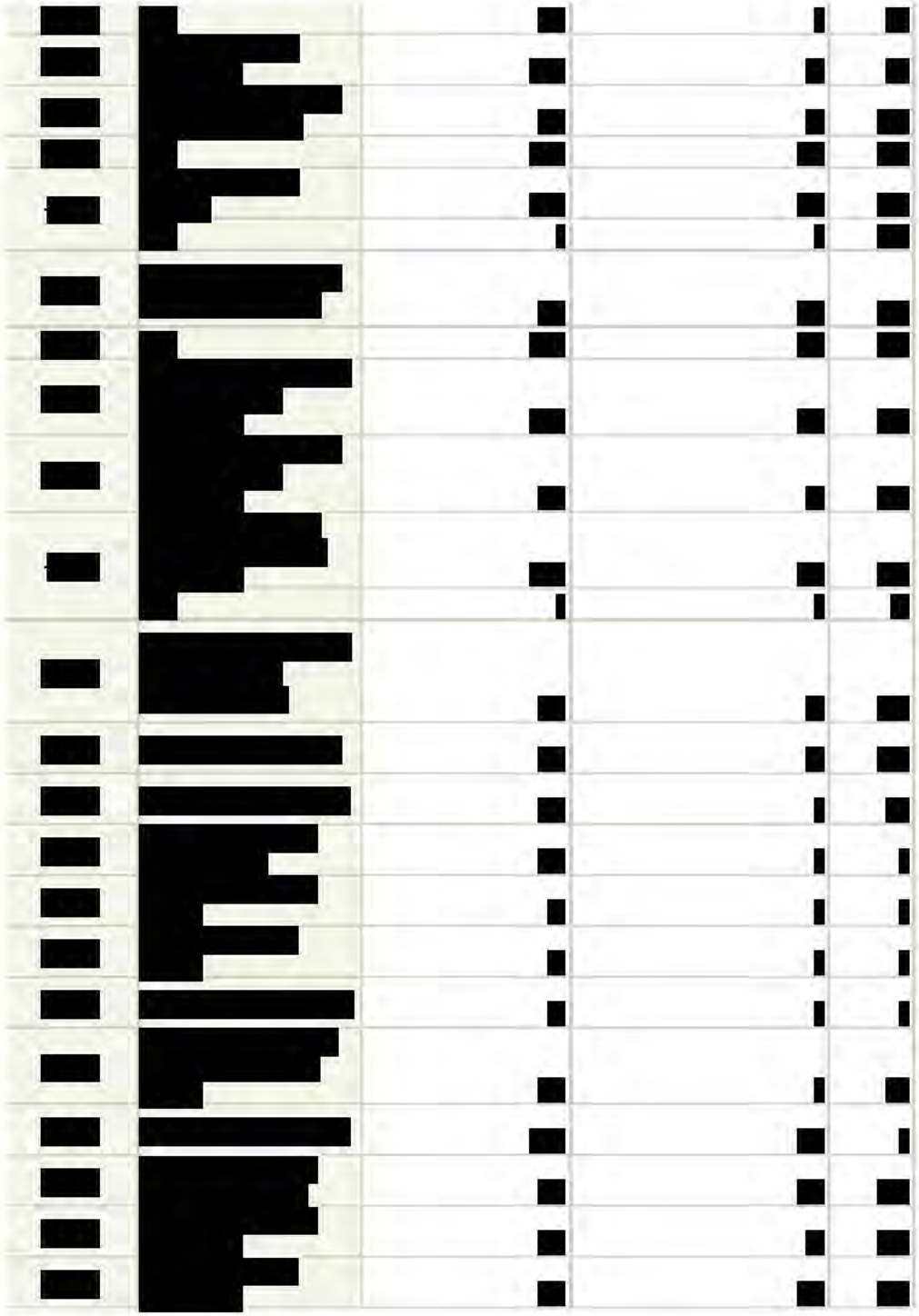


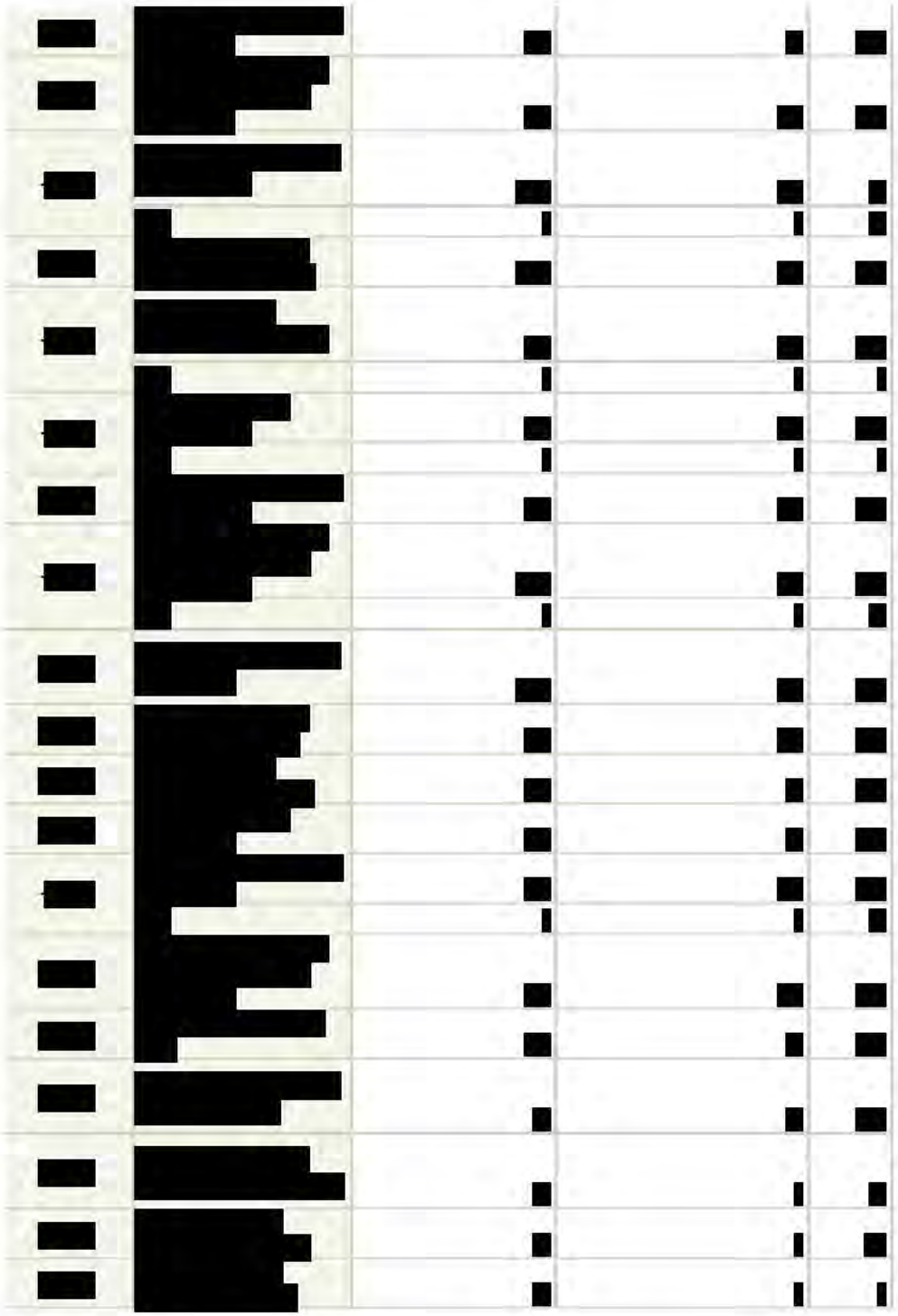


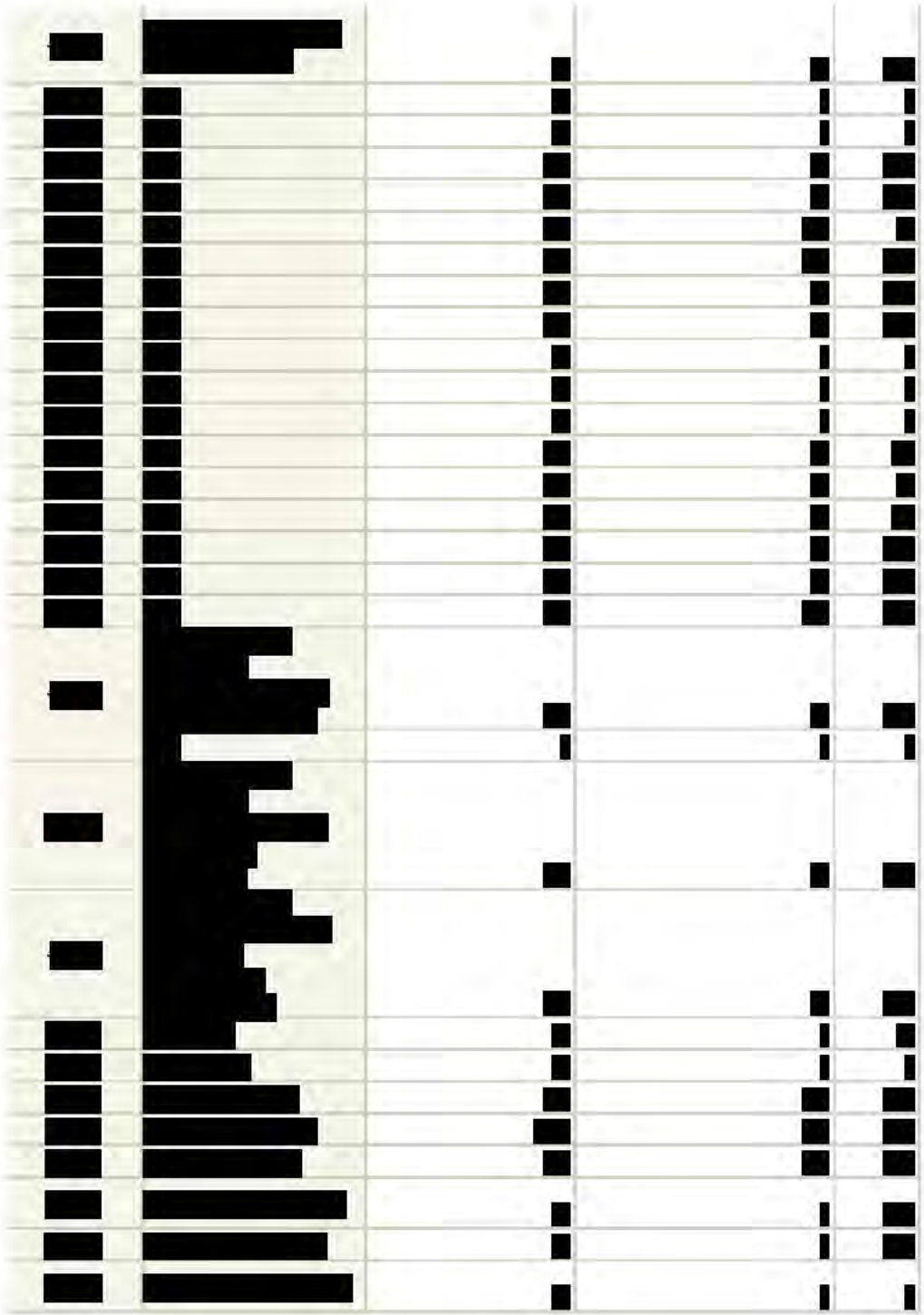


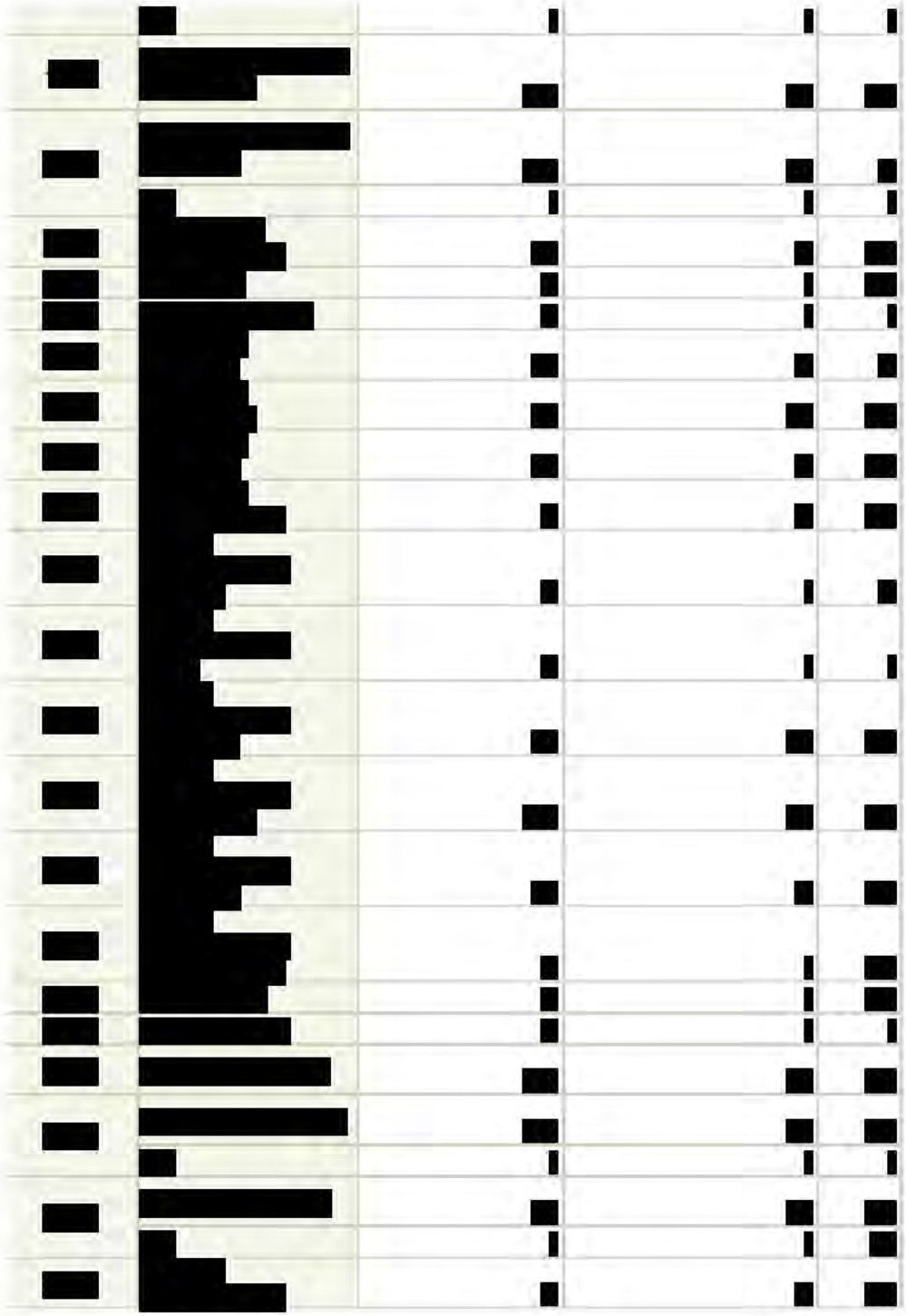


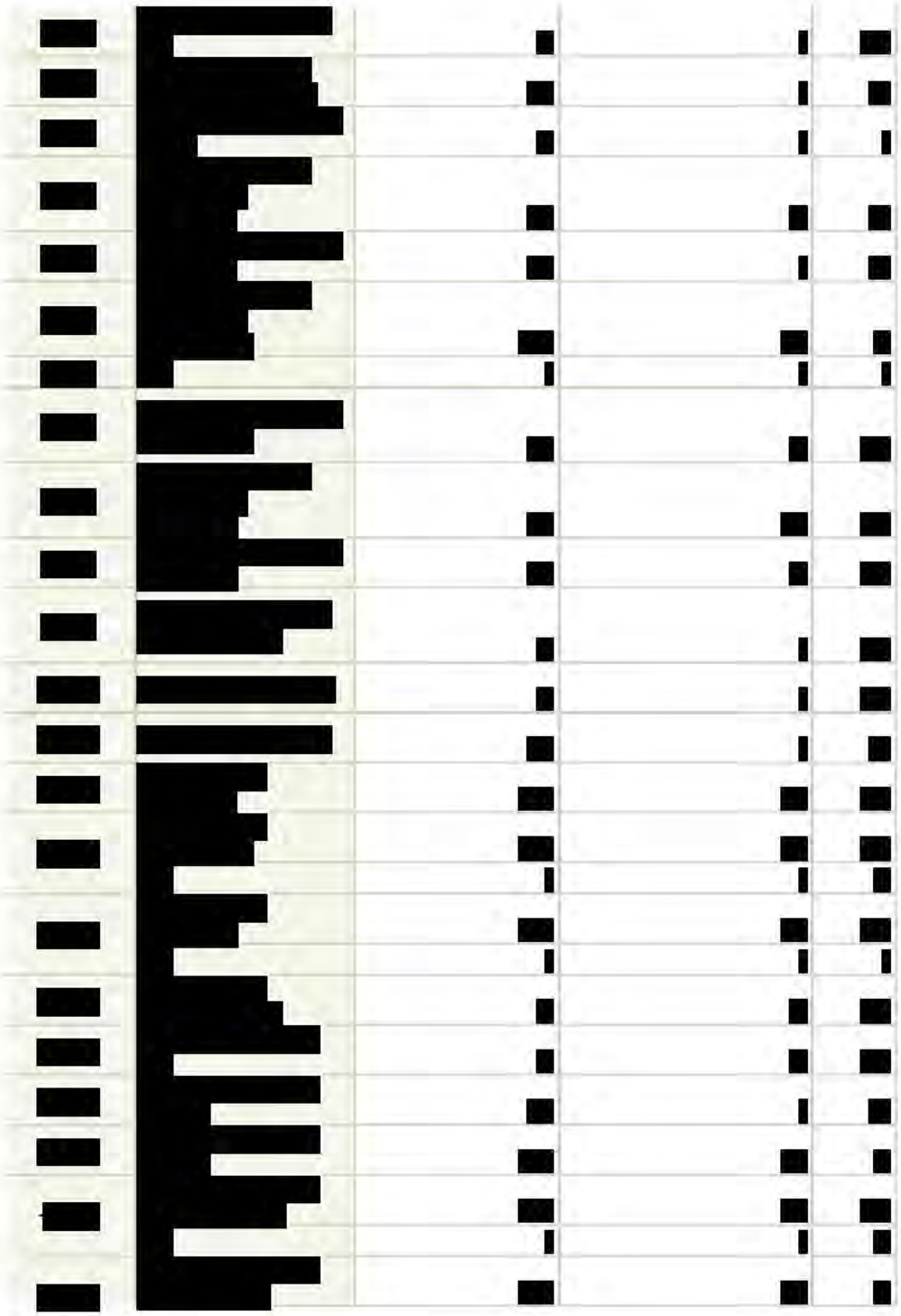


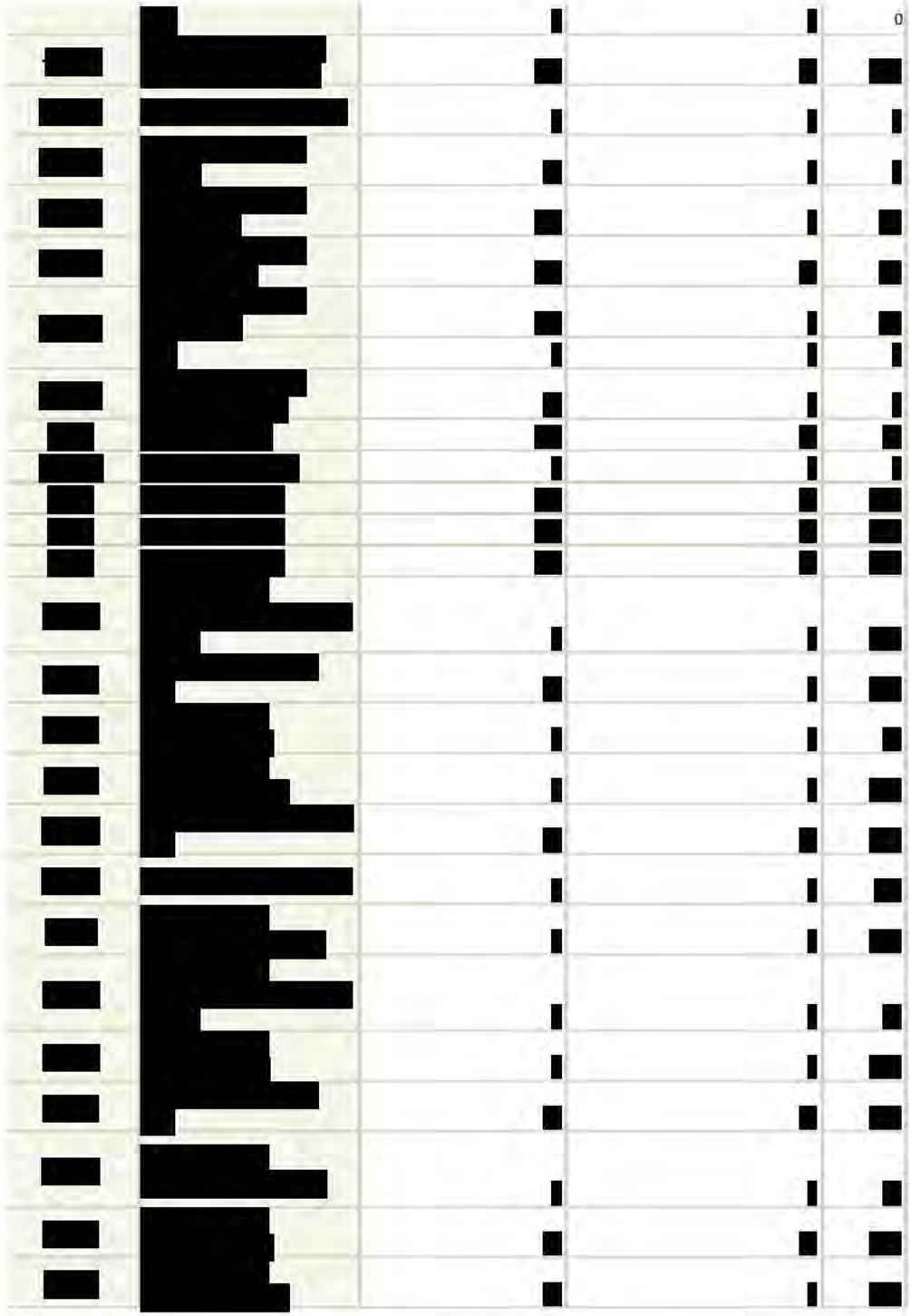


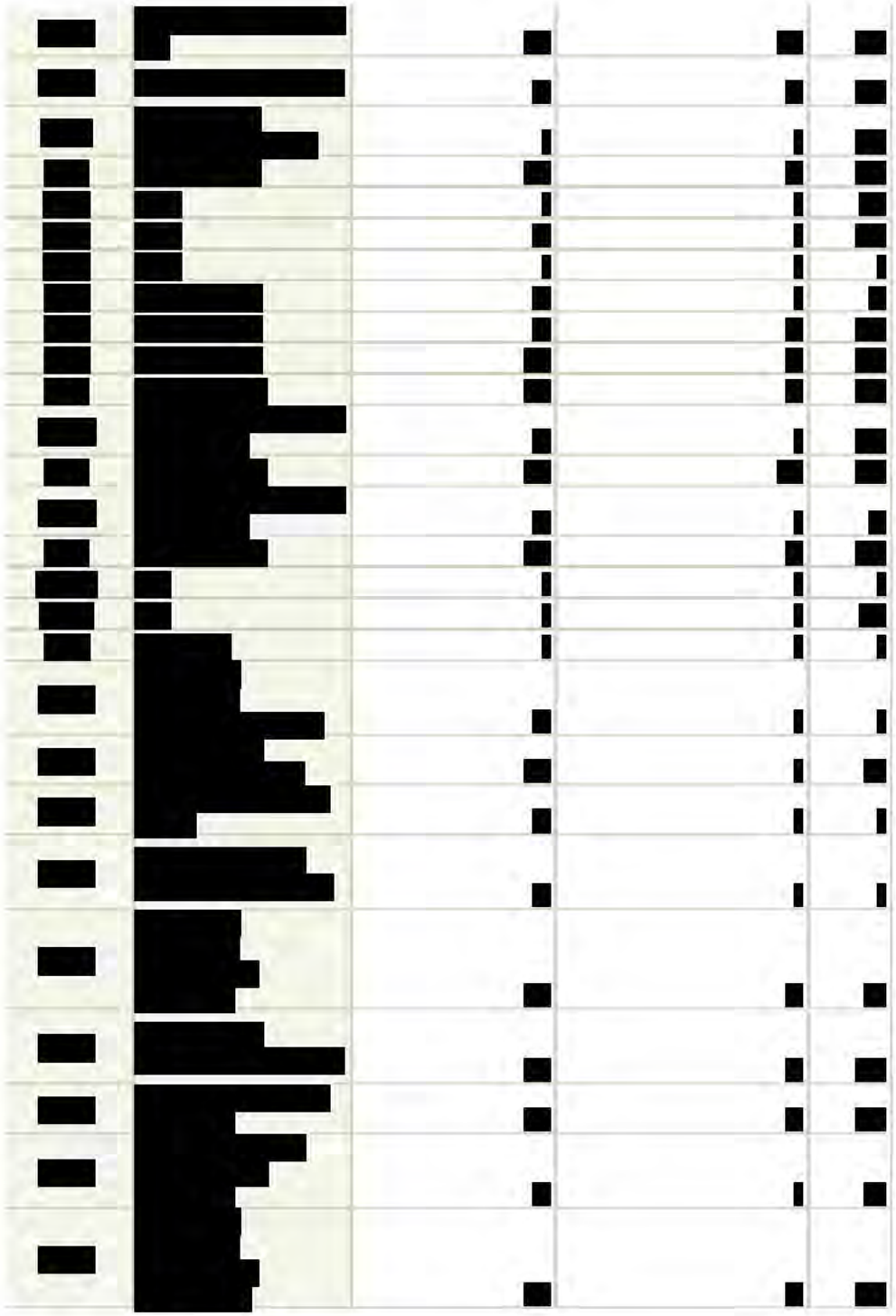


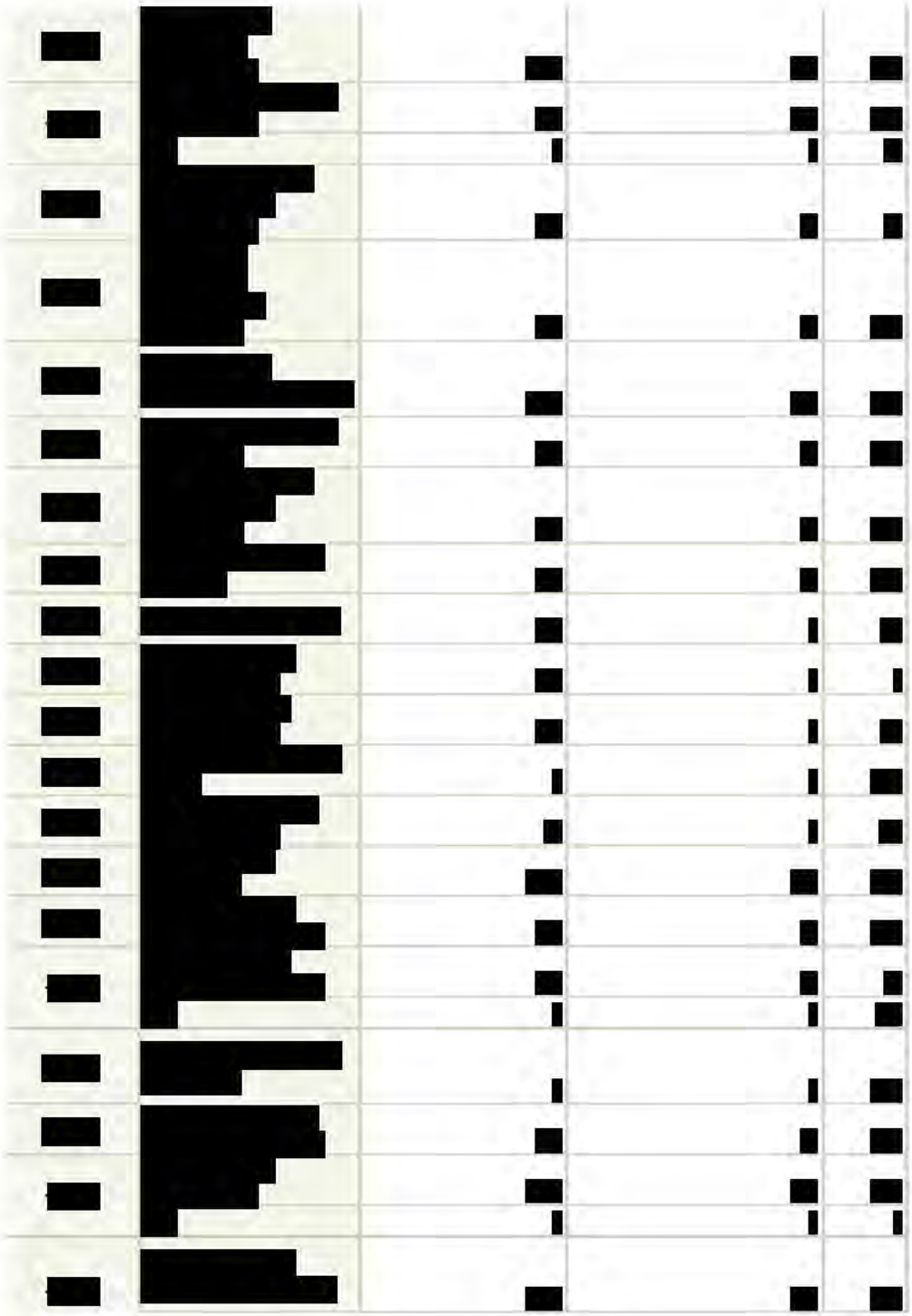


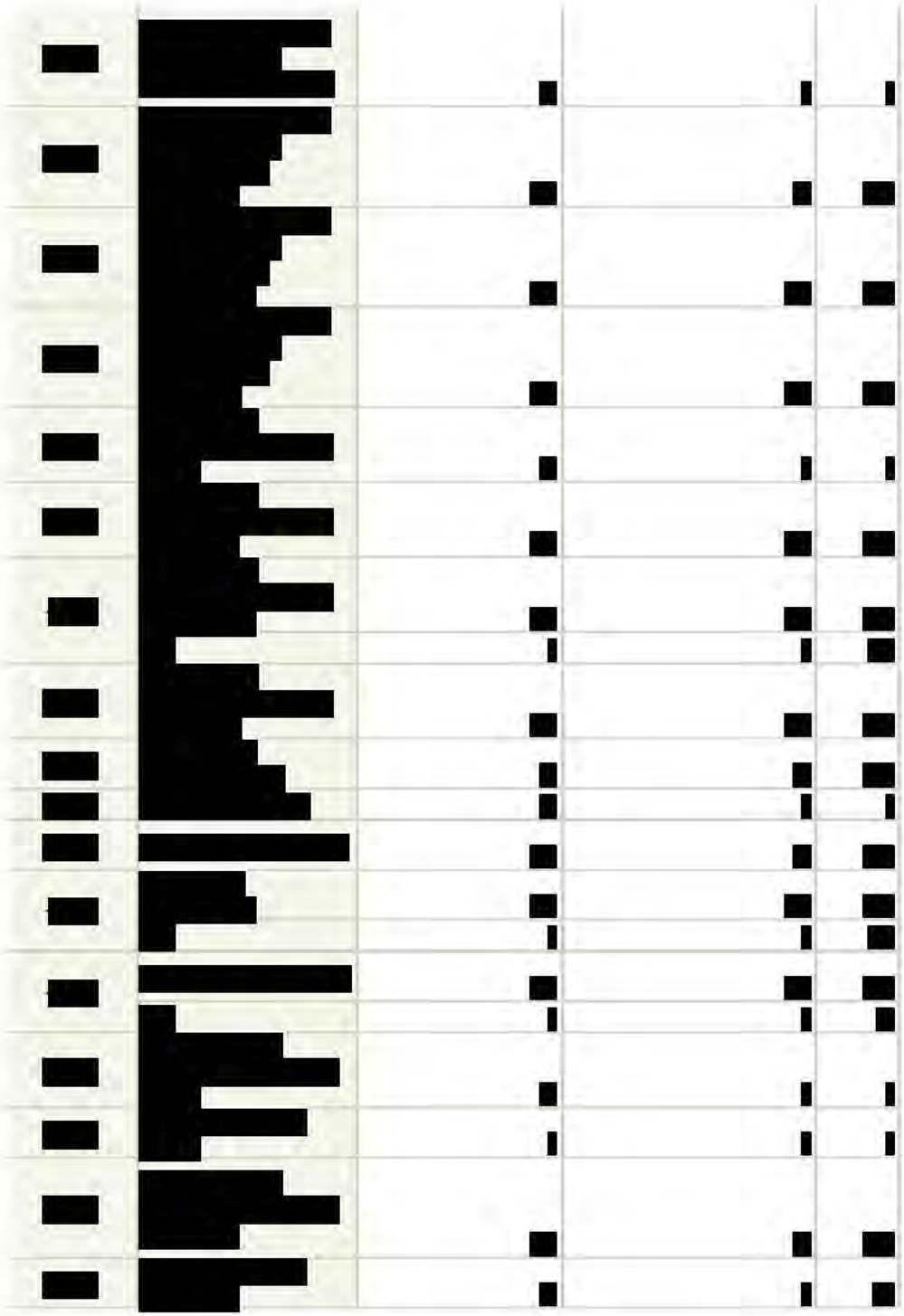


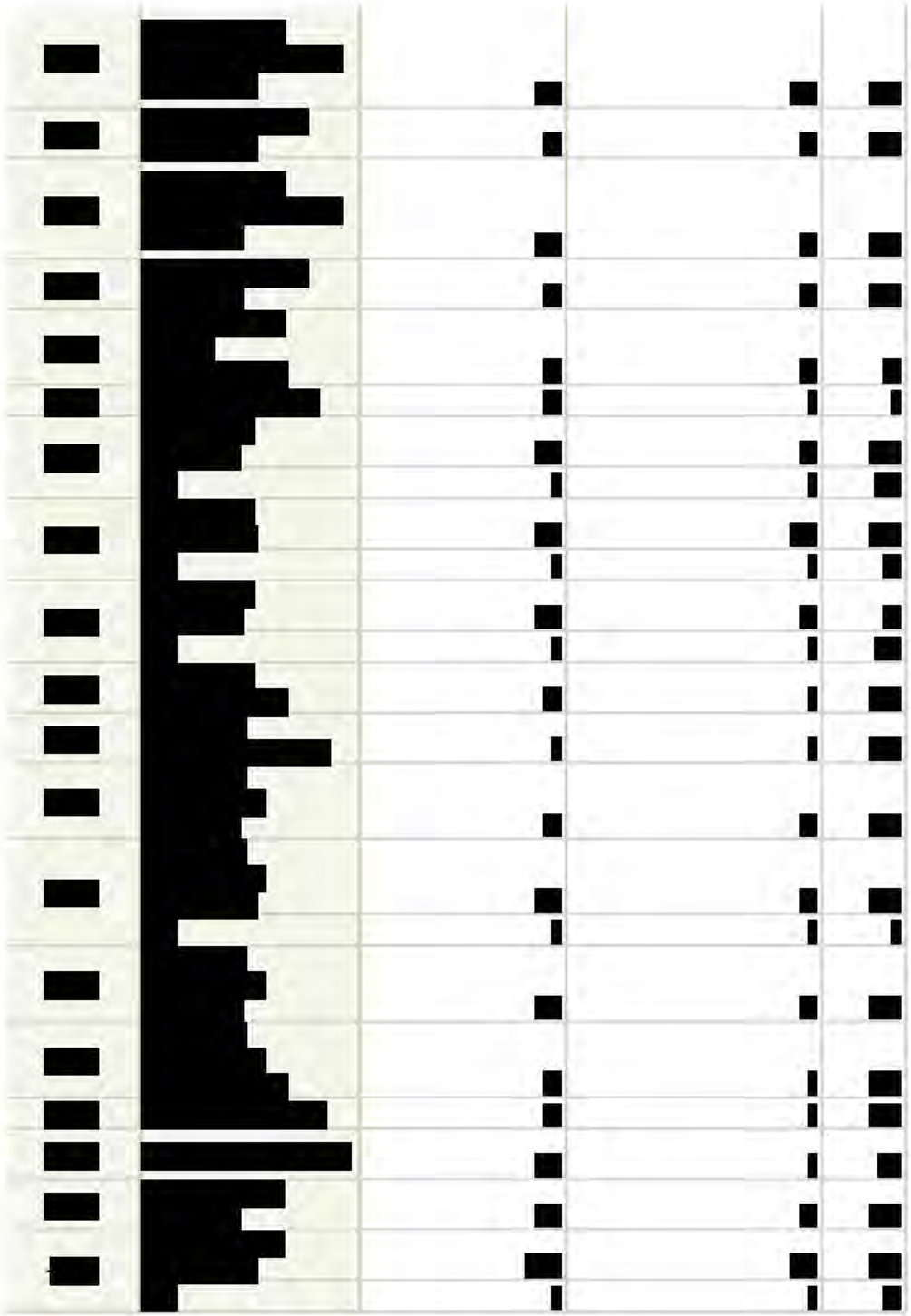


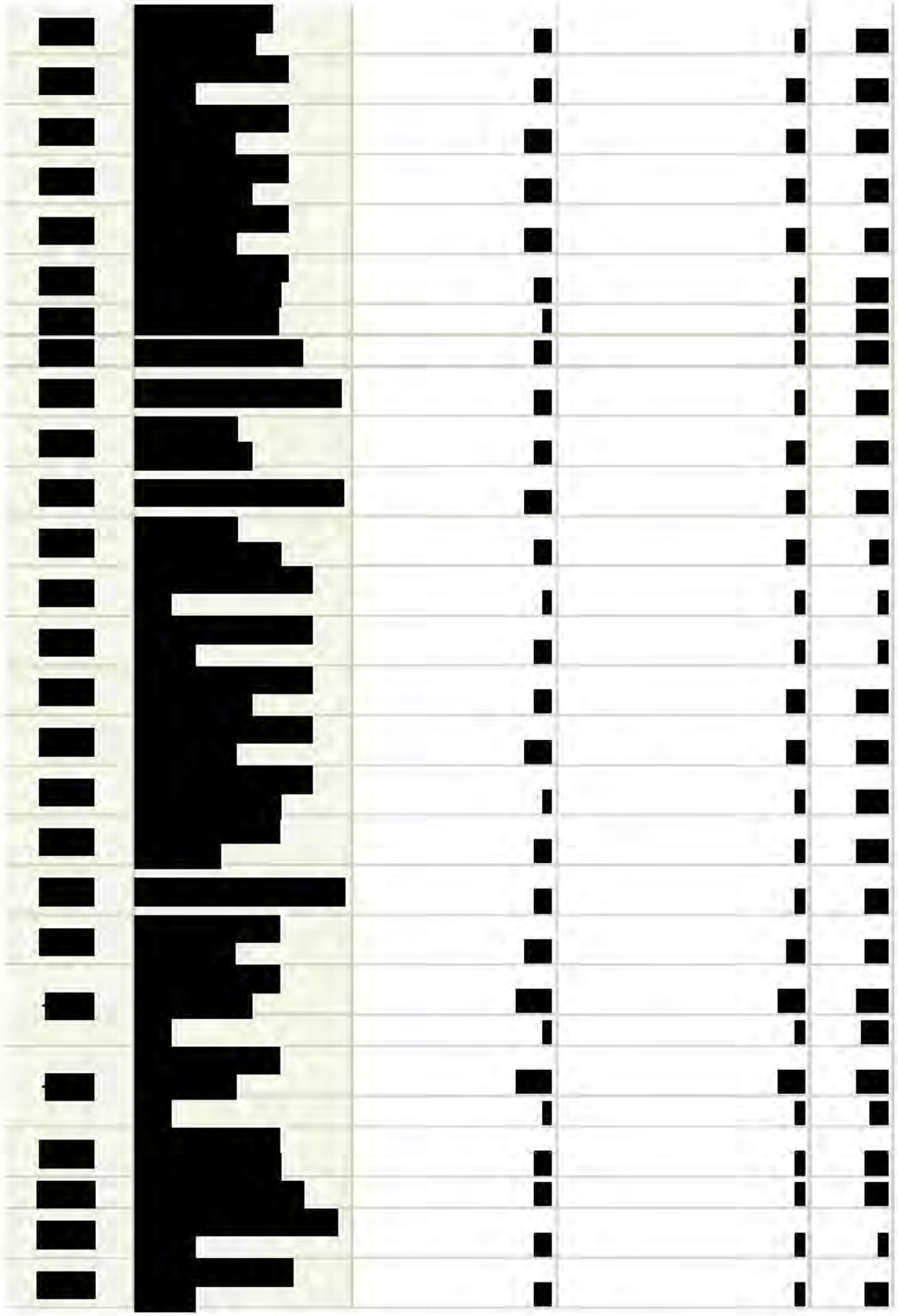


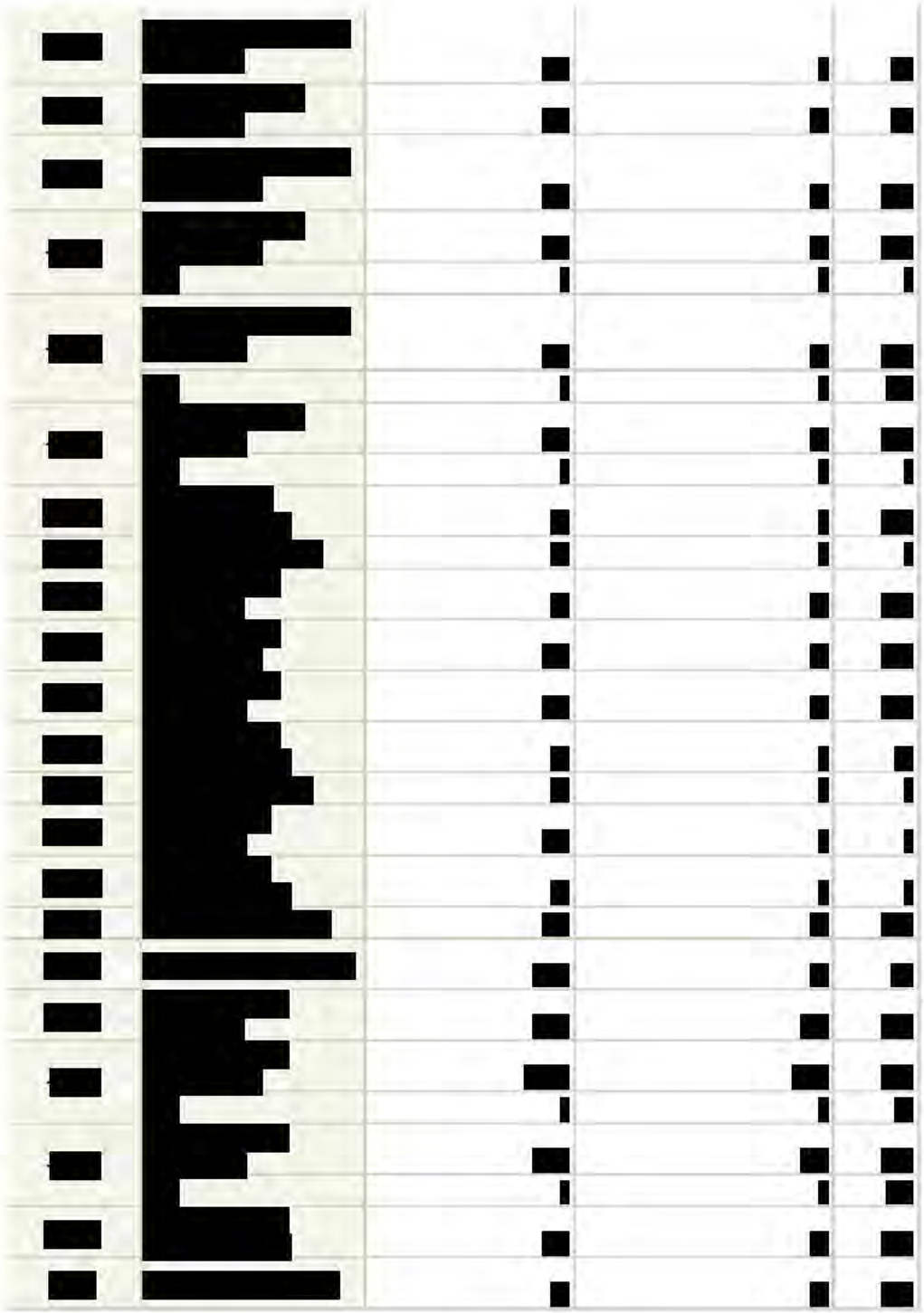


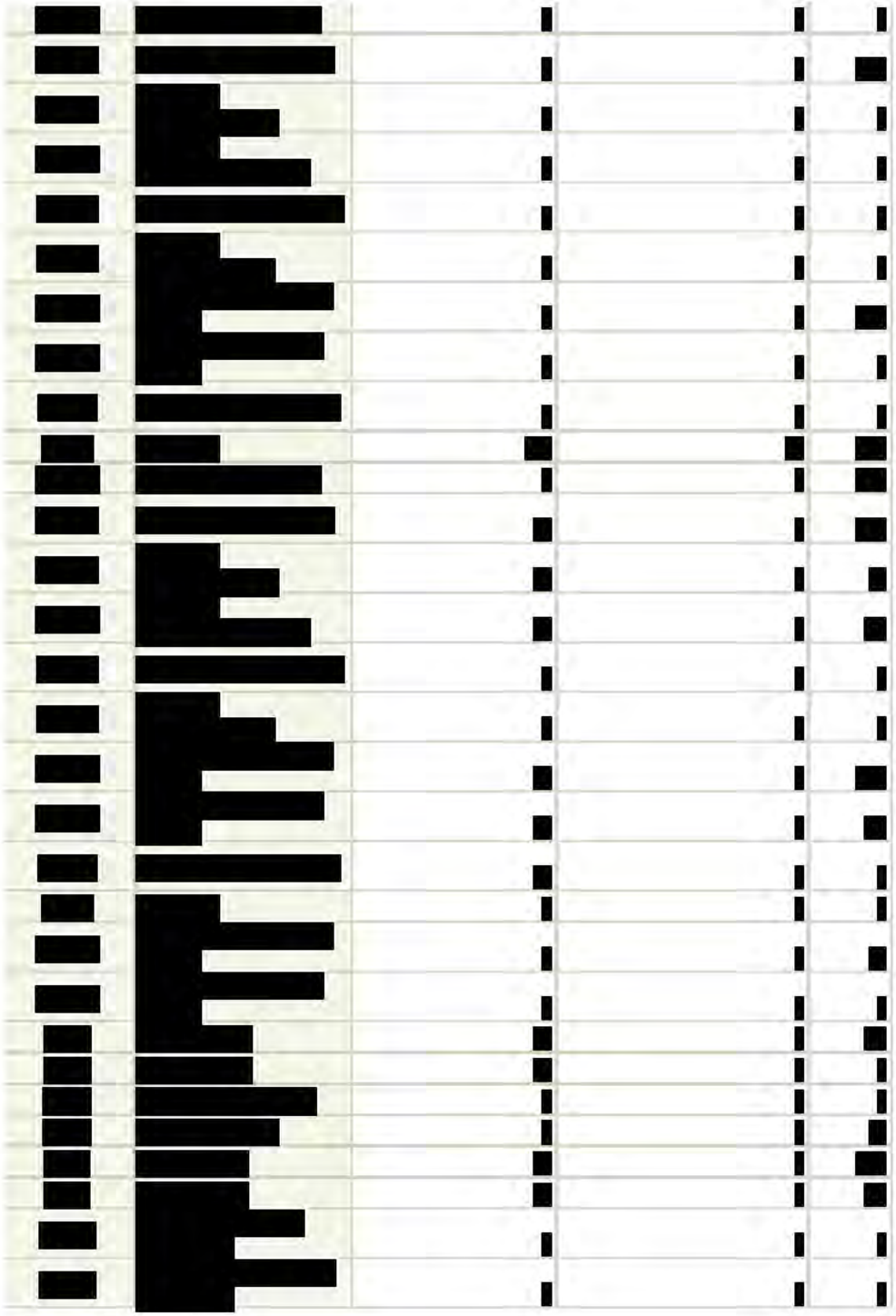


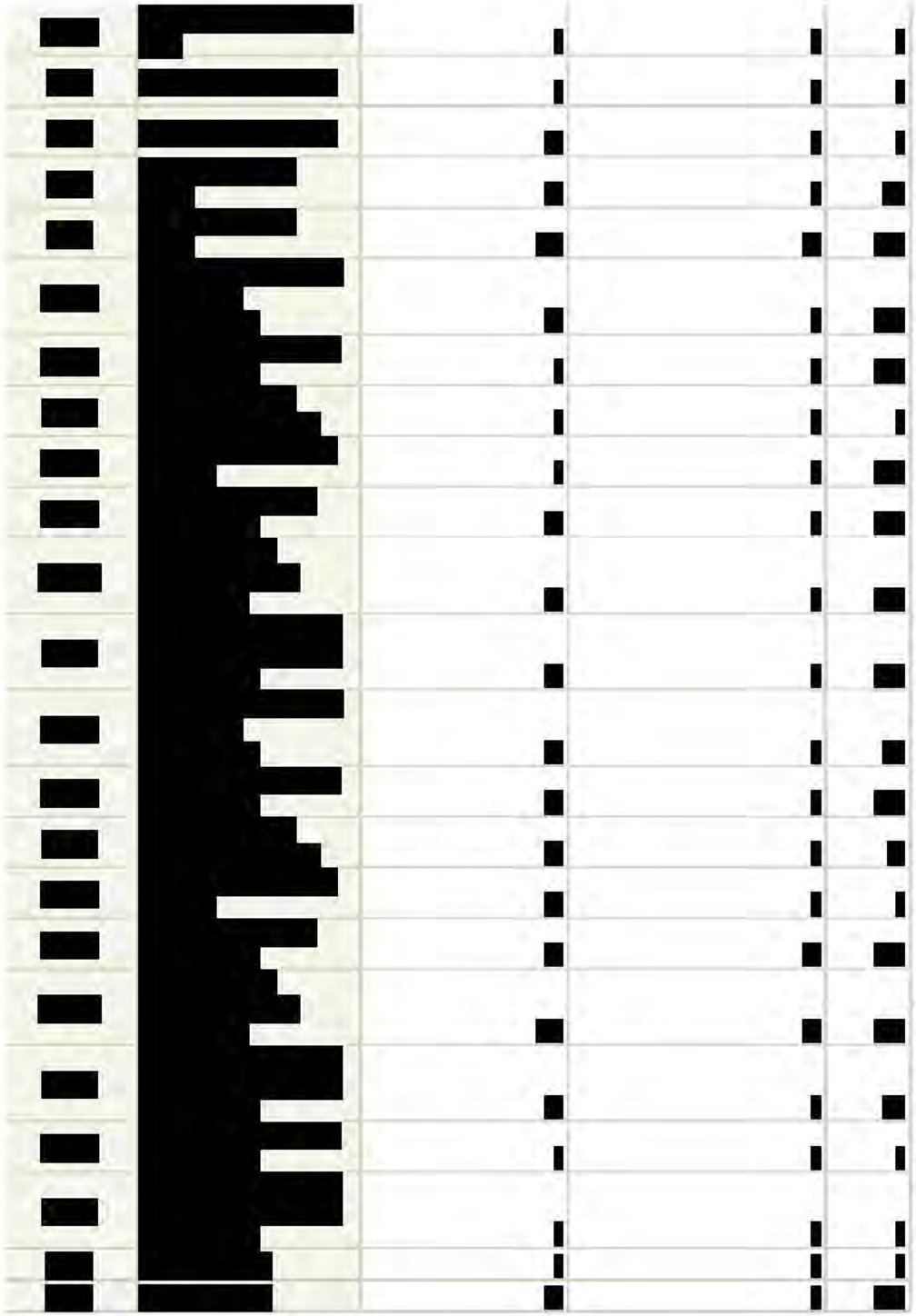


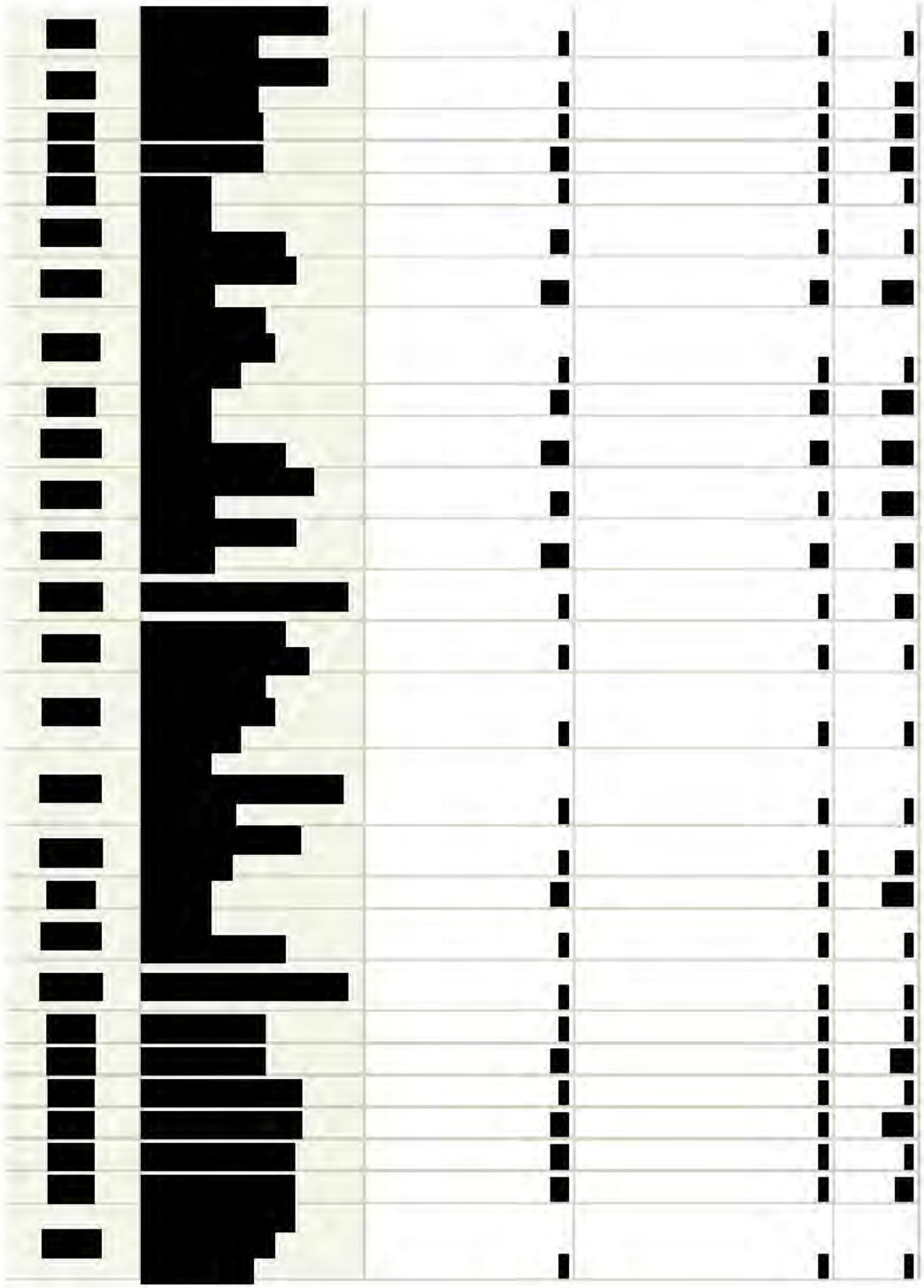


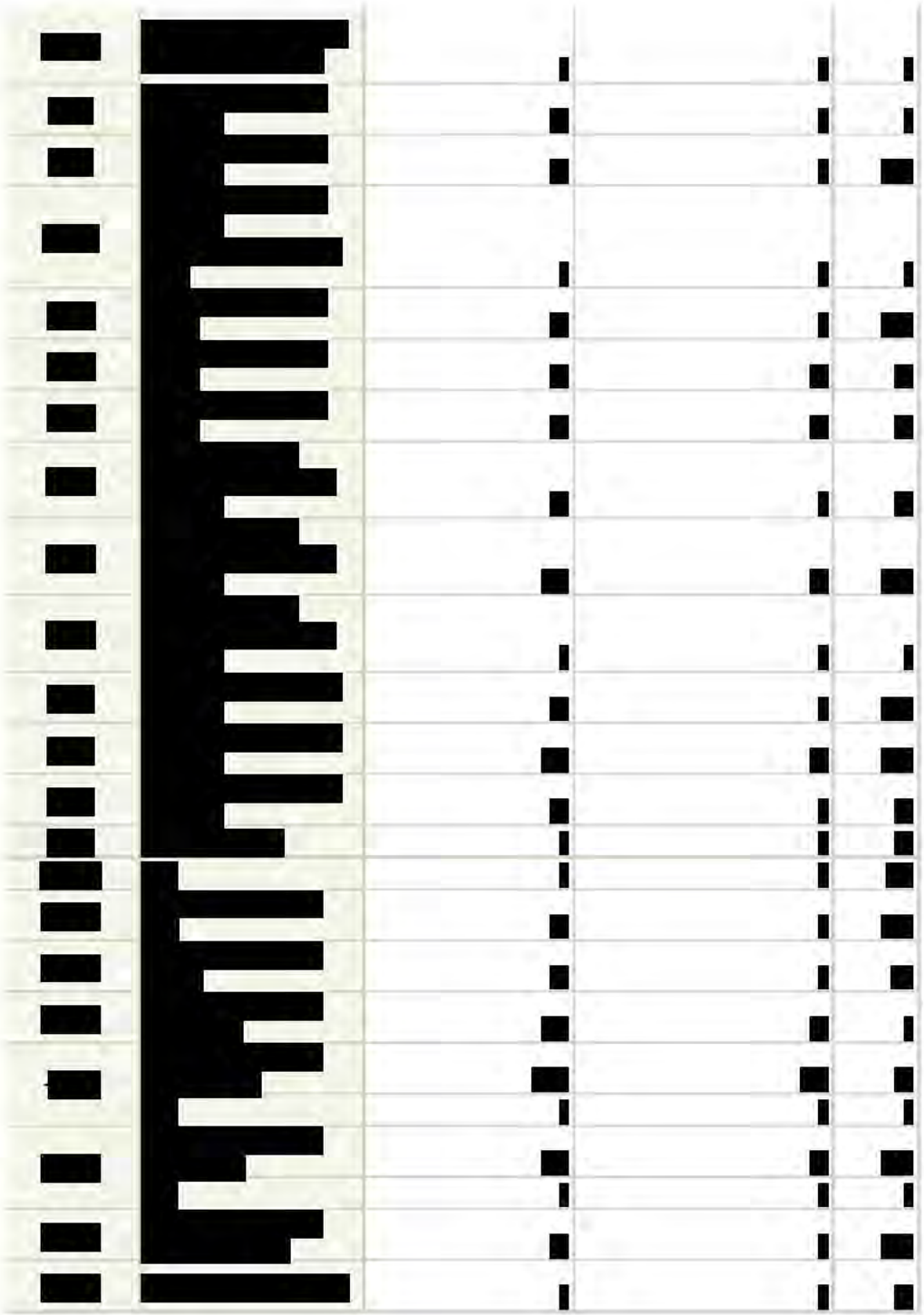


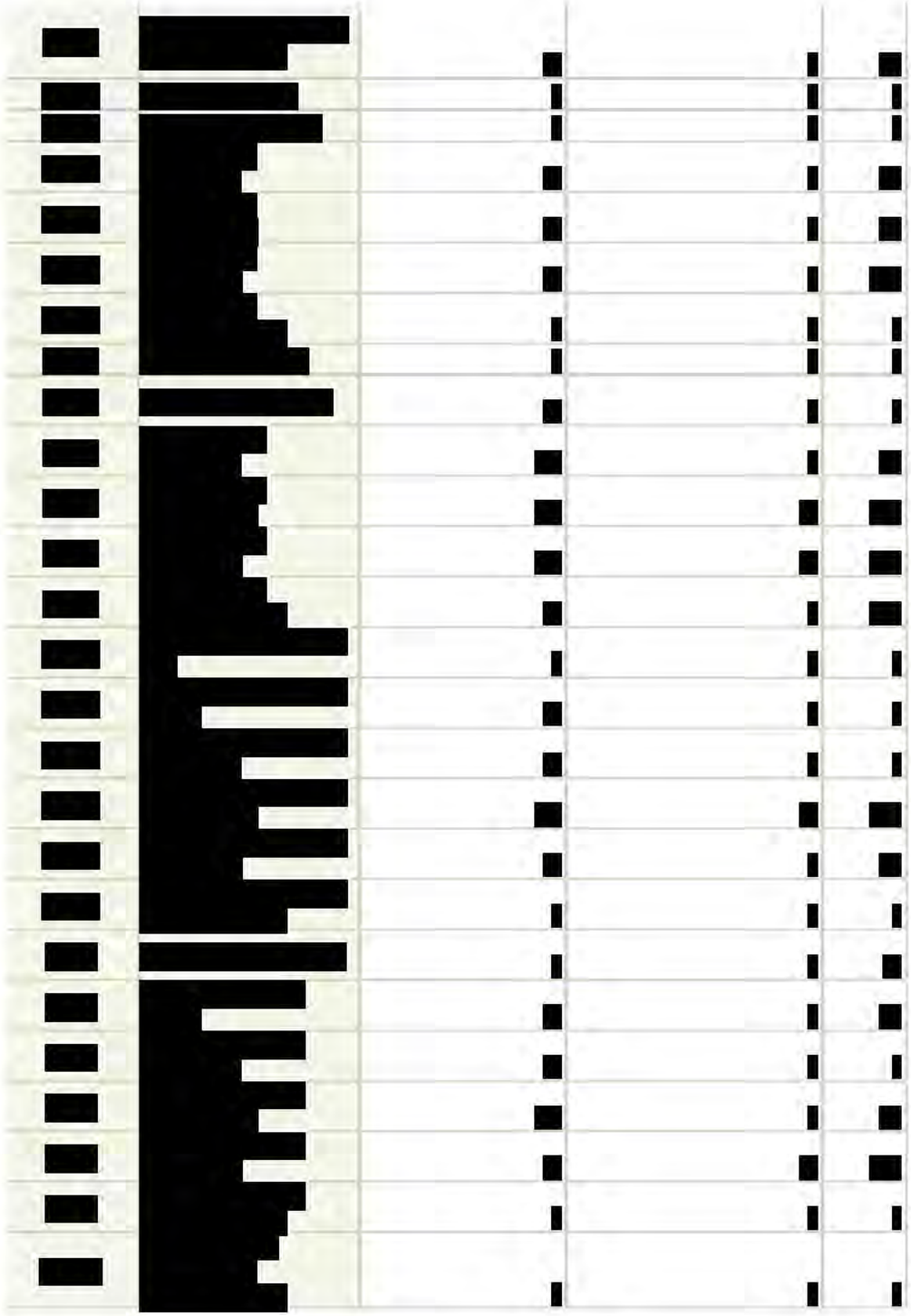


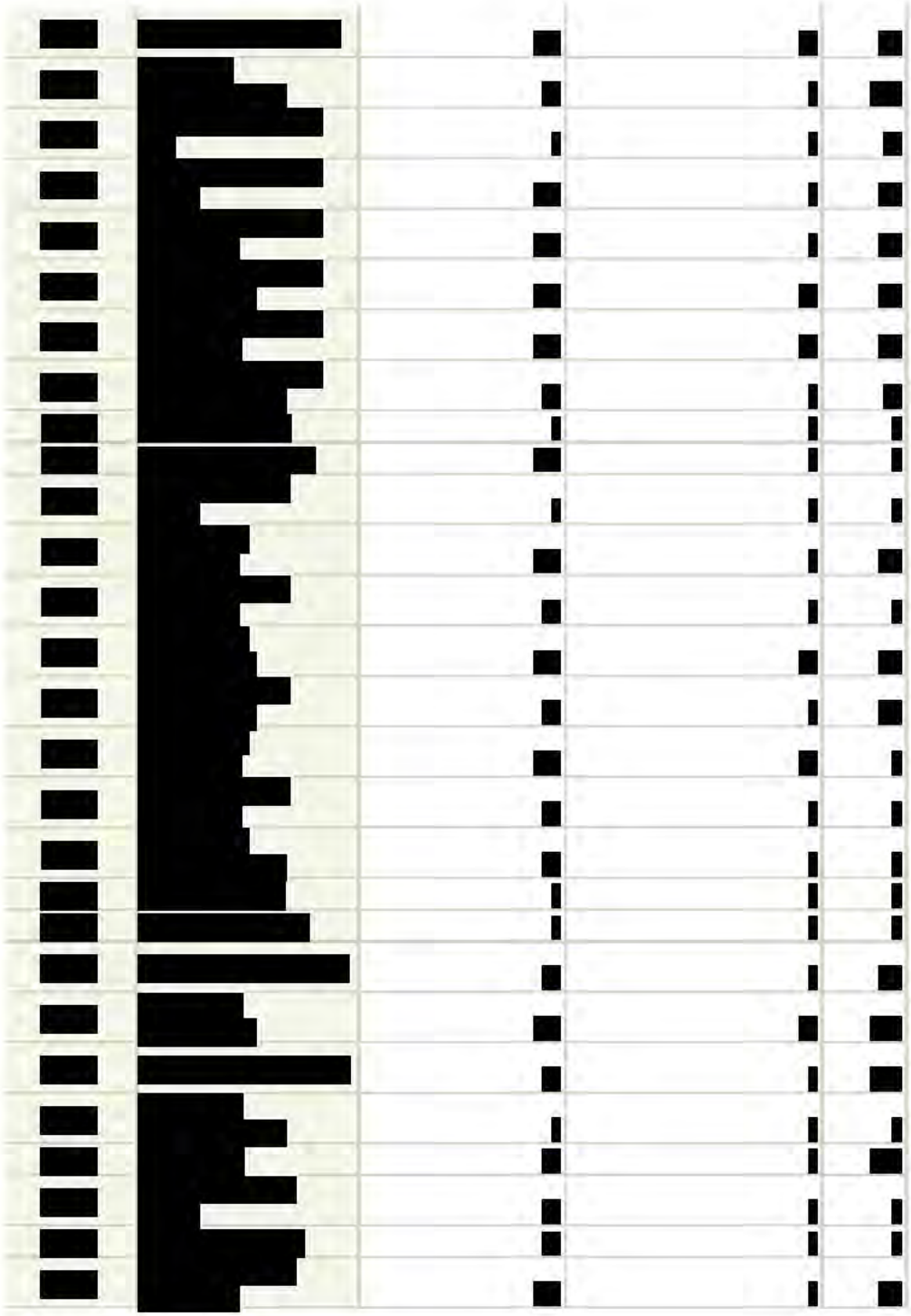


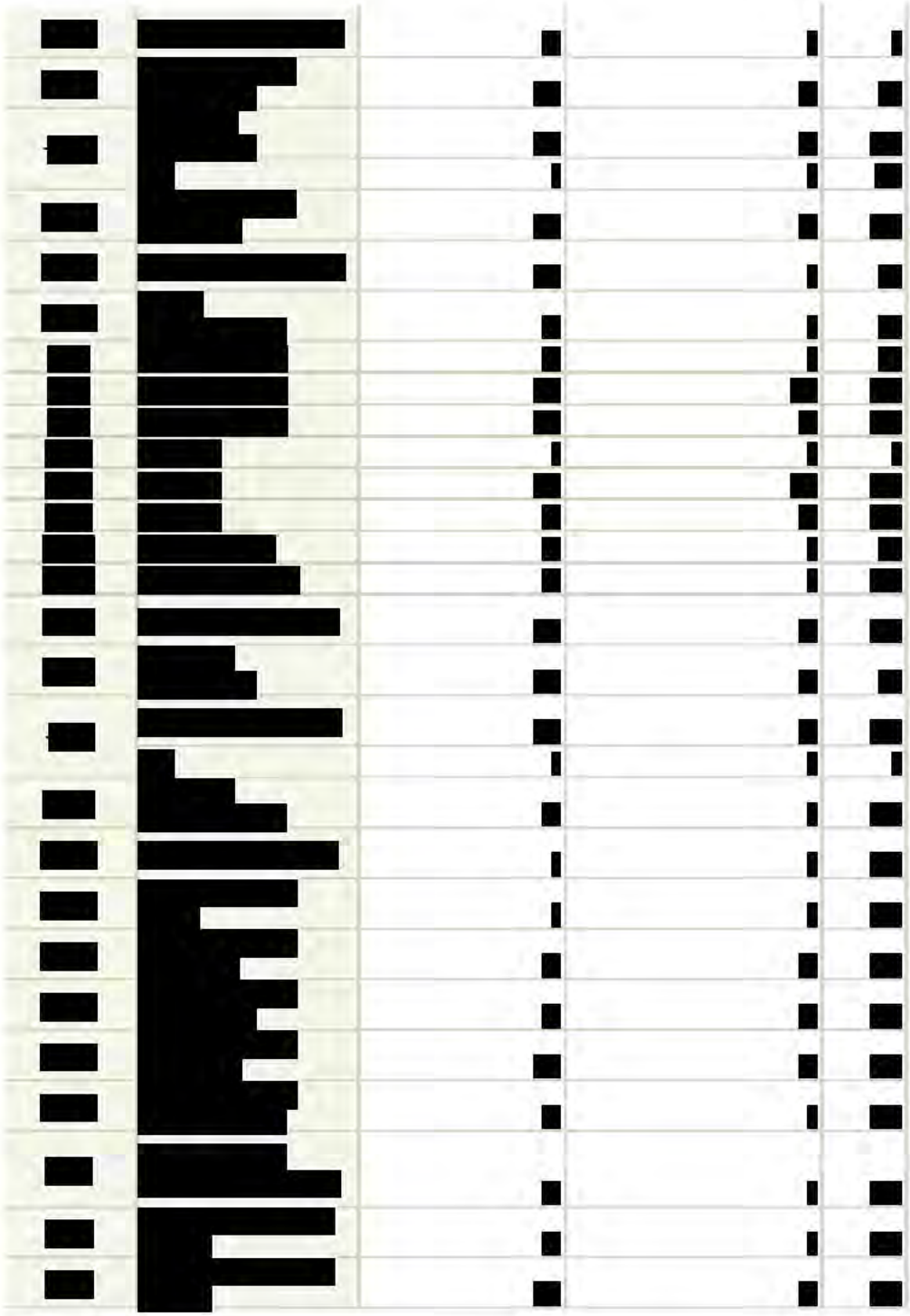


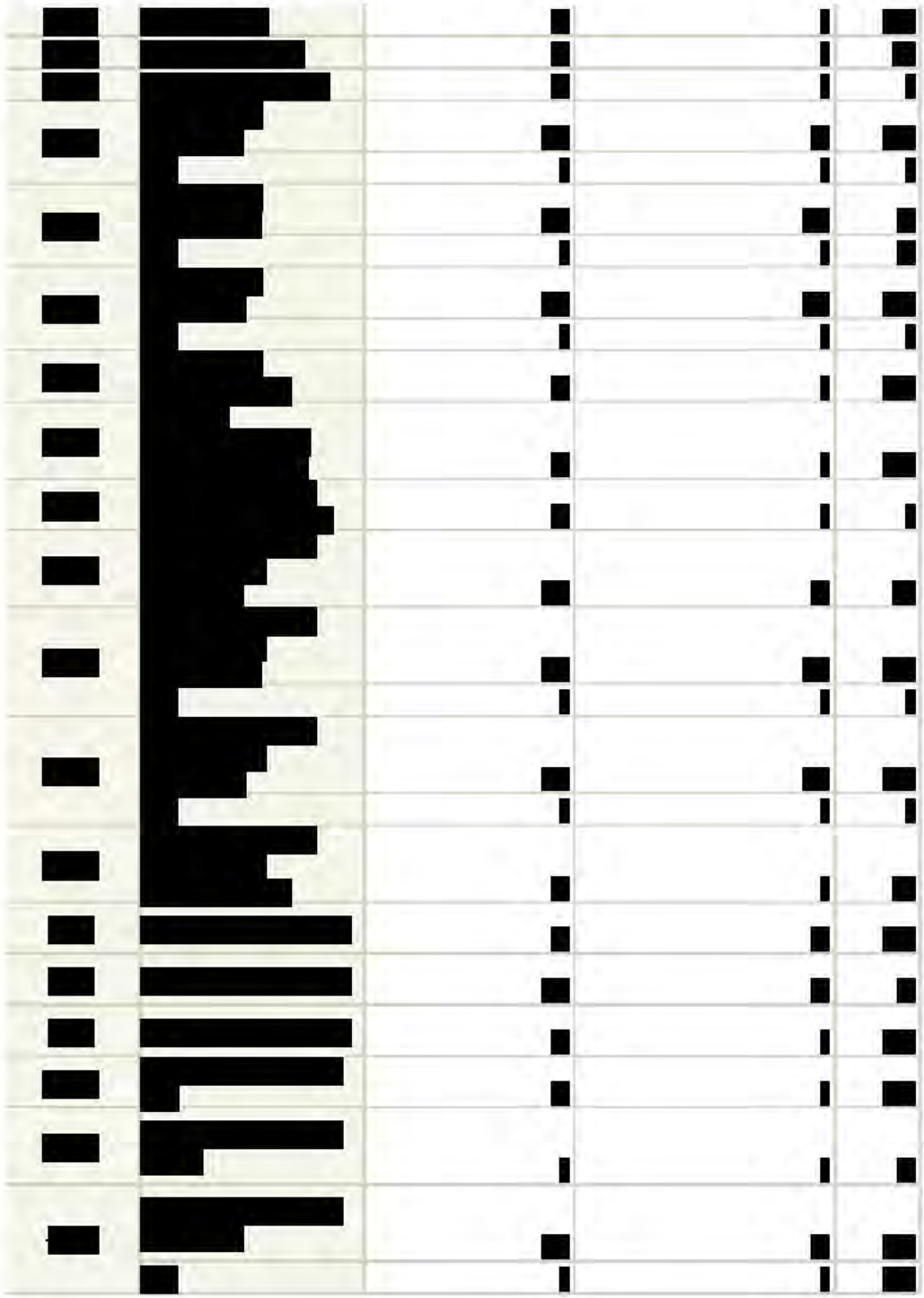


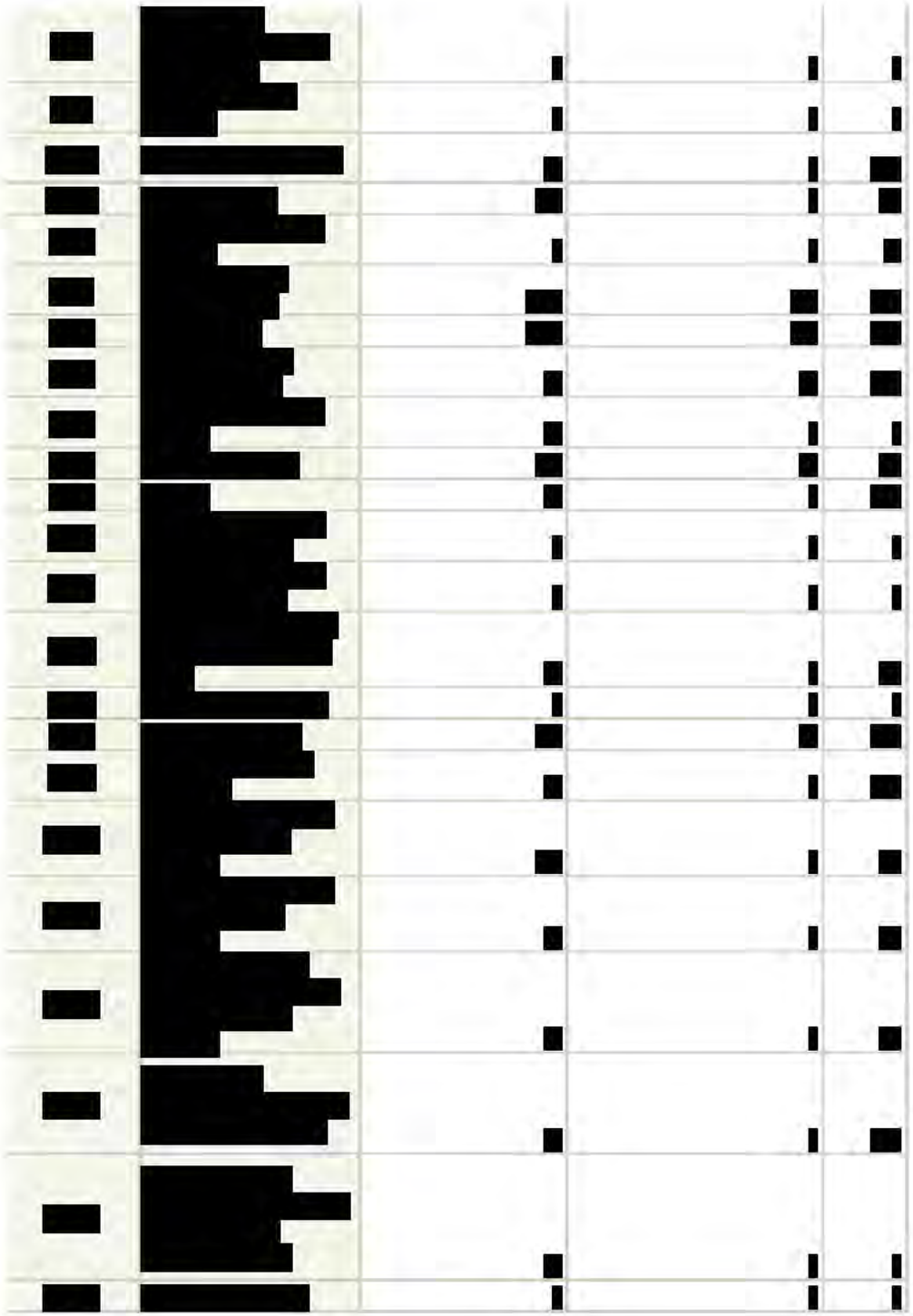


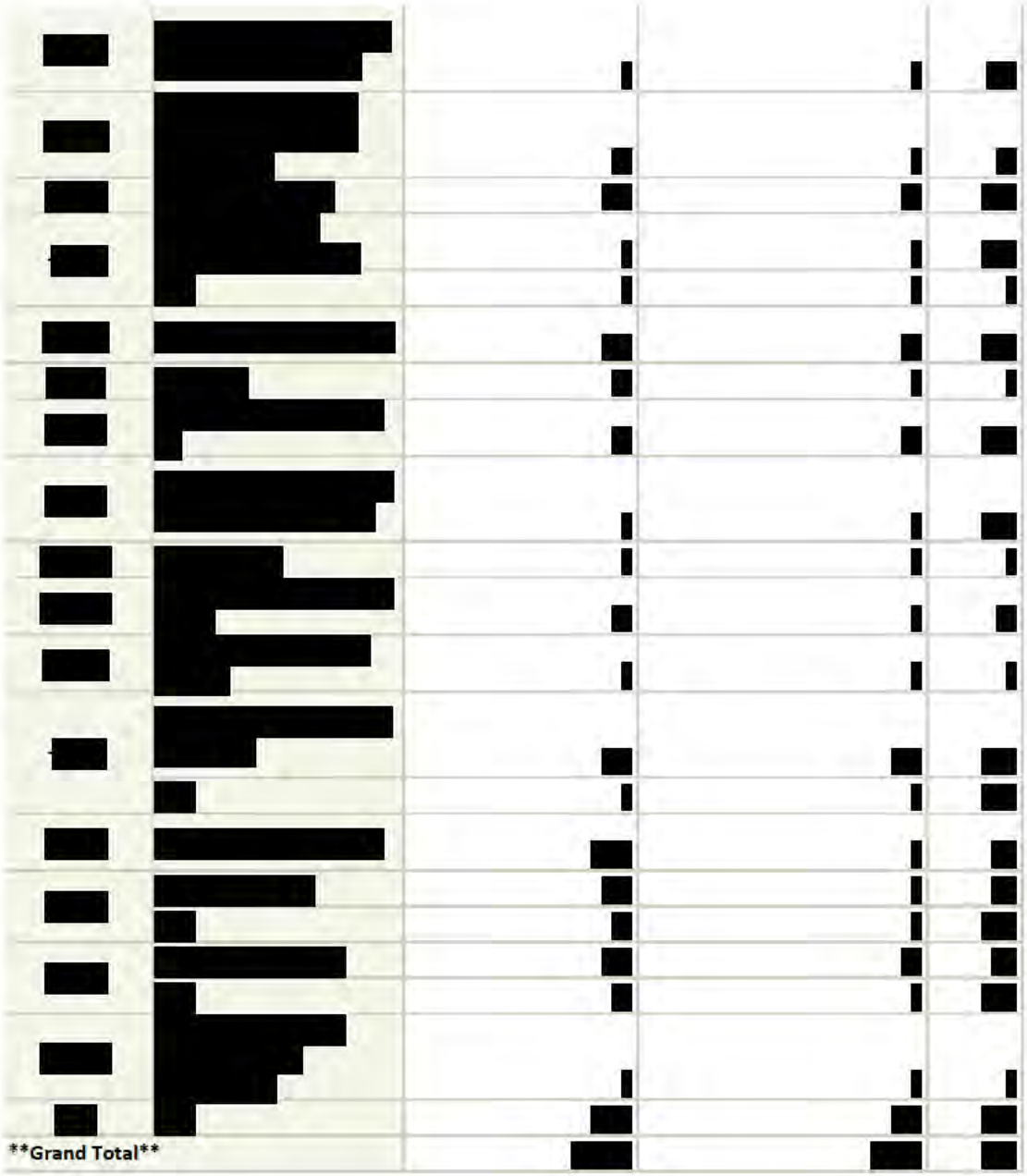








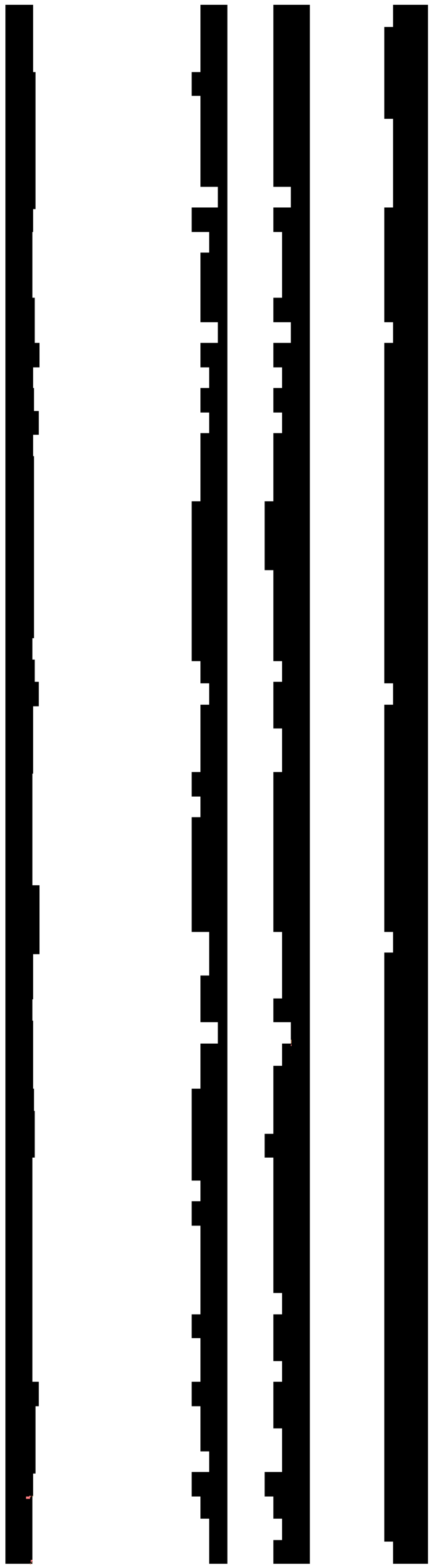


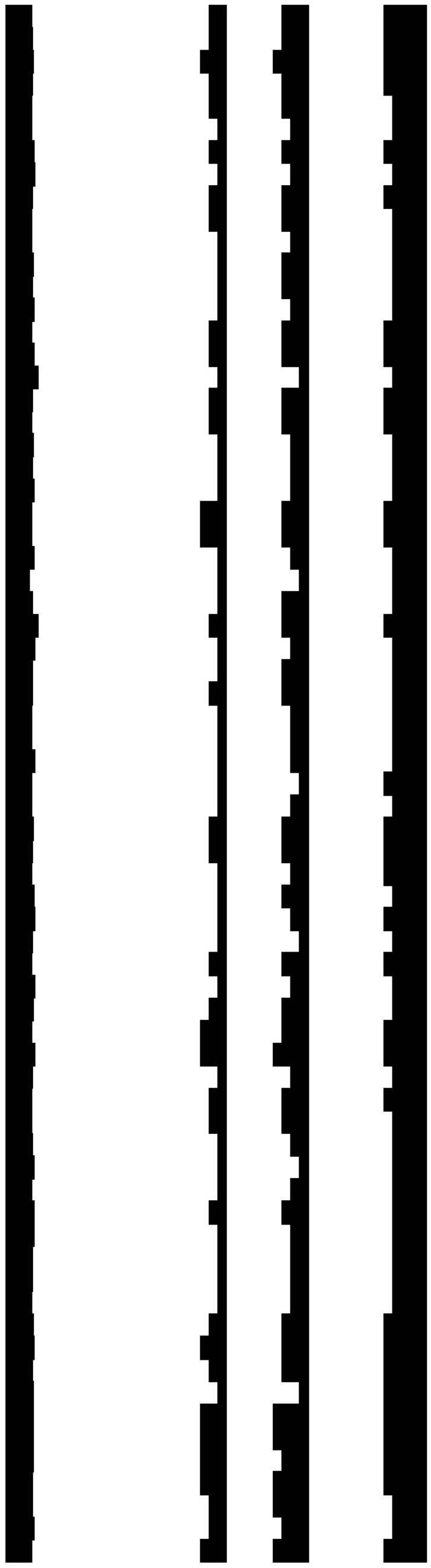

**Grand Total**

**(FOUO) FOR OFFICIAL USE ONLY; Information which must be protected under the Privacy Act and AFI 33-332**

# DEPLOYERS - NUMBERS OF **ACTIVE DUTY** MEMBERS WHO DEPLOYED AT LEAST ONCE FROM FY15-17 BY CONTROL/DUTY AFS (CONTINGENCIES ONLY)
# ASGN - NUMBER OF UNIQUE SOCIALS (**ACTIVE DUTY ONLY**) BY THEIR **LAST** CONTROL/DUTY AFS FROM FY15-17
**Note - If an Airmen deploys and then changes AFS, his ASGN AFS will not match DEPLOYED AFS. Thus, three AFSs (18G, 18E, 86M) show more deployed than assigne*

| CAFS/DAFS | # OF DEPLOYERS | # ASGN | % DEPLOYED |
|---|---|---|---|
| [redacted] | | | |





[redacted]

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE EASTERN DISTRICT OF VIRGINIA**
**Alexandria Division**

| | | |
|---|---|---|
| RICHARD ROE; VICTOR VOE; and OUTSERVE-SDLN, INC.,<br><br>Plaintiffs,<br><br>v.<br><br>PATRICK M. SHANAHAN, in his official capacity as Acting Secretary of Defense; HEATHER A. WILSON, in her official capacity as Secretary of the Air Force; and the UNITED STATES DEPARTMENT OF DEFENSE,<br><br>Defendants. | ) | No. 1:18-cv-1565-LMB-IDD |

**CERTIFICATION OF THE ADMINISTRATIVE RECORD**

Pursuant to 28 U.S.C. § 1746, I, Master Sergeant Christina H. Herrera, do hereby declare and state:

1. I am the Superintendent, Medical Directorate of the Air Force Review Boards Agency. My duties include the administrative management of personnel and cases reviewed within the Air Force Review Boards Agency, which includes the Secretary of the Air Force Personnel Council and the Air Force Personnel Board.

2. The facts attested to herein are based on my personal knowledge or on information made available to me in the course of my official duties.

3. I certify to the best of my knowledge and belief that the documents annexed hereto and described in the attached index are all of the non-privileged materials considered in the adjudication of the case of [redacted] and constitute the contents of the Administrative

Record before the Secretary of the Air Force Personnel Council. Pursuant to 28 U.S.C. § 1746(2), I declare under penalty of perjury that the foregoing is true and correct.

1/25/2019

X Christina Herrera

Christina Herrera, MSgt, USAF
Superintendent, Medical Directorate, AFRBA
Signed by: HERRERA.CHRISTINA.HERNANDEZ.1250977758

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE EASTERN DISTRICT OF VIRGINIA**
**Alexandria Division**

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Superintendent, Medical Directorate, AFRBA
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