OMB Control No. 2900-0747
Respondent Burden: 25 minutes
Expiration Date: 11/30/2025

Department of Veterans Affairs

**VA DATE STAMP**
(DO NOT WRITE IN THIS SPACE)

# APPLICATION FOR DISABILITY COMPENSATION AND RELATED COMPENSATION BENEFITS

**IMPORTANT**: Please read the Privacy Act and Respondent Burden on Page 14 before completing the form. Use this form to determine your eligibility for compensation. For more information, you can contact us online through Ask VA: https://ask.va.gov. Ask us a question online or call us toll-free at 1-800-827-1000 (TTY: 711). If you prefer you may complete and submit the form online at www.va.gov. VA forms are available at www.va.gov/vaforms.

1. SELECT THE TYPE OF CLAIM PROGRAM/PROCESS THAT APPLIES TO YOU. **NOTE**: Your claim will be processed as described on pages 1 through 8 unless one of the following special programs is selected. See Instruction pages 1 through 3 for definitions of the Fully Developed Claim (FDC) Program (Optional Expedited Process) or the Standard Claim Process.

- [X] FDC PROGRAM
- [ ] STANDARD CLAIM PROCESS
- [ ] IDES (Select this option ***only*** if you have been referred to the IDES Program by your Military Service Department)
- [ ] BDD Program Claim (Select this option ***only*** if you meet the criteria for the BDD Program specified on Instruction Page 5)

## SECTION I: VETERAN'S IDENTIFICATION INFORMATION
## (If claim is not an original claim, only Section I, IV (if applicable), V and a signature are required)

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

2. VETERAN/SERVICEMEMBER'S NAME (First, Middle Initial, Last)

John A Doe

3. SOCIAL SECURITY NUMBER (SSN)

111 – 11 – 1111

4. HAVE YOU EVER FILED A CLAIM WITH VA?

[ ] YES [X] NO (If "Yes," provide your file number in Item 5)

5. VA FILE NUMBER

6. DATE OF BIRTH (MM-DD-YYYY)

01 – 01 – 1970

7. SERVICE NUMBER/DOD ID NUMBER (If applicable)

111111111

8. **BDD CLAIMS ONLY: PROVIDE THE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE DUTY** (MM-DD-YYYY)

– –

9. TELEPHONE NUMBER (Optional) (Include Area Code)

123 – 245 – 7890

Enter International Phone Number (If applicable)

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

No. & Street: 123 Veteran Rd

Apt./Unit Number:

City: Houston

State/Province: TX

Country: US

ZIP Code/Postal Code: 12345 –

11. EMAIL ADDRESS (Optional) [ ] I agree to receive electronic correspondence from VA in regards to my claim.

johndoe@gmail.com

[ ] 12. IF YOU ARE CURRENTLY A VA EMPLOYEE, CHECK THE BOX (Includes Work Study/Internship) (If you are not a VA employee skip to Section II, if applicable).

## SECTION II: CHANGE OF ADDRESS

**NOTE**: If you are temporarily or permanently changing your address, complete Items 13A through 13C.

13A. TYPE OF ADDRESS CHANGE (Complete if applicable) (Check only one box)

[ ] TEMPORARY [ ] PERMANENT

13B. NEW ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street:

Apt./Unit Number:

City:

State/Province:

Country:

ZIP Code/Postal Code: –

13C. EFFECTIVE DATE(S) OF NEW ADDRESS (If your change of address is **temporary**, complete both the beginning and ending date of your temporary address) (If your change of address is **permanent**, please enter your effective date in the beginning date only)

| | Month | Day | Year | Month | Day | Year |
|---|---|---|---|---|---|---|
| **BEGINNING DATE:** | – | – | | **ENDING DATE:** | – | – |

## SECTION III: HOMELESS INFORMATION

**IMPORTANT**: The following questions (Items 14A through 14F) should **only** be completed if you are currently homeless or at risk of becoming homeless. If this item does not apply to you, skip to Section IV.

14A. ARE YOU CURRENTLY HOMELESS?

☐ YES (If "Yes," complete Item 14B regarding your living situation)

☐ NO

14B. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION:

☐ LIVING IN A HOMELESS SHELTER

☐ NOT CURRENTLY IN A SHELTERED ENVIRONMENT (e.g., living in a car or tent)

☐ STAYING WITH ANOTHER PERSON

☐ FLEEING CURRENT RESIDENCE

☐ OTHER (Specify)

14C. ARE YOU CURRENTLY AT RISK OF BECOMING HOMELESS?

☐ YES (If "Yes," complete Item 14D regarding your living situation)

☐ NO

14D. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION:

☐ HOUSING WILL BE LOST IN 30 DAYS

☐ LEAVING PUBLICLY FUNDED SYSTEM OF CARE (e.g., homeless shelter)

☐ OTHER (Specify)

14E. POINT OF CONTACT (Name of person VA can contact in order to get in touch with you)

14F. POINT OF CONTACT TELEPHONE NUMBER (Include Area Code)

– –

Enter International Phone Number (If applicable)

## SECTION IV: EXPOSURE INFORMATION

15A. ARE YOU CLAIMING ANY CONDITIONS RELATED TO TOXIC EXPOSURES? **NOTE**: See Page 4 of the Instructions for further information on the evidence needed to support your claim for presumptive service connection. (You can also refer to the following websites for more information: PACT ACT (https://www.va.gov/PACT) and PUBLIC HEALTH MILITARY EXPOSURES (https://www.publichealth.va.gov/exposures/index.asp))

☐ YES (If "Yes," complete Items 15B, 15C, 15D and 15E) ☒ NO (If "No," skip to Item 16, Section V: Claim Information)

15B. DID YOU SERVE IN ANY OF THE FOLLOWING GULF WAR HAZARD LOCATIONS?
Iraq; Kuwait; Saudi Arabia; the neutral zone between Iraq and Saudi Arabia; Bahrain; Qatar; the United Arab Emirates; Oman; Yemen; Lebanon; Somalia; Afghanistan; Israel; Egypt; Turkey; Syria; Jordan; Djibouti; Uzbekistan; the Gulf of Aden; the Gulf of Oman; the Persian Gulf; the Arabian Sea; and the Red Sea.

☐ YES ☐ NO

WHEN DID YOU SERVE IN THESE LOCATIONS? (MM-YYYY)
Note: Please provide an approximate time frame (month and year).

FROM: – TO: –

15C. DID YOU SERVE IN ANY OF THE FOLLOWING HERBICIDE (e.g., Agent Orange) LOCATIONS?
Republic of Vietnam to include the 12 nautical mile territorial waters; Thailand at any United States or Royal Thai base; Laos; Cambodia at Mimot or Krek; Kampong Cham Province; Guam or American Samoa; or in the territorial waters thereof; Johnston Atoll or a ship that called at Johnston Atoll; Korean demilitarized zone; aboard (to include repeated operations and maintenance with) a C-123 aircraft known to have been used to spray an herbicide agent (during service in the Air Force and Air Force Reserves).

Please list other location(s) where you served, if not listed above:

☐ YES ☒ NO

WHEN DID YOU SERVE IN THESE LOCATIONS? (MM-YYYY)
Note: Please provide an approximate time frame (month and year).

FROM: – TO: –

15D. HAVE YOU BEEN EXPOSED TO ANY OF THE FOLLOWING? (Check all that apply)

☐ ASBESTOS ☐ MUSTARD GAS ☐ RADIATION

☐ SHAD (Shipboard Hazard and Defense) ☐ MILITARY OCCUPATIONAL SPECIALTY (MOS)-related toxin ☐ CONTAMINATED WATER AT CAMP LEJEUNE

☐ OTHER (Specify)

WHEN WERE YOU EXPOSED? (MM-YYYY)
Note: Please provide an approximate time-frame (month and year).

FROM: – TO: –

15E. IF YOU WERE EXPOSED MULTIPLE TIMES, PLEASE PROVIDE ALL ADDITIONAL DATES AND LOCATIONS OF POTENTIAL EXPOSURE

## SECTION V: CLAIM INFORMATION
## (For additional space, use Section XIII: Claim Information (Addendum))

16. LIST THE CURRENT DISABILITY(IES) OR SYMPTOMS THAT YOU CLAIM ARE RELATED TO YOUR MILITARY SERVICE AND/OR SERVICE-CONNECTED DISABILITY (If applicable, identify whether a disability is due to a service-connected disability; confinement as a prisoner of war; exposure to Agent Orange, asbestos, mustard gas, ionizing radiation, or Gulf War environmental hazards; or a disability for which compensation is payable under 38 U.S.C. 1151)
**NOTE:** List your claimed conditions below. **See the following three examples for guidance on how to complete Section V**.

| EXAMPLES OF DISABILITY(IES) | EXAMPLES OF EXPOSURE TYPE | EXAMPLES OF HOW THE DISABILITY(IES) RELATES TO SERVICE | EXAMPLES OF DATES |
|---|---|---|---|
| Example 1. HEARING LOSS | NOISE | HEAVY EQUIPMENT OPERATOR IN SERVICE | JULY 1968 |
| Example 2. DIABETES | AGENT ORANGE | SERVICE IN VIETNAM WAR | DECEMBER 1972 |
| Example 3. LEFT KNEE, SECONDARY TO RIGHT KNEE | | INJURED LEFT KNEE WHEN BRACE ON RIGHT KNEE FAILED | 6/11/2008 |

VETERAN'S SOCIAL SECURITY NO. 1 1 1 – 1 1 – 1 1 1 1

## SECTION V: CLAIM INFORMATION (Continued)
## (For additional space, use Section XIII: Claim Information (Addendum))

| | CURRENT DISABILITY(IES) | IF DUE TO EXPOSURE, EVENT, OR INJURY, PLEASE SPECIFY (e.g., Agent Orange, radiation, burn pits) | EXPLAIN HOW THE DISABILITY(IES) RELATES TO THE IN-SERVICE EVENT/EXPOSURE/INJURY | APPROXIMATE DATE DISABILITY(IES) BEGAN OR WORSENED |
|---|---|---|---|---|
| 1. | **Hyperthyroidism** | **Prolonged exposure to unknown environmental** | **Condition linked to chronic exposure in military environments.** | July 1996 |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |
| 11. | | | | |
| 12. | | | | |
| 13. | | | | |
| 14. | | | | |
| 15. | | | | |

17. 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) LISTED IN ITEM 16 AND PROVIDE APPROXIMATE BEGINNING DATE (Month and Year) OF TREATMENT. IF ADDITIONAL SPACE IS NEEDED ATTACH A SEPARATE SHEET AND INCLUDE YOUR NAME, SOCIAL SECURITY NUMBER AND ITEM NUMBER.

**NOTE**: If treatment began from 2005 to present, you **do not** need to provide dates in Item 17B.

| A. ENTER THE DISABILITY TREATED AND NAME/LOCATION OF THE TREATMENT FACILITY | B. DATE OF TREATMENT (MM-YYYY) | C. CHECK THE BOX IF YOU DO NOT HAVE DATE(S) OF TREATMENT |
|---|---|---|
| **chest pain:**<br>**Ft. Bragg Medical Facility, North Carolina** | 0 7 – 1 9 9 6 | ☐ Don't have date |
| **blurry vision:**<br>**Ft. Bragg Medical Facility, North Carolina** | 0 2 – 1 9 9 7 | ☐ Don't have date |
| **nausea:**<br>**Ft. Bragg Medical Facility, North Carolina** | 0 5 – 1 9 9 8 | ☐ Don't have date |

**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): |
|---|---|
| Supplemental Claims | VA Form 20-0995 |
| 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 |
| Mental Health Condition(s) | VA Form 21-0781 |
| 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 |

VETERAN'S SOCIAL SECURITY NO. 1 1 1 – 1 1 – 1 1 1 1

## SECTION VI: SERVICE INFORMATION

18A. DID YOU SERVE UNDER ANOTHER NAME?
☐ YES (If "Yes," complete Item 18B) ☒ NO (If "No," skip to Item 19A)

18B. LIST THE OTHER NAME(S) YOU SERVED UNDER:

19A. BRANCH OF SERVICE
☒ ARMY ☐ NAVY ☐ MARINE CORPS
☐ AIR FORCE ☐ COAST GUARD ☐ SPACE FORCE
☐ NOAA ☐ USPHS

19B. COMPONENT
☐ ACTIVE ☐ RESERVES ☐ NATIONAL GUARD

20A. MOST RECENT ACTIVE SERVICE DATES

| | Month | Day | Year |
|---|---|---|---|
| ENTRY DATE: | 01 | 01 | 1992 |
| EXIT DATE: | 01 | 01 | 2015 |

20B. PLACE OF LAST OR ANTICIPATED SEPARATION
Ft Knox KY

20C. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001?
☐ YES ☒ NO

20D. ADDITIONAL PERIODS OF SERVICE (Indicate enlistment and discharge date(s), if applicable)

| | Month | Day | Year |
|---|---|---|---|
| FROM: | | | |
| TO: | | | |

21A. ARE YOU CURRENTLY SERVING OR HAVE YOU EVER SERVED IN THE RESERVES OR NATIONAL GUARD?
☒ YES (If "Yes," complete Items 21B through 21F)
☐ NO (If "No," skip to Item 22A)

21B. COMPONENT
☐ NATIONAL GUARD
☒ RESERVES

21C. OBLIGATION TERM OF SERVICE

| | Month | Day | Year |
|---|---|---|---|
| FROM: | 01 | 01 | 2016 |
| TO: | 01 | 01 | 2020 |

21D. CURRENT OR LAST ASSIGNED NAME AND ADDRESS OF UNIT:
**45th BN**
**124 Veteran Blvd., Ft. Knox, KY 12345**

21E. CURRENT OR ASSIGNED PHONE NUMBER OF UNIT (Include Area Code)
**(123)456-7979**

21F. ARE YOU CURRENTLY RECEIVING INACTIVE DUTY TRAINING PAY?
☐ YES ☒ NO

22A. ARE YOU CURRENTLY ACTIVATED ON FEDERAL ORDERS WITHIN THE NATIONAL GUARD OR RESERVES?
☐ YES (If "Yes," complete Items 22B & 22C)
☒ NO

22B. DATE OF ACTIVATION: Month – Day – Year

22C. ANTICIPATED SEPARATION DATE: Month – Day – Year

23A. HAVE YOU EVER BEEN A PRISONER OF WAR?
☐ YES (If "Yes," complete Item 23B)
☒ NO

23B. DATES OF CONFINEMENT

| | FROM: (Month – Day – Year) | TO: (Month – Day – Year) |
|---|---|---|
| 1 | | |
| 2 | | |

## SECTION VII: SERVICE PAY (Retired Pay, Separation Pay, and Disability Severance Pay)

24A. ARE YOU RECEIVING MILITARY RETIRED PAY?
☒ YES (If "Yes," complete Items 24C and 24D)
☐ NO

24B. WILL YOU RECEIVE MILITARY RETIRED PAY IN THE FUTURE?
☐ YES (If "Yes," explain below (e.g. future Reserve/National Guard retirement, pending MEB/PEB and also complete Items 24C and 24D)
☐ NO

24C. BRANCH OF SERVICE
☒ ARMY ☐ NAVY ☐ MARINE CORPS
☐ AIR FORCE ☐ COAST GUARD ☐ SPACE FORCE
☐ NOAA ☐ USPHS

24D. MONTHLY AMOUNT
$ 3,200.00

25. RETIRED STATUS
☒ RETIRED ☐ PERMANENT DISABILITY RETIRED LIST
☐ TEMPORARY DISABILITY RETIRED LIST

**IMPORTANT INFORMATION ON MILITARY RETIRED PAY (Includes all Uniformed Services Retired Pay):**
Submission of this application constitutes a waiver of military retired pay in an amount equal to VA compensation awarded, if you are entitled to both benefits. Your retired pay may be reduced by the amount of VA compensation awarded. Receipt of the full amount of military retired pay and VA compensation at the same time ***may*** result in an overpayment, which ***may*** be subject to collection. If you qualify for concurrent receipt of VA compensation and military retired pay, the waiver of retired pay will not apply. If you do not want to waive any retired pay to receive VA compensation, you should check the box in **Item 26**.

**Note that if you check the box in Item 26, you will not receive VA compensation, if granted. If you are currently in receipt of VA compensation and you check the box in Item 26, your VA compensation will be terminated, if you are also eligible for military retired pay.**

**IMPORTANT: VA COMPENSATION PAY IS NON-TAXABLE. THEREFORE, VA COMPENSATION PAY MAY BE THE GREATER BENEFIT.**

☐ **26. Do NOT pay me VA compensation. I do NOT want to receive VA compensation in lieu of retired pay.**

VETERAN'S SOCIAL SECURITY NO. 1 1 1 – 1 1 – 1 1 1 1

**IMPORTANT INFORMATION ON SEPARATION/SEVERANCE PAY:**
VA compensation, if granted, may be withheld to recoup any disability severance or separation pay such as involuntary separation pay, voluntary separation pay, or special separation benefit, you receive from your branch of service. In addition, if you receive a Voluntary Separation Incentive (VSI), your VSI payments may be reduced if you are awarded VA compensation. Receipt of VA compensation and VSI at the same time may result in an overpayment of VSI, which **may** be subject to collection.

27A. HAVE YOU EVER RECEIVED SEPARATION PAY, DISABILITY SEVERANCE PAY, OR ANY OTHER LUMP SUM PAYMENT FROM YOUR BRANCH OF SERVICE?

☐ YES (If "Yes," complete Items 27B through 27D)

☒ NO

| 27B. DATE PAYMENT RECEIVED (MM-DD-YYYY) | 27C. BRANCH OF SERVICE | 27D. AMOUNT RECEIVED (Provide pre-tax amount) |
|---|---|---|
| – – | ☐ ARMY ☐ NAVY ☐ MARINE CORPS<br>☐ AIR FORCE ☐ COAST GUARD ☐ SPACE FORCE<br>☐ NOAA ☐ USPHS | $ , .00 |

**IMPORTANT INFORMATION ON INACTIVE DUTY TRAINING PAY:**
You may elect to keep the active or inactive duty training pay 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 28**, VA will retroactively adjust your VA award to withhold benefits equal to the total number of training days waived and at the monthly rate in effect for the fiscal year period for which you received training pay. This action may result in an overpayment of compensation, which ***may*** be subject to collection.

**IMPORTANT: VA COMPENSATION PAY IS NON-TAXABLE. THEREFORE VA COMPENSATION PAY MAY BE THE GREATER BENEFIT.**

☐ **28. Do NOT pay me VA compensation. I do NOT want to receive VA compensation in lieu of training pay.**

## SECTION VIII: DIRECT DEPOSIT INFORMATION
## (Note: If you have already signed up for direct deposit, skip to Section IX)

The Department of the Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. **To enroll in direct deposit, provide the information requested below.** If you ***do not*** have a bank account, please visit https://www.benefits.va.gov/benefits/banking.asp. This website provides information about the Veterans Benefits Banking Program (VBBP), and a link to banks and credit unions that may fit your needs. You may also call 1-800-827-1000. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of the Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

☐ 29. I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT. (If you check this box skip to Section IX)

30. ACCOUNT NUMBER (Check only **one** box below and provide the account number)

Account No.: 0 1 2 7 8 7 7 7 3 2 1 4 5 5 6 ☒ CHECKING ☐ SAVINGS

| 31. NAME OF FINANCIAL INSTITUTION (Provide the name of the bank where you want your direct deposit) | 32. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check) |
|---|---|
| **Bank of America** | 0 1 0 2 3 4 4 5 5 |

## SECTION IX: CLAIM CERTIFICATION AND SIGNATURE

### VETERAN/SERVICEMEMBER 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. For the limited purpose of providing VA with this information as it may relate to my claim, I waive any privilege that may apply and would otherwise make the information confidential and not discloseable.

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 1, on page 9, indicating I want my claim processed under the standard claim process because I plan to submit additional evidence in support of my claim.

| 33A. VETERAN/SERVICE MEMBER SIGNATURE (**REQUIRED**) | 33B. DATE SIGNED (MM-DD-YYYY) |
|---|---|
| *John A. Doe* | 0 2 – 0 2 – 2 0 2 5 |

## SECTION X: WITNESSES TO SIGNATURE

| 34A. SIGNATURE OF WITNESS (**Note**: Only sign if veteran signed in Item 33A using an "X") | 34B. PRINTED NAME AND ADDRESS OF WITNESS |
|---|---|
| | |
| 35A. SIGNATURE OF WITNESS (**Note**: Only sign if veteran signed in Item 33A using an "X") | 35B. PRINTED NAME AND ADDRESS OF WITNESS |
| | |

VETERAN'S SOCIAL SECURITY NO. 1 1 1 – 1 1 – 1 1 1 1

## SECTION XI: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE (NOTE: REQUIRED ONLY IF ITEM 33A IS BLANK)

**NOTE:** An alternate signer signature **will not** be accepted unless a valid VA Form 21-0972, *Alternate Signer Certification*, is of record or attached to this request.

I certify that by signing on behalf of the claimant, 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 a 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.

| 36A. ALTERNATE SIGNER SIGNATURE (**REQUIRED**) | 36B. DATE SIGNED (MM-DD-YYYY) |
|---|---|
| | – – |

## SECTION XII: POWER OF ATTORNEY (POA) SIGNATURE (NOTE: POA'S CANNOT SIGN FOR AN ORIGINAL CLAIM ONLY)

I certify that the claimant has authorized the undersigned representative to file this 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.

| 37A. POA/AUTHORIZED REPRESENTATIVE SIGNATURE | 37B. DATE SIGNED (MM-DD-YYYY) |
|---|---|
| | – – |

**PENALTY:** The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.

**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 Veteran Readiness 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 response 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**: An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-0747, and it expires 11/30/2025. Public reporting burden for this collection of information is estimated to average 25 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing the burden to VA Reports Clearance Officer at **VACOPaperworkReduAct@VA.gov**. Please refer to OMB Control No. 2900-0747 in any correspondence. Do not send your completed VA Form 21-526EZ to this email address.

VETERAN'S SOCIAL SECURITY NO. 1 1 1 – 1 1 – 1 1 1 1

## SECTION XIII: CLAIM INFORMATION (ADDENDUM)

**(Please submit this page with the completed application if you have additional disabilities to add to your claim. If more space is needed, please make additional copies of this page to submit with your application.)**

LIST THE CURRENT DISABILITY(IES) OR SYMPTOMS THAT YOU CLAIM ARE RELATED TO YOUR MILITARY SERVICE AND/OR SERVICE-CONNECTED DISABILITY (If applicable, identify whether a disability is due to a service-connected disability; confinement as a prisoner of war; exposure to Agent Orange, asbestos, mustard gas, ionizing radiation, or Gulf War environmental hazards; or a disability for which compensation is payable under 38 U.S.C. 1151)

**NOTE:** List your claimed conditions below. **See the following three examples on guidance on how to complete Section XIII**.

| EXAMPLES OF DISABILITY(IES) | EXAMPLES OF EXPOSURE TYPE | EXAMPLES OF HOW THE DISABILITY(IES) RELATES TO SERVICE | EXAMPLES OF DATES |
|---|---|---|---|
| Example 1. HEARING LOSS | NOISE | HEAVY EQUIPMENT OPERATOR IN SERVICE | JULY 1968 |
| Example 2. DIABETES | AGENT ORANGE | SERVICE IN VIETNAM WAR | DECEMBER 1972 |
| Example 3. LEFT KNEE, SECONDARY TO RIGHT KNEE | | INJURED LEFT KNEE WHEN BRACE ON RIGHT KNEE FAILED | 6/11/2008 |

| | CURRENT DISABILITY(IES) | IF DUE TO EXPOSURE, EVENT, OR INJURY, PLEASE SPECIFY (e.g., Agent Orange, radiation, burn pits) | EXPLAIN HOW THE DISABILITY(IES) RELATES TO THE IN-SERVICE EVENT/EXPOSURE/INJURY | APPROXIMATE DATE DISABILITY(IES) BEGAN OR WORSENED |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |
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CAUTION: NOT TO BE USED FOR IDENTIFICATION PURPOSES | THIS IS AN IMPORTANT RECORD. SAFEGUARD IT. | ANY ALTERATIONS IN SHADED AREAS RENDER FORM VOID

# CERTIFICATE OF UNIFORMED SERVICE

When completed, this form contains personally identifiable information and is protected in accordance with the Privacy Act of 1974, as amended, and DoD 5400.11-R, DoD Privacy Program.

| 1. NAME (Last, First, Middle) | 2. BRANCH AND COMPONENT | 3. DOD ID NUMBER | 4. SERIAL NUMBER: |
|---|---|---|---|
| Doe, John A | ARMY | 111111111 | 111111111 |

| 5a. GRADE, RATE OR RANK | b. PAY GRADE | 6. DATE OF BIRTH (YYYYMMDD) |
|---|---|---|
| E-7 | E-7 | 19700101 |

| 7a. MILITARY SERVICE OBLIGATION TERMINATION DATE (YYYYMMDD) | b. RESERVE STATUS FOR OBLIGATION (SELRES/IRR) | c. CONTACT PHONE NUMBER (Civilian) | d. CONTACT EMAIL ADDRESS (Civilian) |
|---|---|---|---|
| 20150101 | | (123)456-7890 | johndoe@gmail.com |

| 8a. PLACE OF ENTRY INTO ACTIVE DUTY | b. HOME OF RECORD AT TIME OF ENTRY (City and state, or complete address if known) |
|---|---|
| HOUSTON, TX | 123 Veteran Rd., Houston, TX 12345 |

| 9a. LAST DUTY ASSIGNMENT AND MAJOR COMMAND | b. STATION WHERE SEPARATED |
|---|---|
| 18th Airborne Corps | Ft. Knox, KY 458521 |

| 10. COMMAND TO WHICH TRANSFERRED | 11. SGLI COVERAGE / AMOUNT: $ |
|---|---|
| 88th Ready Reserve, Ft. McCoy, WI 45787 | ☐ NONE |

**12. SPECIALITY** *(List number, title, and years and months in specialties involving periods of one or more years.)*

11B INFANTRYMAN - 15 YRS 0 MOS//NOTHING FOLLOWS

| 13. RECORD OF SERVICE | YEAR(S) | MONTH(S) | DAY(S) |
|---|---|---|---|
| a. DATE ENTERED AD THIS PERIOD | 1992 | 10 | 01 |
| b. SEPARATION DATE THIS PERIOD | 2015 | 09 | 03 |
| c. NET ACTIVE SERVICE THIS PERIOD | 0023 | 00 | 00 |
| d. TOTAL PRIOR ACTIVE SERVICE | 0000 | 00 | 00 |
| e. TOTAL ACTIVE SERVICE | 0023 | 00 | 00 |
| f. TOTAL INACTIVE SERVICE | 0000 | 00 | 00 |
| g. FOREIGN SERVICE | 0000 | 00 | 00 |
| h. SEA SERVICE | 0000 | 00 | 00 |
| i. INITIAL ENTRY TRAINING | | | |
| j. EFFECTIVE DATE OF PAY GRADE | 2010 | 01 | 01 |

**14. DECORATIONS, MEDALS, BADGES, CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED** *(All periods of service)*

ARMY ACHIEVEMENT MEDAL (2ND AWARD)//NATIONAL DEFENSE SERVICE MEDAL (2ND AWARD)//A//CONT IN BLOCK 18

**15. UNIFORMED SERVICE EDUCATION** *(Course title, number of weeks, and month and year completed)*



| 16. DAYS ACCRUED LEAVE PAID | 17. MEMBER WAS PROVIDED COMPLETE DENTAL EXAMINATION AND ALL APPROPRIATE DENTAL SERVICES AND TREATMENT WITHIN 90 DAYS PRIOR TO SEPARATION | 18. RETIREMENT SYSTEM OPTION | 19. DD214-1 (Accompanies this DD214) |
|---|---|---|---|
| | ☒ YES ☐ NO | ☐ FINAL ☐ HIGH-3 ☒ REDUX ☐ BRS | ☒ YES ☐ NO |

**20. REMARKS**

INDIVIDUAL COMPLETED PERIOD FOR WHICH ORDERED TO ACTIVE DUTY FOR PURPOSE OF POST SERVICE BENEFITS AND ENTITLEMENTS//MEMBER HAS COMPLETED FIRST FULL TERM OF SERVICE//CONT FROM BLOCK 13: MEDAL// GLOBAL WAR ON TERRORISM SERVICE MEDAL//ARMED FORCES SERVICE MEDAL (AFSM)//ARMY SERVICE RIBBON//OVERSEAS SERVICE RIBBON (2ND AWARD)//ARMED FORCES

The information contained herein is subject to computer matching within the Department of Defense or with any other affected Federal or non-Federal agency for verification purposes and to determine eligibility for, and/or continued compliance with, the requirements of a Federal benefit program.

| 21a. MAILING ADDRESS AFTER SEPARATION (Include ZIP Code) | 21b. NEAREST RELATIVE (Name and address - include ZIP code) |
|---|---|
| 123 Veteran Rd., Houston, TX 12345 | Mary Doe<br>123 Veteran Rd., Houston, Tx 12345 |

**22. MEMBER REQUESTS DATA SHARE WITH** *(Specify state/locality)* **OFFICE OF VETERANS AFFAIRS** ☒ YES ☐ NO

| 23a. MEMBER SIGNATURE | b. DATE (YYYYMMDD) | 24. OFFICIAL AUTHORIZED TO SIGN | |
|---|---|---|---|
| | | a. NAME, GRADE AND TITLE | c. DATE (YYYYMMDD) |
| | | b. SIGNATURE | |

# INJURY STATEMENT

**John A. Doe**
123 Veteran Rd.
Houston, TX 12345

**Date:** March 3, 2025

**Subject:** Injury Statement for VA Claim Submission – Hyperthyroidism

To Whom It May Concern,

I, **John A. Doe**, submit this statement in support of my VA claim for service-connected **Hyperthyroidism**.

While stationed at **Ft. Bragg, North Carolina**, I began experiencing **chest pain, blurry vision, and nausea**, which significantly affected my ability to function in daily life. These symptoms prompted me to seek medical attention, leading to my **diagnosis of Hyperthyroidism in July 1996**.

I received medical treatment for this condition at **Ft. Bragg Medical Facility** on the following occasions:

- **July 1996**
- **February 1997**
- **May 1998**

## Current Treatment

To manage my condition, my treatment includes:

- **Prescription medication**, including **Methimazole,** to help regulate thyroid hormone levels.
- **Radio Iodine Therapy** to manage and control the symptoms of hyperthyroidism.

## Impact on Daily Life

Since the onset of this condition, I have had to **give up many daily living activities**. Due to **chest pain and fatigue**, I can no longer engage in **exercising or strenuous activities such as household chores**. Additionally, my symptoms have made **driving difficult**, and I am unable to spend as much **quality time with family and friends** due to the limitations imposed by my condition.

Given the significant and lasting impact of hyperthyroidism on my daily life, I respectfully request that my medical history and service records be reviewed in support of my claim for service-connected disability benefits.

I certify that the information provided is true and accurate to the best of my knowledge. Thank you for your time and consideration.

**Sincerely,**

*John A. Doe*
**John A. Doe**

# NEXUS LETTER

**[Doctor's Letterhead]**
**Houston Medical Group**
124 Bronson Street
Houston, TX
Phone: (718) 242-5254

**March 3, 2025**

**Department of Veterans Affairs**
To Whom It May Concern,

**Subject: Medical Nexus Letter in Support of VA Disability Claim for John A. Doe**

I, **Dr. William Stryker, MD**, am a licensed **orthopedic specialist** at **Houston Medical Group** and have been treating **John A. Doe** for **Hyperthyroidism**. This letter serves as a **medical nexus statement** supporting his **VA disability claim** by providing my professional medical opinion regarding the relationship between his **current disability** and his **military service**.

## Patient Information:

- **Patient Name:** John A. Doe
- **Patient Address:** 123 Veteran Rd., Houston, TX 12345
- **Primary Disability:** Hyperthyroidism
- **Initial Diagnosis Date:** July 1996
- **Treatment Facility:** Ft. Bragg Medical Facility

## Medical History and Current Condition

Mr. Doe was diagnosed with **Hyperthyroidism in July 1996** while stationed at **Ft. Bragg, North Carolina**. Since his diagnosis, his condition has persisted and required ongoing **medical intervention and treatment**. His symptoms include:

- **Chest pain**, which occurs intermittently and can become severe.
- **Blurry vision**, affecting his ability to perform daily tasks and operate a vehicle.
- **Frequent nausea**, leading to disruptions in his daily life and appetite.

## Current Treatment Plan

Mr. Doe has been under continuous treatment, including:

- **Methimazole**, an antithyroid medication used to control his thyroid hormone levels.
- **Radioiodine therapy**, used to manage and regulate his hyperthyroidism.

Despite ongoing treatment, his condition has caused **long-term health effects and lifestyle limitations**.

## Medical Nexus Opinion

Based on my **medical expertise, review of Mr. Doe's medical history, and clinical evaluation**, it is my professional opinion that:

1. **It is at least as likely as not (50% or greater probability) that Mr. Doe's Hyperthyroidism is directly related to his military service at Ft. Bragg, North Carolina.**

## Rationale for Service Connection

Hyperthyroidism is a condition that can develop due to prolonged **stress, environmental exposure, and other service-related factors**. Given that Mr. Doe's **initial diagnosis occurred during active duty and has continued to persist**, there is strong **medical evidence supporting a direct connection between his condition and his military service**. His **service records, documented medical treatment, and long-term effects** reinforce the likelihood that his hyperthyroidism is **service-connected**.

## Impact on Daily Life

Mr. Doe's hyperthyroidism has significantly impacted his **ability to perform daily living activities**, including:

- **Driving**, due to **blurry vision and unpredictable symptoms**.
- **Exercising or performing physical tasks**, as **chest pain and fatigue** have made physical exertion difficult.
- **Social interactions**, as nausea and discomfort often prevent him from spending time with family and friends.
- **Household maintenance**, as **strenuous activities** such as lifting, bending, or prolonged movement worsen his symptoms.

## Conclusion

Given the **chronic and progressively worsening nature of Mr. Doe's Hyperthyroidism**, I strongly support his **VA disability claim for service connection**. His **functional limitations, medical history, and continued need for treatment** confirm that his condition is **service-related** and has **severely impacted his quality of life**.

If any additional medical documentation or clarification is required, please feel free to contact my office at **(718) 242-5254**.

**Sincerely,**

*William Stryker*

**Dr. William Stryker, MD**
**Orthopedic Specialist**
Houston Medical Group
124 Bronson Street, Houston, TX

# BUDDY LETTER #1

**Barry Sharpton**
804 Culver Rd.
Baton Rouge, LA 70801
Email: BarrySharpton@gmail.com
Phone: (225) 346-4141

**March 3, 2025**

**Department of Veterans Affairs**
To Whom It May Concern,

I, **Barry Sharpton**, am writing this letter in support of my friend, **John A. Doe's**, VA disability claim for **Hyperthyroidism**. I have known John for many years, and during that time, I have personally observed the challenges he has faced due to his condition.

From **May 2018 to June 2025**, I have noticed that John **struggles with completing tasks due to the effects of Hyperthyroidism**. His condition has caused **noticeable fatigue, weakness, and difficulty focusing**, which make everyday responsibilities more difficult for him. At times, I have seen him appear extremely exhausted, even after minimal physical activity. Additionally, he has expressed frustration about the impact of his condition on his ability to stay active and productive.

I have also observed John dealing with **episodes of dizziness, nervousness, and difficulty regulating his energy levels**, which further interfere with his ability to carry out tasks efficiently. There have been occasions when he had to stop what he was doing to rest, and he has often mentioned feeling overwhelmed by symptoms that make it hard for him to concentrate or stay engaged in activities.

John's hyperthyroidism has had a significant impact on his daily life, making routine tasks that were once simple much more difficult. I have seen firsthand how this condition has affected his well-being, and I believe he deserves the support and benefits needed to help manage his health.

I am submitting this letter as a firsthand witness to John's struggles and to support his claim for the benefits and assistance he rightfully deserves. I certify that the statements in this letter are true to the best of my knowledge and belief. Please feel free to contact me at **(225) 346-4141** or **BarrySharpton@gmail.com** if any further information is needed.

**Sincerely,**

*Barry Sharpton*

**Barry Sharpton**

# BUDDY LETTER #2

**Mary Doe**
123 Veteran Rd.
Houston, TX 12345
Email: marydoe@gmail.com
Phone: (123) 456-7891

**March 3, 2025**

**Department of Veterans Affairs**
To Whom It May Concern,

I, **Mary Doe**, am writing this letter in support of my husband, **John A. Doe's**, VA disability claim for **Hyperthyroidism**. As his wife, I have personally witnessed the struggles he has endured due to this condition and how it has significantly impacted his daily life.

Since **July 1996 to the present**, I have observed John experiencing **difficulty completing everyday tasks due to the effects of Hyperthyroidism**. He frequently **struggles with fatigue, weakness, and difficulty concentrating**, making routine activities much more challenging for him. I have seen him become easily exhausted, even after minimal effort, and he often needs to take breaks throughout the day.

Additionally, John experiences **episodes of nervousness, dizziness, and difficulty regulating his energy levels**, which cause further disruptions to his daily activities. There have been many instances where he has had to stop what he was doing due to **overwhelming fatigue or trouble focusing**, making it difficult for him to manage household responsibilities and engage in social activities.

His condition has significantly affected his **quality of life and independence**, as he is no longer able to handle tasks with the same ease as he once could. I have seen how this has impacted his confidence and emotional well-being, leading to frustration and stress over the years.

I am submitting this letter as a firsthand witness to John's ongoing struggles and to support his claim for the benefits and assistance he rightfully deserves. I certify that the statements in this letter are true to the best of my knowledge and belief. Please feel free to contact me at **(123) 456-7891** or **marydoe@gmail.com** if any further information is needed.

**Sincerely,**

*Mary Doe*

**Mary Doe**

# ADD MEDICAL DOCUMENTS HERE

# DBQ

[This is optional.  One will be filled out at the C&P Exam by a VA Doctor regardless of whether you submit one or not.]

# DBQ's can be found here:

[https://www.benefits.va.gov/compensation/dbq_publicdbqs.asp]