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

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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.	**Knee Pain**	**Parachute landing impact**	**Result of repeated stress on joints from military duties.**	July 2013
2.	**Back Pain**	**Due to knee injury**	**Knee injury caused changes**	July 2020
3.			**to my walking pattern**	
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
Pain in left knee: **Ft. Bragg Medical Facility**	0 7 – 2 0 1 3	☐ Don't have date
Pain in right knee: **Ft. Bragg Medical Facility**	0 2 – 2 0 1 4	☐ Don't have date
pain in both left and right knee: **Ft. Bragg Medical Facility**	0 5 – 2 0 1 5	☐ 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

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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.**

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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 ☐ AIR FORCE ☐ COAST GUARD ☐ SPACE FORCE ☐ 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.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				

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 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

March 3, 2025

Department of Veterans Affairs
To Whom It May Concern,

I, **John A. Doe**, am submitting this statement in support of my request for an **increase in disability rating** for my **service-connected Knee Pain**. I had previously received a 20% rating. My condition has worsened significantly over time, further limiting my mobility, daily functioning, and overall quality of life.

Current Condition and Worsening Symptoms

Since my initial diagnosis in **July 2013**, my **bilateral knee pain (left and right knees)** has progressively deteriorated despite continued medical treatment. I have received ongoing care at **Ft. Bragg Medical Facility**, with documented treatment dates including:

- **July 2013**
- **February 2014**
- **May 2015**

Current Treatment and Limitations

To manage my condition, I currently require:

- **Daily use of painkillers** such as **Naproxen and Advil**, which provide only temporary relief.
- **Regular physical therapy**, which has become increasingly difficult due to my worsening condition.
- **A knee brace**, which I now rely on for stability, as my knees frequently give out while walking.

Despite these treatments, my **pain, instability, and mobility issues have significantly increased**, causing severe limitations in my daily life.

Impact on Daily Life

My **knee pain has now reached a debilitating level**, affecting my ability to perform even the most basic tasks. The following issues have worsened since my last disability evaluation:

- **Severe pain while walking or standing for more than a few minutes.** I now require frequent breaks and must limit my physical activities.

- **Difficulty navigating stairs.** I actively avoid stairs whenever possible due to extreme pain and weakness in my knees.
- **Increased knee instability.** My knees now **frequently buckle**, causing me to lose balance and increasing my risk of falls.
- **Constant stiffness and swelling.** My knees are often swollen and stiff, especially in the mornings and after minimal activity.
- **Sleep disturbances due to pain.** I wake up multiple times throughout the night due to knee discomfort, resulting in chronic fatigue.

Request for Increased Rating

Due to the **worsening severity of my condition and the increasing limitations it has placed on my daily life**, I respectfully request that the VA reevaluate my current disability rating for **Knee Pain**. I believe my condition now qualifies for a **higher rating** based on the chronic pain, loss of function, and significant lifestyle restrictions I experience daily.

I appreciate your time and consideration in reviewing my case. I certify that the statements in this letter are true and accurate to the best of my knowledge. Please feel free to contact me for any additional information.

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 Increased VA Disability Rating 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 **bilateral knee pain and secondary back pain**. This letter serves as a **medical nexus statement** supporting his **VA disability claim for an increased rating**, as his condition has worsened significantly despite ongoing treatment.

Patient Information:

- **Patient Name:** John A. Doe
- **Patient Address:** 123 Veteran Rd., Houston, TX 12345
- **Primary Disability:** Knee Pain (bilateral)
- **Secondary Disability:** Back Pain
- **Initial Diagnosis Date:** July 2013
- **Treatment Facility:** Ft. Bragg Medical Facility

Medical History and Current Condition

Mr. Doe was diagnosed with **bilateral knee pain** in **July 2013**, with **progressive deterioration over time**. He also developed **chronic back pain** as a secondary condition due to altered gait and instability from his knee injuries. Despite treatment, **his condition has significantly worsened**, leading to **increased pain, functional limitations, and mobility impairments**. His current symptoms include:

- **Persistent, severe knee pain**, which has progressively worsened over time.
- **Joint instability and weakness**, leading to frequent falls and difficulty walking.
- **Severe stiffness and swelling**, limiting his range of motion.
- **Popping and grinding sensations**, consistent with joint deterioration.
- **Back pain and muscle spasms**, aggravated by his knee instability and altered gait.
- **Inability to bear weight for prolonged periods**, preventing him from standing or walking long distances.
- **Increased difficulty with stairs and uneven surfaces**, requiring assistive devices.

Current Treatment Plan

Mr. Doe continues to undergo **medical treatment and therapy**, including:

- **Naproxen and Advil** for pain and inflammation.
- **Regular physical therapy** to improve knee and back strength, but with limited effectiveness.
- **Knee brace usage** for stability and pain management.
- **Mobility assistance**, including the need for a cane.

Despite these interventions, **his condition remains chronic and has significantly deteriorated**, leading to **greater functional impairment** than previously rated.

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 knee pain and associated back pain have worsened significantly beyond their previous rating.**
2. **His current disability rating does not accurately reflect the severity of his condition or functional limitations.**

Rationale for Increased Rating

Mr. Doe's **deteriorating condition warrants a reevaluation of his VA disability rating**, as his **functional impairments, pain levels, and mobility challenges have significantly increased**. The **limitations he experiences now severely impact his ability to perform daily activities, maintain employment, and live independently**.

Given that:

- **His condition has worsened despite medical intervention**.
- **His mobility has decreased, requiring additional support and assistive devices**.
- **His secondary back pain has become a disabling factor due to altered gait and instability**.
- **His ability to perform daily tasks has been drastically reduced** due to pain and physical limitations.

There is **strong medical evidence that his current disability rating no longer reflects the full extent of his condition and impairment**.

Impact on Daily Life

Mr. Doe's **knee and back pain have profoundly affected his personal, social, and occupational life**, including:

- **Significant difficulty with walking, standing, and using stairs**.

- **Increased reliance on pain medication and assistive devices**.
- **Limited ability to perform household chores, work responsibilities, or engage in social activities**.
- **Frequent falls due to joint instability**, increasing the risk of further injury.
- **Chronic pain and fatigue**, leading to depression, anxiety, and emotional distress.

Conclusion

Due to the **progressive nature of Mr. Doe's knee and back conditions**, I strongly recommend **an increased VA disability rating**. His **documented medical decline, ongoing treatment, and significant functional impairments confirm that his condition is more severe than previously rated**.

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

William Sharp
84 West Hampton Rd.
Chicago, IL 12121
Email: williamsharp@gmail.com
Phone: (212) 312-6451

March 3, 2025

Department of Veterans Affairs
To Whom It May Concern,

Subject: Buddy Letter in Support of VA Disability Claim for Increased Rating – John A. Doe

I, **William Sharp**, am writing this letter in support of my friend, **John A. Doe**, regarding his **VA disability claim for an increased rating** due to the worsening of his **knee pain and back pain**. I have known John for many years and have personally witnessed how his condition has deteriorated over time, making it more difficult for him to perform basic daily activities.

Observations of Worsened Symptoms

From **May 2018 to June 2019**, I observed John struggling significantly with **walking due to his worsening knee pain and experiencing severe back pain** as a result. One specific instance that stands out occurred in **June 2019** when John and I attended a local gathering. During the event, he had difficulty standing for more than a few minutes at a time and had to frequently sit down due to knee pain and discomfort in his lower back.

At one point, when attempting to walk across a parking lot, **his knee gave out**, and he nearly fell. He had to lean on me for support just to make it back to the car. I could see the frustration on his face, as this was something he never struggled with before. After that, he started relying more on assistive devices like a **cane** to support his mobility.

John also mentioned during our conversations that **stairs had become a major challenge for him**. Even something as simple as going up a few steps took a lot of effort and caused him considerable pain. Additionally, his back pain became more severe, leading to noticeable **stiffness and discomfort when sitting for long periods**.

Impact on His Daily Life

Due to these worsening conditions, John has **severely limited his physical activity**. He often has to decline social outings because standing and walking for too long causes unbearable pain. Even simple tasks like **grocery shopping, household chores, and getting in and out of a car** have become **extremely difficult for him**. I have seen firsthand how much this has negatively affected his quality of life, and I truly believe his current disability rating does not fully reflect the extent of his struggles.

I am submitting this letter as a **firsthand witness to John's deteriorating condition** and to support his **claim for an increased VA disability rating**. 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 **(212) 312-6451** or **williamsharp@gmail.com** if any further information is needed.

Sincerely,

William Sharp

William Sharp

BUDDY LETTER #2

Frank Boyd
101 Saint Michael Way
Houston, TX 77101
Email: frankboyd@gmail.com
Phone: (713) 444-5454

March 3, 2025

Department of Veterans Affairs
To Whom It May Concern,

Subject: Buddy Letter in Support of VA Disability Claim for Increased Rating – John A. Doe

I, **Frank Boyd**, am writing this letter in support of my **brother-in-law, John A. Doe**, regarding his **VA disability claim for an increased rating** due to the worsening of his **knee pain and back pain**. Over the years, I have personally witnessed how his condition has deteriorated, making daily tasks and mobility significantly more difficult for him.

Observation of Worsened Symptoms

From **May 2020 to June 2024**, I have noticed a steady decline in John's ability to **walk, stand for extended periods, and manage his back pain**. One specific instance that stands out took place in **March 2023** when John and I went to a family gathering at my home.

During the event, I noticed John struggling to move around, especially when trying to get up from his chair. He **winced in pain every time he took a step**, and I could see he was placing most of his weight on his **right leg to compensate for his knee pain**. At one point, while attempting to step down from the porch, **his knee gave out**, causing him to nearly fall. He had to grab onto the railing for support, and I had to help him stabilize himself. He told me that this kind of instability was becoming more frequent, making him fearful of walking long distances without assistance.

Additionally, John's **back pain has worsened considerably**. He frequently complains about **stiffness and discomfort, especially after sitting for too long**. At family dinners, he often has to **stand up and stretch every few minutes** to relieve the tension in his lower back. He mentioned to me that **sleep has become increasingly difficult** due to the constant aching in his knees and back, which leaves him feeling **fatigued and in pain throughout the day**.

Impact on His Daily Life

Due to the **worsening of his knee and back pain**, John's ability to perform **basic activities has been significantly impaired**. He avoids stairs as much as possible and **relies heavily on a cane** for support. Activities he once enjoyed, like **yard work and going for walks, are now impossible** due to his limited mobility. Even **household chores, such as carrying groceries or standing for extended periods while cooking, have become unbearable for him**.

John has also expressed frustration and emotional distress over his loss of independence. He used to be a very active and self-sufficient person, but now he frequently needs help with even the simplest of tasks. This has taken a toll on his **mental and emotional well-being**, and I strongly believe his current disability rating does not accurately reflect the severity of his condition.

I am submitting this letter as a **firsthand witness to John's worsening condition** and to support his **claim for an increased VA disability rating**. 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 **(713) 444-5454** or **frankboyd@gmail.com** if any further information is needed.

Sincerely,

Frank Boyd

Frank Boyd

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]