OMB Approved No. 2900-0659
Respondent Burden: 45 minutes
Expiration Date: 03/31/2027

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

STATEMENT IN SUPPORT OF CLAIMED MENTAL HEALTH DISORDER(S) DUE TO AN IN-SERVICE TRAUMATIC EVENT(S)

INSTRUCTIONS: Before completing this form, we encourage you to read the Privacy Act and Respondent Burden on page 7. Use this form to provide a statement in support of a claimed mental health disorder(s) due to an in-service traumatic event(s). For more information, you can contact us online through Ask VA: **https://ask.va.gov/** or call us toll-free at 1-800-698-2411 (TTY:711). VA forms are available at **www.va.gov/vaforms**.

SECTION I: VETERAN/SERVICE MEMBER'S IDENTIFICATION INFORMATION

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

1. VETERAN/SERVICE MEMBER'S NAME (First, Middle Initial, Last)

John A Doe

2. SOCIAL SECURITY NUMBER: 111-11-1111

3. VA FILE NUMBER (If applicable): 111111111

4. DATE OF BIRTH (MM/DD/YYYY): 01-01-1970

5. VETERAN'S SERVICE NUMBER (If applicable): 111111111

6. TELEPHONE NUMBER (Include Area Code): 123-456-7890

Enter International Phone Number (If applicable) _____

7. E-MAIL ADDRESS (Optional)

123 Veteran Rd., Houston, TX 12345

SECTION II: TRAUMATIC EVENT(S) INFORMATION

8. SELECT THE TYPE OF IN-SERVICE TRAUMATIC EVENT(S) YOU EXPERIENCED (Check more than one, if applicable)

- [X] COMBAT TRAUMATIC EVENT(S)
- [ ] PERSONAL TRAUMATIC EVENT(S) (not involving military sexual trauma (MST)
- [ ] PERSONAL TRAUMATIC EVENT(S) (involving MST) (if checked review Section VI)
- [ ] OTHER TRAUMATIC EVENT(S)

IMPORTANT: It is helpful, but not required, to complete all applicable sections of the form. Please provide information about where and when the in-service traumatic event(s) occurred. Including this information will help to identify records and sources of information that may support your claim. If you are unable to include this information or only provide approximate dates or locations, VA will still review and consider all the evidence available to support your claim. **See the following three examples for guidance on how to complete Items 9A through 9C**.

EXAMPLES OF BRIEF DESCRIPTION OF THE TRAUMATIC EVENT(S)	EXAMPLES OF LOCATION OF THE TRAUMATIC EVENT(S)	EXAMPLES OF DATES THE TRAUMATIC EVENT(S) OCCURRED
Example 1. Corpsman on medical ship in Da Nang harbor, Vietnam	STATIONED ON U.S.S. XYZ	SUMMER OF '70
Example 2. Mugged	BACK ALLEY IN BIG TOWN, USA	JUNE 2007
Example 3. Sexually assaulted by drill instructor	FORT XYZ	BOOT CAMP

Note: Briefly summarize the nature of the traumatic event(s) you experienced. While providing this information may be difficult, this information may help identify evidence to support your claim. If you provide name(s) of other individuals who were involved or present during the traumatic event(s), VA will not contact these individual(s). Please know providing name(s) is not required for VA to continue processing your claim. **Use Section V: "Remarks" if additional space is needed**.

	9A. BRIEF DESCRIPTION OF THE TRAUMATIC EVENT(S) (e.g., injury in warfare, physical assault, sexual harassment, witnessed the death or injury of a person, etc.)	9B. LOCATION OF THE TRAUMATIC EVENT(S) (e.g., unit assignment, residence, off-base, duty station or state, if known)	9C. DATE(S) THE TRAUMATIC EVENT(S) OCCURRED (e.g., month(s) or year(s), if known, or approximate dates are acceptable)
1.	I experienced constant indirect artillery fire and IEDs	Green Zone, Baghdad,Iraq	01/2010-01/2011
2.			
3.			

SECTION II: TRAUMATIC EVENT(S) INFORMATION (Continued)			
4.			
5.			
6.			

SECTION III: ADDITIONAL INFORMATION ASSOCIATED WITH THE IN-SERVICE TRAUMATIC EVENT(S)

IMPORTANT: This information will help us identify records or sources of evidence that may support your claim. If you are unable to include this information, VA will still review and consider all the evidence available to support your claim. **If additional space is needed, use Section V: "Remarks"**.

Note: VA understands that in-service traumatic event(s) may not have been reported or documented. In these situations, other information, such as behavioral changes and/or sources of evidence, may be used to support the in-service traumatic event(s).

10. INDICATE ANY BEHAVIORAL CHANGES FOLLOWING THE IN-SERVICE PERSONAL TRAUMATIC EVENT(S) (**Note**: Behavioral changes can include but are not limited to the examples listed in Items 10A through 10C. If your traumatic event(s) is combat only, you may skip to Item 11.)

A. BEHAVIORAL CHANGES EXPERIENCED FOLLOWING THE TRAUMATIC EVENT(S) (Check any box that applies)		B. ADDITIONAL INFORMATION ABOUT THE BEHAVIORAL CHANGES (If applicable) (e.g., approximate time change occurred, documentation, or record)
☒	INCREASED/DECREASED VISITS TO A HEALTHCARE PROFESSIONAL, COUNSELOR, OR TREATMENT FACILITY	difficulty sleeping and increase in anxiety level
☐	REQUEST FOR A CHANGE IN OCCUPATIONAL SERIES OR DUTY ASSIGNMENT	
☐	INCREASED/DECREASED USE OF LEAVE	
☒	CHANGES IN PERFORMANCE OR PERFORMANCE EVALUATIONS	It became difficult to stay focus on getting assigned tasks done. It became difficult to concentrate.
☒	EPISODES OF DEPRESSION, PANIC ATTACKS, OR ANXIETY	I experience constant emotional distress, including persistent mood swings and anxiety.
☐	INCREASED/DECREASED USE OF PRESCRIPTION MEDICATIONS	
☐	INCREASED/DECREASED USE OF OVER-THE-COUNTER MEDICATIONS	
☒	INCREASED/DECREASED USE OF ALCOHOL OR DRUGS	I turned to drinking as a way to numb the emotional pain.
☐	DISCIPLINARY OR LEGAL DIFFICULTIES	
☐	CHANGES IN EATING HABITS, SUCH AS OVEREATING OR UNDEREATING, OR SIGNIFICANT CHANGES IN WEIGHT	

SECTION III: ADDITIONAL INFORMATION ASSOCIATED WITH THE IN-SERVICE TRAUMATIC EVENT(S) (Continued)

☐	PREGNANCY TESTS AROUND THE TIME OF THE TRAUMATIC EVENT(S)	
☐	TESTS FOR SEXUALLY TRANSMITTED INFECTIONS	
☒	ECONOMIC OR SOCIAL BEHAVIORAL CHANGES	I became socially withdrawn as I find it difficult to engage with others or trust people around me.
☐	CHANGES IN OR BREAKUP OF A SIGNIFICANT RELATIONSHIP	

C. AS NEEDED, LIST ANY ADDITIONAL BEHAVIORAL CHANGES FOLLOWING THE IN-SERVICE PERSONAL TRAUMATIC EVENT(S) THAT WERE **NOT LISTED** IN ITEM 10A.

Since the incident I experience sleep disturbances, as nightmares and intrusive thoughts prevent me from getting adequate rest. I also developed a diminished sense of safety, making it difficult for me to function in both personal and professional settings.

11. WAS AN OFFICIAL REPORT FILED? (**Note**: When reporting a sexual assault during military service, the Department of Defense offers two different reporting options, restricted or unrestricted. Knowing the report type will help VA take the necessary steps to obtain a copy of the report. If you are unsure which report was filed, VA may send you a follow up letter with additional information. Submitting a restricted or unrestricted report was not an option prior to 2005.)

☐ YES (If "Yes," check the appropriate box below indicating which type of report was filed)

☐ NO (If "No," skip to Item 12)

☐ RESTRICTED ☐ UNRESTRICTED ☐ NEITHER

☐ POLICE REPORT (Provide location, if known)

☐ OTHER (e.g., After Action Report (AAR), incident report, formal complaint, Judge Advocate General (JAG), Criminal Investigative Division (CID), Naval Criminal Investigative Service (NCIS), etc.)

12. POSSIBLE SOURCES OF EVIDENCE FOLLOWING THE TRAUMATIC EVENT(S) (Check all that apply) (**Note**: The following sources of evidence may provide additional information for your claim. This list is not all inclusive. If you have any individual(s)/witness(es) who know(s) about the in-service traumatic event(s) or would have knowledge of a behavioral change you experienced after the personal traumatic event(s), and wants to provide a statement on your behalf, use VA Form 21-10210, *Lay/Witness Statement*. If your individual(s)/witness(es) is a veteran, they may be requested to provide their DD Form 214, or other evidence of service.)

☐ A RAPE CRISIS CENTER OR CENTER FOR DOMESTIC ABUSE
☐ A COUNSELING FACILITY OR HEALTH CLINIC
☐ FAMILY MEMBERS OR ROOMMATES
☐ A FACULTY MEMBER
☐ CIVILIAN POLICE REPORTS
☒ MEDICAL REPORTS FROM CIVILIAN PHYSICIANS OR CAREGIVERS WHO TREATED YOU IMMEDIATELY FOLLOWING THE INCIDENT OR SOMETIME LATER
☐ A CHAPLAIN OR CLERGY
☐ FELLOW SERVICE MEMBER(S)
☐ PERSONAL DIARIES OR JOURNALS
☐ NONE
☐ OTHER (Specify below):

SECTION IV: TREATMENT INFORMATION

13A. HAVE YOU RECEIVED TREATMENT RELATED TO THE IMPACT OF THE TRAUMATIC EVENT(S) LISTED IN ITEM 9A?

☒ YES (If "Yes," complete Items 13B through 13E) ☐ NO (If "No," skip to Item 14)

13B. IDENTIFY WHERE YOU HAVE RECEIVED TREATMENT (Check all that apply)

☐ PRIVATE HEALTHCARE PROVIDER (including non-Federal records)
☐ VA VET CENTER
☐ COMMUNITY CARE (Paid for by VA)
☒ VA MEDICAL CENTER(S) (VAMC) AND COMMUNITY-BASED OUTPATIENT CLINICS (CBOC)
☐ DEPARTMENT OF DEFENSE (DOD) MILITARY TREATMENT FACILITY(IES) (MTF)

Note: VA has access to VAMC, CBOC, and MTF records. A consent form is not needed. However, if you would like VA to attempt to obtain your **private provider (excluding community care (paid for by VA)) or VA Vet Center health records**, VA requires your consent by completing VA Form 21-4142, and VA Form 21-4142a. VA forms are available at **www.va.gov/vaforms**

SECTION IV: TREATMENT INFORMATION (Continued)

Note: If VAMC, CBOC, or MTF treatment began from 2005 to present, you **do not** need to provide dates in Item 13D.

13C. NAME AND LOCATION OF THE TREATMENT FACILITY	13D. DATE(S) OF TREATMENT (Approximate dates are acceptable) (MM-YYYY)	13E. CHECK THE BOX IF YOU DO NOT HAVE DATE(S) OF TREATMENT
Houston VA Houston, TX	05 – 2020	☐ Don't have date
Houston VA Houston, TX	01 – 2021	☐ Don't have date
Houston VA Houston, TX	08 – 2021	☐ Don't have date

SECTION V: REMARKS

Note: This section is optional and can be left blank. However, if additional space is needed to fully answer a previous question or if needed, use this section to provide any additional information that you feel is important for us to know that may support your claim.

14. REMARKS (If any)

Despite undergoing therapy and taking prescribed medication, I continue to experience severe and persistent symptoms that make it difficult to live a normal life, maintain employment, and engage with loved ones. The chronic nature of PTSD has disrupted my ability to function both socially and professionally.

SECTION VI: OPTION FOR VETERANS BENEFITS ADMINISTRATION (VBA) TO NOTIFY VETERANS HEALTH ADMINISTRATION (VHA) ABOUT CERTAIN UPCOMING EVENTS DURING THE CLAIM AND/OR APPEAL PROCESS

(Note: This section only applies if you checked personal traumatic event(s) (involving MST) in Item 8)

15. If you are filing a claim for compensation for a condition due to a personal traumatic event(s) (involving MST) and you are registered and/or enrolled for VHA health care, you have the option for VBA to electronically notify VHA about certain upcoming event(s) during your claim and/or appeal process. These events are any scheduled compensation and pension (C&P) examination, hearing before the Board of Veterans' Appeals, and any decision notification. When notified, VHA will place an indicator in your medical record to alert VA health care providers that these events are scheduled to occur. Notifications to VHA would only indicate the type of event and potential time frame, not any details specific to your claim. The indicator in your medical record would not identify your claim as MST-related, but at this time, only claimants filing MST-related claims are provided this notification option. For this reason, providers may know that the indicator is in relation to an MST-related claim. The decision to **consent, not consent,** or **revoke prior consent** into the automatic notification system will not affect the status or outcome of your claim. If you would like VBA to send these electronic notifications to VHA, please indicate your consent by selecting a check box below.

☐ A. I **CONSENT** TO HAVE VBA NOTIFY VHA ABOUT CERTAIN UPCOMING EVENTS RELATED TO MY CLAIM AND/OR APPEAL (**Note**: I understand that an indicator for these events will appear in my VHA medical record)

☐ B. I **DO NOT CONSENT** TO HAVE VBA NOTIFY VHA ABOUT CERTAIN UPCOMING EVENTS RELATED TO MY CLAIM AND/OR APPEAL (**Note**: I understand that an indicator for these events will not appear in my VHA medical record)

☐ C. I **REVOKE PRIOR CONSENT** TO HAVE VBA NOTIFY VHA ABOUT CERTAIN UPCOMING EVENTS RELATED TO MY CLAIM AND/OR APPEAL (**Note**: I understand that in the future, notice of these events will no longer appear in my VHA medical record)

☒ D. **NOT APPLICABLE AND/OR NOT ENROLLED OR REGISTERED IN VHA HEALTHCARE**

Note: You have the option to modify your previous selection at any time. Mail your correspondence to: **Department of Veterans Affairs, Compensation Intake Center, P.O. Box 4444, Janesville, WI 53547-4444**.

SECTION VII: CERTIFICATION AND SIGNATURE

I CERTIFY THAT the foregoing statement(s) are true and correct to the best of my knowledge and belief.

16A.VETERAN/SERVICE MEMBER'S SIGNATURE	16B. DATE SIGNED (MM/DD/YYYY)
John A. Doe	03 – 11 – 2025

SECTION VIII: WITNESSES TO SIGNATURE
(Note: Only use this section if the veteran/service member signed Item 16A with an "X")

17A. SIGNATURE OF WITNESS	17B. PRINTED NAME AND ADDRESS OF WITNESS

18A. SIGNATURE OF WITNESS	18B. PRINTED NAME AND ADDRESS OF WITNESS

SECTION IX: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE
(Note: Only required if Item 16A 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.

19A. ALTERNATE SIGNER'S SIGNATURE	19B. DATE SIGNED (MM/DD/YYYY)
	– –

SECTION X: POWER OF ATTORNEY (POA) SIGNATURE
(Note: Only required if Item 16A is blank)

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.

20A. POA/AUTHORIZED REPRESENTATIVE'S SIGNATURE	20B. DATE SIGNED (MM/DD/YYYY)
	– –
20C. ACCREDITATION NUMBER	20D. DATE LAST VA FORM 21-22 OR VA FORM 21-22A WAS SUBMITTED (If known)
	– –

PRIVACY ACT NOTICE: 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 VA system of records, 58VA21/22/28, Compensation, Pension, Education and Veteran Readiness and Employment Records - VA, published in the Federal Register. Completion and submission of this form is voluntary. However, the requested information is important to assist VA in thoroughly researching your military record and other sources to obtain supporting evidence of traumatic event(s) in service. The responses you submit are considered confidential (38 U.S.C. 5701).

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 2900-0659, and it expires 03/31/2027. Public reporting burden for this collection of information is estimated to average 45 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. 2900-0659 in any correspondence. Do not send your completed VA Form 21-0781 to this email address.

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	0001	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)*

BRONZE STAR MEDAL//ARMY COMMENDATION MEDAL (2ND AWARD)//ARMY ACHIEVEMENT MEDAL (2ND AWARD)//NATIONAL DEFENSE SERVICE MEDAL (2ND AWARD)//ARMED FORCES EXPEDITIONARY MEDAL//GLOBAL WAR ON TERRORISM EXPEDITIONARY//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
	☒ YES ☐ NO

18. RETIREMENT SYSTEM OPTION					19. DD214-1 (Accompanies this DD214)	
☐ FINAL	☐ HIGH-3	☒ REDUX	☐ BRS		☒ YES	☐ NO

20. REMARKS

SERVED IN A DESIGNATED IMMINENT DANGER PAY AREA/ SERVICE IN IRAQ 20100101-20110101//
INDIVIDUAL COMPLETED PERIOD FOR WHICH ORDERED TO ACTIVE DUTY FOR PURPOSE OF POST SERVICE BENEFITS AND ENTITLEMENTS//ORDERED TO ACTIVE DUTY IN SUPPORT OF OPERATION IRAQI FREEDOM IAW 10 USC 12302//MEMBER HAS COMPLETED FIRST FULL TERM OF SERVICE//CONT FROM BLOCK 13: MEDAL//
GLOBAL WAR ON TERRORISM SERVICE MEDAL//ARMED FORCES SERVICE MEDAL (AFSM)//IRAQ CAMPAIGN MEDAL W/ CAMPAIGN STAR//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 am submitting this statement in support of my VA claim for **Post-Traumatic Stress Disorder (PTSD)**, which has significantly impacted my daily life and ability to function normally.

Disability and Symptoms

After my military service, I began experiencing persistent Flashbacks, nightmares, physical reactions, feeling detached, irritability while living in **Houston, Texas**. I was formally diagnosed with **PTSD in May 2020**, and my condition has **deteriorated despite ongoing medical treatment**.

Current Treatment Plan:

- **Cognitive Behavioral Therapy (CBT)** to help manage intrusive thoughts and emotional distress
- **Antidepressant Medication** to address anxiety, depression, and sleep disturbances

Impact on My Daily Life

Since my diagnosis of PTSD, my **normal life has been shattered**. The effects of this condition have made it nearly impossible to function as I once did.

- **Social Isolation:** I struggle to socialize and often feel detached from those around me. To cope with my symptoms, I isolate myself, which has **strained relationships with my family and friends**.
- **Sleep Disturbances:** I experience **severe nightmares and flashbacks**, waking up frequently throughout the night. The lack of sleep leaves me **lethargic and exhausted**, making it difficult to get through the day.
- **Cognitive Impairment:** My **ability to focus and complete tasks has declined significantly**. Simple tasks that I used to handle with ease now require extra time and effort.
- **Irritability and Hypervigilance:** I feel **constantly on edge and easily startled**, which affects my ability to relax or engage in everyday activities.
- **Loss of Appetite:** Due to ongoing anxiety and stress, I struggle to **maintain a normal eating schedule**, which has negatively impacted my overall health.

Conclusion

Despite undergoing therapy and taking prescribed medication, I continue to experience **severe and persistent symptoms** that make it difficult to live a normal life, maintain employment, and engage with loved ones. The chronic nature of PTSD has disrupted my ability to function both socially and professionally.

I respectfully request that my claim be **reviewed and considered for benefits** to reflect the **ongoing and life-altering impact** of my condition.

Sincerely,

John A. Doe

John A. Doe

NEXUS STATEMENT

Jennifer Jenkins, MD
124 Bronson Street
Houston, TX 12345
(718)242-5255

NEXUS LETTER
Date: March 3, 2025

Patient Name: John Doe
Patient Address: 123 Veteran Rd., Houston, TX 12345

To Whom It May Concern,

I am writing this medical opinion letter on behalf of **John Doe** in support of his **VA disability claim for Post-Traumatic Stress Disorder (PTSD)**. I have reviewed Mr. Doe's medical history, including his **service treatment records, mental health evaluations, and personal accounts of his trauma**. Based on my professional assessment and expertise, I conclude that **Mr. Doe's PTSD is at least as likely as not (50% or greater probability) caused by his military service and combat exposure during his deployment to Iraq.**

Medical History & Cause of Disability

Mr. Doe served in **Iraq from January 2010 – January 2011**, during which he was subjected to **constant indirect artillery fire, IED explosions, and life-threatening combat conditions.** As a result of these traumatic experiences, he has developed **severe PTSD symptoms that continue to impact his daily life.** He was diagnosed with **PTSD on July 2020** at **Ft. Bragg Medical Facility**, where he first sought treatment for **flashbacks, nightmares, and heightened anxiety.**

Symptoms & Functional Limitations

Mr. Doe presents with the following **PTSD symptoms**:

- **Frequent flashbacks** and **intrusive thoughts** related to combat
- **Severe nightmares** causing chronic sleep disturbances
- **Hyperarousal**, including **irritability, mood swings, and physical reactions** (sweating, rapid heart rate)
- **Detachment and avoidance**, including **difficulty maintaining relationships and social interactions**
- **Difficulty focusing and processing thoughts**, impacting his ability to work or complete daily tasks

These symptoms **severely limit his ability to function in social, occupational, and personal settings**. Mr. Doe has **expressed difficulty maintaining employment due to his PTSD-related anxiety, irritability, and inability to focus.** Additionally, he **struggles with normal daily activities, including eating and sleeping, due to hypervigilance and emotional distress.**

Current Treatment & Prognosis

Mr. Doe's **ongoing treatment plan** includes:

- **Cognitive Behavioral Therapy (CBT)** to address intrusive thoughts and trauma-related emotions
- **Antidepressant medication** to manage anxiety, depression, and sleep disturbances
- **Trauma-focused therapy** aimed at improving coping mechanisms

Despite treatment, **Mr. Doe continues to experience persistent PTSD symptoms that impair his ability to live a normal life.**

Medical Opinion & Causal Link to Service

Based on my **professional medical evaluation**, review of Mr. Doe's **combat history, symptoms, and treatment records**, it is my opinion that:

- **John Doe's PTSD is at least as likely as not (50% or greater probability) a direct result of his combat exposure in Iraq.**
- **His current symptoms, as documented in medical records, are consistent with trauma-related PTSD.**
- **His condition has resulted in significant impairments in daily functioning, relationships, and occupational stability.**

Conclusion

Given the severity of Mr. Doe's PTSD symptoms and the direct connection to his military service, it is my professional recommendation that **his PTSD be recognized as a service-connected disability.** If any additional medical documentation or clarification is required, I am available for further consultation.

Sincerely,

Jennifer Jenkins

Jennifer Jenkins, MD
Psychologist

BUDDY LETTER #1

Buddy Letter in Support of PTSD VA Disability Claim
Date: March 3, 2025

To Whom It May Concern,

I, **Vincent Parker**, am writing this letter in support of my friend, **John A. Doe**, regarding his **PTSD** disability claim. I have known John for several years, and during this time, I have personally witnessed the challenges he faces due to **his service-related PTSD**.

From **July 2019 to March 2025**, I have observed **numerous instances where John struggled with PTSD symptoms, including flashbacks, nightmares, physical reactions, feeling detached, and extreme irritability.**

One specific event that stands out occurred in **November 2022** when John and I went to a **local grocery store**. While we were shopping, there was a sudden **loud noise from a dropped item**, and John immediately became **startled and visibly shaken.** His breathing became heavy, and he gripped the cart tightly as if he was bracing for something to happen. He seemed **disoriented and overwhelmed**, and it took several minutes for him to calm down. He later told me that the noise **triggered a flashback from his deployment**, making him feel as though he was back in a combat situation.

Additionally, I have noticed that John **frequently isolates himself** and avoids social gatherings. In the past, he used to be much more outgoing, but over time, he has become withdrawn. He often **declines invitations** to spend time with friends and family, stating that he doesn't feel comfortable around crowds. There have also been nights when he called me in distress, stating that he had just woken up from **a terrible nightmare** related to his time in service.

John's PTSD has significantly impacted his ability to function normally in day-to-day life. **His sleep is severely disrupted**, making him exhausted during the day. He has **difficulty concentrating and maintaining focus**, and even simple tasks sometimes feel overwhelming for him. His **irritability and heightened anxiety** have made it difficult for him to hold steady employment or maintain personal relationships.

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 **(419) 913-9878** or **vincentparker@gmail.com** if any further information is needed.

Sincerely,

Vincent Parker

Vincent Parker

Vincent Parker
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BUDDY LETTER #2

Buddy Letter in Support of 38 U.S.C. 1151 VA Disability Claim
Date: March 3, 2025

To Whom It May Concern,

I, **Jerry Johnson**, am writing this letter in support of my friend, **John A. Doe**, regarding his **PTSD** disability claim under **38 U.S.C. 1151**. I have known John for several years and have personally witnessed the difficulties he faces due to his condition, which has been exacerbated by improper medical treatment.

From **July 2019 to March 2025**, I have observed John struggle with **flashbacks, nightmares, physical reactions, detachment from others, and severe irritability.**

One specific instance that stands out occurred in **September 2023** when John and I were **at a local diner in Las Vegas**. As we were eating, a loud commotion occurred when a customer accidentally knocked over a stack of trays. John **immediately froze, his hands clenched tightly around the table, and he started sweating profusely.** His breathing became rapid, and his eyes darted around the room as if he was scanning for threats. It took me several minutes to help calm him down. When he finally relaxed, he told me that the **loud noise triggered a combat-related flashback from his deployment.**

John's PTSD symptoms have worsened over time due to **improper medication management and ineffective mental health treatment at the VA hospital.** He has mentioned on multiple occasions that **his prescribed medications were frequently changed without proper monitoring, causing severe mood swings, increased anxiety, and worsening nightmares.** There have been times when he has called me late at night, saying he couldn't sleep because the **nightmares were too intense** and that he was **experiencing severe paranoia and hypervigilance.**

Additionally, John has become **increasingly withdrawn from social activities** and avoids public places. In the past, he was more engaged and active, but now, he prefers to **stay isolated at home**. Even family gatherings have become overwhelming for him, leading to further emotional distress. His **irritability and inability to regulate emotions have caused strain on his personal relationships and ability to work.**

I strongly believe that John's worsening PTSD symptoms are **a direct result of inadequate care provided by the VA medical system.** His condition has significantly affected his **quality of life, social interactions, and ability to maintain employment.**

I am submitting this letter as a firsthand witness to John's struggles and to support his claim for **the benefits and compensation 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 **(702) 207-2425** or **jerryjohnson@gmail.com** if any further information is needed.

Sincerely,

Jerry Johnson

Jerry Johnson
1211 Saint Way
Las Vegas, NV 89138
(702) 207-2425
jerryjohnson@gmail.com

ADD MEDICAL DOCUMENTS HERE