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.

- ☐ 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)

James R Row

3. SOCIAL SECURITY NUMBER (SSN)

222 – 22 – 2222

4. HAVE YOU EVER FILED A CLAIM WITH VA?

☐ YES ☒ 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)

222222222

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

08 – 01 – 2025

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

222 – 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: 222 Veteran Way

Apt./Unit Number:

City: Fort Bragg

State/Province: NC

Country: US

ZIP Code/Postal Code: 82345 –

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

Jamesrow@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:**			

VETERAN'S SOCIAL SECURITY NO. 2 2 2 – 2 2 – 2 2 2 2

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. 222 – 22 – 2222

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 to my walking pattern**	July 2020
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
Pain in left knee: **Ft. Bragg Medical Facility**	07 – 2013	☐ Don't have date
Pain in right knee: **Ft. Bragg Medical Facility**	02 – 2014	☐ Don't have date
pain in both left and right knee: **Ft. Bragg Medical Facility**	05 – 2015	☐ 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:	08	01	2025

20B. PLACE OF LAST OR ANTICIPATED SEPARATION
Ft Bragg NC

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:			
TO:			

18th ABN Corps
Ft. Bragg, NC 24567

21E. CURRENT OR ASSIGNED PHONE NUMBER OF UNIT (Include Area Code)
(222)245-7890

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)
It will be retirement from active duty
☐ NO

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

24D. MONTHLY AMOUNT
$ 4,200.00

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. 222 – 22 – 2222

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.: 012787773214556 ☒ 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	010234455

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)
James R Row	02 – 02 – 2025

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**

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. 2 2 2 – 2 2 – 2 2 2 2

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:
Row, James R	ARMY	222222222	222222222

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)
20250801		(222)256-7890	jamesrow@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)
Ft. Bragg, NC	222 Veteran Way., Ft. Bragg, NC 82345

9a. LAST DUTY ASSIGNMENT AND MAJOR COMMAND	b. STATION WHERE SEPARATED
18th Airborne Corps	Ft. Bragg, NC

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	01	01
b. SEPARATION DATE THIS PERIOD	2025	08	01
c. NET ACTIVE SERVICE THIS PERIOD	0033	00	00
d. TOTAL PRIOR ACTIVE SERVICE	0000	00	00
e. TOTAL ACTIVE SERVICE	0033	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	2015	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
	☒ YES ☐ NO

18. RETIREMENT SYSTEM OPTION					19. DD214-1 (Accompanies this DD214)	
☐ 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 Way
Fayetville, NC 82345

March 3, 2025

Department of Veterans Affairs
To Whom It May Concern,

I, **John A. Doe**, am submitting this statement in support of my **pre-discharge disability claim** for my **service-connected knee pain**. Due to the severity of my condition and its impact on my ability to perform my military duties, I am filing for disability compensation before my separation from service.

Disability and Symptoms

I was diagnosed with **bilateral knee pain** while stationed at **Ft. Bragg, North Carolina**, in **July 2013**. Since then, my condition has worsened despite medical intervention, and I have undergone treatment at **Ft. Bragg Medical Facility** on the following dates:

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

Currently, I experience **persistent swelling, stiffness, weakness, instability, and severe pain in both knees**. These symptoms **prevent me from performing physical tasks required for active-duty service** and have significantly limited my overall mobility and quality of life.

Current Treatment and Functional Limitations

To manage my condition, my current treatment plan includes:

- **Daily use of painkillers** such as Naproxen and Advil, though they provide only temporary relief.
- **Regular physical therapy sessions**, which have shown minimal improvement.
- **Use of a knee brace** to provide additional stability, as my knees frequently buckle, increasing my risk of falls.

Despite adhering to my treatment plan, my **symptoms have worsened**, further impairing my ability to perform essential military tasks and daily activities.

Impact on Military Service and Daily Life

Due to the **severity of my knee pain and instability**, I am **unable to continue serving in an active-duty capacity**. My limitations include:

- **Inability to perform physical training (PT), including running or extended marching.**
- **Severe difficulty navigating stairs or uneven terrain**, making field exercises and operational duties impossible.
- **Unstable knees that frequently give out**, increasing my risk of falls and injuries.
- **Constant pain and swelling**, which interfere with standing or walking for extended periods.
- **Disrupted sleep due to knee pain, resulting in chronic fatigue and reduced readiness.**

Because of these limitations, I can **no longer meet the physical demands of military service**. My **inability to complete required duties** has negatively impacted my performance and has made it impossible for me to continue serving.

Request for Pre-Discharge Disability Compensation

As I prepare for separation from service, I am requesting **service-connected disability compensation** for my **bilateral knee condition**. Given the documented history of my disability, my **ongoing medical treatment, and its direct impact on my ability to serve**, I ask that my **VA disability claim be processed prior to my discharge to ensure a smooth transition to civilian life with the necessary support and benefits**.

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 STATEMENT

[Doctor's Letterhead]
Ft. Bragg Medical Facility
124 Honor Road
Ft. Bragg, NC 52345
Phone: (818) 248-8254

March 3, 2025

Department of Veterans Affairs
To Whom It May Concern,

Subject: Medical Nexus Letter in Support of Pre-Discharge VA Claim – John A. Doe

I, **Dr. Mathew Haines, MD**, am a board-certified **orthopedic specialist** at **Ft. Bragg Medical Facility** and have been treating **John A. Doe** for his **bilateral knee pain and secondary back pain**. This letter serves as a **medical nexus statement** in support of his **Pre-Discharge VA Disability Claim** for conditions that have significantly impacted his ability to perform military duties and daily activities.

Patient Information:

- **Patient Name:** John A. Doe
- **Patient Address:** 123 Veteran Way, Fayetteville, NC 82345
- **Primary Disability:** Bilateral Knee Pain
- **Secondary Disability:** Back Pain
- **Initial Diagnosis Date:** July 2013
- **Treatment Facility:** Ft. Bragg Medical Facility

Medical History & Treatment Plan

Mr. Doe has been under my care for **bilateral knee pain and associated back pain** that has progressively worsened. His treatment history includes:

1. **Pain Management:** Prescription of **Naproxen and Advil** to manage chronic inflammation and discomfort.
2. **Physical Therapy:** Regular sessions to improve joint mobility and muscle function, though symptoms persist.
3. **Assistive Devices:** Use of a **knee brace** for stability and mobility support.
4. **Physical Limitations:** Difficulty walking, standing for prolonged periods, and navigating stairs due to **persistent pain, stiffness, and weakness in both knees**.

Impact on Military Duties & Daily Life

Due to his **chronic knee and back pain**, Mr. Doe experiences **significant functional limitations**, including:

- **Inability to perform physical training (PT) without severe pain.**
- **Difficulty standing for extended periods, running, or engaging in load-bearing exercises.**
- **Limited ability to perform fieldwork or carry heavy equipment.**
- **Daily discomfort affecting his mobility and overall quality of life.**

Medical Opinion Supporting Pre-Discharge Claim

Based on my **review of Mr. Doe's medical history, treatment records, and clinical evaluations**, I conclude that:

1. **It is at least as likely as not (50% or greater probability) that his bilateral knee and back conditions are directly related to his military service.**
2. **These conditions have progressively worsened despite treatment, limiting his ability to continue active duty.**
3. **Mr. Doe's functional impairments will continue post-discharge and will require ongoing medical care and VA benefits.**

Conclusion

Given the severity and **chronic nature of his disabilities**, I **strongly support Mr. Doe's Pre-Discharge VA Claim**. His **bilateral knee and back conditions are directly service-connected**, and he should be **granted the appropriate VA disability benefits upon separation** to ensure continued treatment and support.

If additional medical documentation or clarification is required, please feel free to contact my office at **(818) 248-8254**.

Sincerely,

Mathew Haines

Dr. Mathew Haines, MD
Orthopedic Specialist
Ft. Bragg Medical Facility
124 Honor Road, Ft. Bragg, NC 52345

BUDDY LETTER #1

Roger Green
84 Airborne Rd.
Fayetteville, NC 82121
Email: rogergreen@gmail.com
Phone: (812) 318-8451

March 3, 2025

Department of Veterans Affairs
To Whom It May Concern,

Subject: Buddy Letter in Support of Pre-Discharge VA Disability Claim – John A. Doe

I, **Roger Green**, am submitting this statement in support of **James R. Row's Pre-Discharge VA Disability Claim** for **bilateral knee pain and back pain**. I have served as James Row's **Unit Commander** in **A Company, 82nd Airborne Division** and have had firsthand experience observing the **progression of his condition** and the **impact on his military duties**.

Observation of Symptoms & Limitations

I first noticed **James R. Row's knee and back issues in July 2013** during **unit physical training exercises** at **Fort Bragg, North Carolina**. While performing **ruck marches and long-distance runs**, he **consistently struggled to keep pace with the unit** due to noticeable **limping and signs of discomfort**. Over time, I observed:

- **Frequent difficulty with prolonged standing, walking, and navigating stairs.**
- **Increased reliance on knee braces and physical therapy to manage pain.**
- **Reduced ability to complete ruck marches and airborne training due to knee instability and back pain.**
- **Challenges in fulfilling standard combat-readiness tasks.**

In one particular instance, during a **field training exercise in October 2015**, I witnessed James **struggle to carry equipment** due to his knee instability. Despite his determination to push through the pain, it was evident that his condition was worsening, and he was unable to perform at the level required of an airborne soldier.

Impact on Military Duties

James's knee and back issues have significantly **affected his ability to perform the physical demands of military service**, including:

- **Difficulty executing airborne jumps and landings without exacerbating his pain.**
- **Reduced endurance during ruck marches and field exercises.**
- **Limited ability to carry heavy gear or stand for extended periods without discomfort.**

- **Frequent absences from training activities due to medical appointments and therapy.**

Final Assessment

As his commander, I have personally observed his **deteriorating physical condition despite treatment and therapy**. Given the **severity and persistence of his symptoms**, it is clear that his **knee and back conditions will continue to impact his mobility and daily life post-discharge**.

I firmly believe that James R. Row's **bilateral knee pain and back pain are service-connected disabilities** and that he **should receive VA benefits and appropriate medical care upon separation**.

Please feel free to contact me at **(812) 318-8451** or via email at **rogergreen@gmail.com** if any further details or verification are needed.

Sincerely,

Roger Green

Roger Green
Unit Commander, A Company, 82nd Airborne Division

BUDDY LETTER #2

James Carroll
10 Saint Street
Fayetteville, NC 87101
Email: jamescarroll@gmail.com
Phone: (812) 288-8882

March 3, 2025

Department of Veterans Affairs
To Whom It May Concern,

Subject: Buddy Letter in Support of Pre-Discharge VA Disability Claim – James R. Row

I, **James Carroll**, am writing this letter in support of **James R. Row's Pre-Discharge VA Disability Claim** for **bilateral knee pain and back pain**. I have served alongside James in the **same unit** since **July 2013**, and I have personally witnessed the **progression of his condition** and the **physical difficulties he has endured** due to his injuries.

Observation of Symptoms & Limitations

I first noticed **James experiencing knee and back pain in July 2013** during our **unit training exercises** at **Fort Bragg, North Carolina**. During our ruck marches, PT runs, and airborne operations, James often **struggled with mobility** and would **frequently complain of knee discomfort and lower back pain**.

One specific instance occurred during a **12-mile ruck march in August 2015**, when James **had to slow down significantly** due to his **knee giving out**. I remember him **limping and shifting his weight to one side** in an attempt to ease the pain. Despite his efforts to keep up with the unit, it was clear that his **knee and back pain were affecting his performance**.

Additionally, I have observed him:

- **Avoiding prolonged standing due to knee and back discomfort.**
- **Struggling to carry gear and maintain balance during airborne operations.**
- **Missing physical training sessions due to medical appointments for his knee and back.**
- **Wearing a knee brace and frequently icing his knee after training exercises.**

Impact on Military Duties

Due to his ongoing **knee and back pain**, James has **faced significant physical limitations** that have affected his ability to perform essential military duties, including:

- **Inability to fully participate in ruck marches and long runs without stopping due to pain.**

- **Limited ability to perform airborne operations without aggravating his knee and back pain.**
- **Difficulty carrying heavy gear, resulting in decreased effectiveness in field exercises.**
- **Frequent need to modify or sit out of physical activities to prevent further injury.**

Final Assessment

Having served alongside James for over a decade, I have seen **firsthand how his knee and back conditions have progressively worsened despite medical treatment and physical therapy**. His condition has affected not only his **military performance** but also his **quality of life**.

I strongly believe that James R. Row's **bilateral knee pain and back pain are service-connected disabilities** that will continue to **affect him post-discharge**, and I fully support his **VA disability claim**.

If further details or verification are needed, please do not hesitate to contact me at **(812) 288-8882** or via email at **jamescarroll@gmail.com**.

Sincerely,

James Carroll

James Carroll
Former Unit Member

ADD MEDICAL DOCUMENTS HERE

HEALTH ASSESSMENT

Department of Veterans Affairs | SEPARATION HEALTH ASSESSMENT

PRIVACY ACT STATEMENT

This statement serves to inform you, as required by the Privacy Act of 1974, as amended, of the purpose for collecting personal information and how that information will be stored and used.

AUTHORITY: Title 10, United States Code (U.S.C.) § 1145, Health Benefits; Department of Defense (DoD) Instruction 6040.46, "Separation History and Physical Examination for DoD Separation Health Assessment Program"; 5 U.S.C. § 301, Departmental Regulations; 10 U.S.C. § 136, Under Secretary of Defense for Personnel and Readiness; Public Law 104-191, Health Insurance Portability and Accountability Act (HIPAA) of 1996; 10 U.S.C., Chapter 55, Medical and Dental Care; DoD Manual 6025.18, "Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs"; DoD Instruction 6490.08, "Command Notification Requirements to Dispel Stigmas in Providing Mental Health Care to Service Members"; and Executive Order 9397 (relating to Federal agency use of Social Security Numbers), as amended.

PURPOSE: The information collected is used to assist the DoD and/or Department of Veterans Affairs (VA) clinical examiners in assessing the health and wellness status of individuals separating from active duty, and in determining disqualifying medical condition(s) for medical retention and/or compensation.

ROUTINE USES: These records may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. § 552a(b)(3) as follows: to contractors and others performing or working for the Federal Government when necessary to accomplish an agency function related to this System of Records; to the Department of Health and Human Services, other Federal agencies, and academic institutions for the purposes of public health activities and conducting research; and to the VA for the purpose of providing medical care, to determine the eligibility for benefits, to coordinate cost sharing activities, and to facilitate collaborative research activities between DoD and VA. For a complete listing of the Routine Uses for this system, refer to the applicable System of Record Notice (SORN) hyperlinked below.

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Rules, as implemented within DoD pursuant to DoD Manual 6025.18. The use and disclosure of PHI concerning mental health care services are further limited by exigent circumstance rules and minimum necessary standards stated in DoDI 6490.08. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

APPLICABLE SORN: DoD SORN: EDHA 07, Military Health Information System (June 15, 2020, 85 FR 36190), <https://www.govinfo.gov/content/pkg/ FR-2020-06-15/pdf/2020-12839.pdf>; VA SORNs: 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records— VA (Nov. 8, 2021, 86 FR 61858), <https://www.govinfo.gov/content/pkg/FR-2021-11-08/pdf/2021-24372.pdf>; and 79VA10P2, Veterans Health Information Systems and Technology Architecture (VistA) Records-VA (Dec. 23, 2020, 85 FR 84114), <https://www.govinfo.gov/content/pkg/FR-2020-12-23/pdf/2020-28340.pdf>.

DISCLOSURE: Voluntary. If you choose not to provide the requested information, there may be an administrative delay; however, no penalty may be imposed. Information provided is deemed an official statement and may be subject to the Uniform Code of Military Justice.

PART A - SERVICE MEMBER IDENTIFICATION AND SELF-ASSESSMENT

SECTION I - IDENTIFICATION

NOTE TO THE SERVICE MEMBER: Please complete the following subsections.

IDENTIFIER

#	Question	Response
1	Name	
2	SSN (Social Security Number)	
3	DoD ID Number	
4	Today's Date (self-assessment date)	(YYYYMMDD)

1. CONTACT INFORMATION

#	Question	Response
1	Current Address	
2	Work Telephone Number	
3	Personal Telephone Number	
4	Government Email	
5	Personal Email	
6	Preferred method(s) of contact	◯ Mail ◯ Work Phone ◯ Personal Phone ◯ Government Email ◯ Personal Email

2. PERSONAL INFORMATION

#	Question	Response
1	Date of Birth (DoB)	(YYYYMMDD)
2	Age	

NAME		DOD ID NUMBER	
3	Race and Ethnicity (mark all that apply)	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Middle Eastern or North African	☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Choose not to answer
4	Birth Gender (biological sex)	◯ Female ◯ Male	◯ Non-binary
5	Gender Identity	◯ Female ◯ Male ◯ Non-binary ◯ Transgender male (Female to Male)	◯ Transgender female (Male to Female) ◯ Other: _____ ◯ Choose not to answer
6	Administrative Gender (gender identified on official military records)	◯ Female ◯ Male	

3. OCCUPATIONAL INFORMATION

#	Question	Response	
1	Service	◯ Army ◯ Navy ◯ Marine Corps ◯ Air Force	◯ Space Force ◯ Coast Guard ◯ Other: _____
2	Component	◯ Active Duty ◯ Reserve	◯ National Guard
3	Duty Status	◯ Active Component ◯ Active Duty – Non-Active Guard Reserve	◯ Active Duty – Active Guard Reserve ◯ Not on active duty
4	Usual Occupation (most recent day-to-day job)		
5	What is your military occupational code (for example: MOS, AOC, AFSC, NEC, or Designator Code)?		

4. EXAMINATION INFORMATION

#	Question	Response	
1	Exam Date (if known)	(YYYYMMDD) _____	
2	Purpose of Exam	◯ Separation from period of active service ◯ Separation from military service ◯ Medical Board	◯ Retirement ◯ Other: _____
3	Provide date or anticipated date of release from Active Duty	(YYYYMMDD) _____	
4	Do you intend to file a claim, or have you already filed a claim, for disability compensation with the Veterans Benefits Administration?	◯ Yes ◯ No (if no, skip to question 6)	

NAME		DOD ID NUMBER
5	Select the type of claim program/process	◯ FDC (Fully Developed Claim) Program ◯ IDES (Integrated Disability Evaluation System) (select this option only if you have been referred to IDES by your Military Service) ◯ BDD (Benefits Delivery at Discharge) (select this option only if you meet the criteria for the BDD program) ◯ Standard Claim Process ◯ Not sure
6	Have you ever filed a disability claim with the VA?	◯ Yes ◯ No
7	Have you had a physical exam within 12 months before your separation date?	◯ Yes ◯ No ◯ Unsure (if no or unsure, skip to Section II)
	Date of exam	(YYYYMM)
	Type of exam (for example: School, Flight, Special Duty)	
	Would you like that exam reviewed to determine if it is sufficient to meet the separation health assessment requirements?	◯ Yes ◯ No

SECTION II - REPORT OF MEDICAL HISTORY

Please complete all information in the following medical history questionnaire before your appointment for a Separation Health Assessment (SHA) Clinical Assessment. Your responses will help us understand your current health status and wellness. For each response, briefly describe the history, including dates, as indicated and applicable. If you are submitting a VA claim, then an appropriate evaluation, to include examinations and completion of any necessary Disability Benefits Questionnaires (DBQs), will be completed at a later date in order to ensure that the available information is sufficient for rating purposes.

Note: "Qualifying military service" includes: active duty; on orders 30 days or more in support of contingency operation(s); on continuous active duty orders for 180 days or more. This includes active duty, any period of active duty for training, and any period of inactive duty. (If additional space is needed to answer a question in this section, continue your response on page 14.)

1. GENERAL MEDICAL REVIEW

#	Question	Response
1	List your current medications, including supplements.	
2	Date of your most recent military service medical assessment/physical exam	(YYYYMMDD)
	Compared to your last military service medical assessment/physical exam, your overall health is:	◯ The Same ◯ Better ◯ Worse
		If better or worse, explain:
3	Overall, how would you rate your health during the PAST MONTH?	◯ The Same ◯ Better ◯ Worse
		If better or worse, explain:
4	During the PAST MONTH, did you have physical health problems (illness or injury) that made it difficult for you to do your work or other regular daily activities?	◯ Yes ◯ No
		If yes, explain:
5	Do you currently require hearing aids, special medical supplies, Continuous Positive Airway Pressure (CPAP), adaptive equipment, assistive technology devices, and/or other special accommodations?	◯ Yes ◯ No
		If yes, explain:
6	Have you had any surgery since your last health assessment/exam? (Include privately paid elective surgeries.)	◯ Yes ◯ No
		If yes, explain:

NAME		DOD ID NUMBER
7	Since your last health assessment/exam, has a health care provider recommended surgery(s) that you have not had (whether you are planning to have it or not)?	◯ Yes ◯ No If yes, explain:
8	Since your last health assessment/exam, have you received care or treatment for any medical and/or mental health condition(s) from a CIVILIAN or NON-MILITARY facility? This includes privately paid treatments and/or procedures (for example: photorefractive keratectomy (PRK), wisdom teeth removal, vasectomy, botox).	◯ Yes ◯ No If yes, explain:
9	Have you suffered from any injury or illness while on active duty for which you did not seek medical care (to include mental health)?	◯ Yes ◯ No If yes, explain:
During qualifying military service, have you ever experienced:		
10	Allergies, including environmental and occupational allergies, and adverse reaction to serum, food, insect stings, or medicine.	◯ Yes ◯ No If yes, explain:
11	High or bad cholesterol	◯ Yes ◯ No If yes, explain:
12	Tuberculosis	◯ Yes ◯ No If yes, explain:
13	Coughing up blood	◯ Yes ◯ No If yes, explain:
14	Asthma	◯ Yes ◯ No If yes, explain:
15	Bronchitis	◯ Yes ◯ No If yes, explain:
16	Chronic cough or cough at night	◯ Yes ◯ No If yes, explain:
17	Wheezing, shortness of breath, or difficulty breathing (other than asthma)	◯ Yes ◯ No If yes, explain:
18	Other lung problems (for example: Chronic Obstructive Pulmonary Disease (COPD), chronic bronchitis, pneumonia, emphysema)	◯ Yes ◯ No If yes, explain:

NAME		DOD ID NUMBER
19	Sinusitis	◯ Yes ◯ No If yes, explain:
20	Thyroid trouble or goiter	◯ Yes ◯ No If yes, explain:
21	Ear, nose, or throat trouble	◯ Yes ◯ No If yes, explain:
22	Frequent indigestion or heartburn (reflux)	◯ Yes ◯ No If yes, explain:
23	Stomach or intestinal problems (for example: ulcer)	◯ Yes ◯ No If yes, explain:
24	Kidney problems (for example: stones, infection)	◯ Yes ◯ No If yes, explain:
25	Liver problems (for example: hepatitis, cirrhosis)	◯ Yes ◯ No If yes, explain:
26	Constipation, loose bowels, or diarrhea	◯ Yes ◯ No If yes, explain:
27	Gallbladder trouble or gallstones	◯ Yes ◯ No If yes, explain:
28	Hernia	◯ Yes ◯ No If yes, explain:
29	Rectal disease, hemorrhoids, or blood from rectum	◯ Yes ◯ No If yes, explain:
30	Frequent or painful urination or blood in urine	◯ Yes ◯ No If yes, explain:
31	High or low blood sugar	◯ Yes ◯ No If yes, explain:

NAME		DOD ID NUMBER
32	Sugar or protein in urine	◯ Yes ◯ No If yes, explain:
33	Diabetes	◯ Yes ◯ No If yes, explain:
34	Recent unexplained gain or loss of weight	◯ Yes ◯ No If yes, explain:
35	A head injury, memory loss, or amnesia	◯ Yes ◯ No If yes, explain:
36	Recurring headaches/ migraines; frequent or severe headaches	◯ Yes ◯ No If yes, explain:
37	Periods of dizziness, fainting, or loss of consciousness	◯ Yes ◯ No If yes, explain:
38	Mental health problems (for example: depression, anxiety, Post-Traumatic Stress Disorder (PTSD), worry, or other mental health diagnosis)	◯ Yes ◯ No If yes, explain:
39	Neurological problems (for example: stroke, seizures, convulsions, epilepsy, fits, tremor)	◯ Yes ◯ No If yes, explain:
40	Paralysis	◯ Yes ◯ No If yes, explain:
41	Meningitis, encephalitis, or other neurological infection or disorder	◯ Yes ◯ No If yes, explain:
42	Rheumatic fever	◯ Yes ◯ No If yes, explain:
43	Prolonged bleeding	◯ Yes ◯ No If yes, explain:
44	Blood problems (for example: hemophilia, sickle cell disease)	◯ Yes ◯ No If yes, explain:

NAME		DOD ID NUMBER
45	Immune system problems (for example: HIV, chemotherapy, radiation)	◯ Yes ◯ No If yes, explain:
46	Angina, also called angina pectoris	◯ Yes ◯ No If yes, explain:
47	Congestive Heart Failure	◯ Yes ◯ No If yes, explain:
48	Pain, pressure, or discomfort in your chest	◯ Yes ◯ No If yes, explain:
49	Palpitations, pounding heart, or abnormal heartbeat	◯ Yes ◯ No If yes, explain:
50	Heart murmur or valve problem (for example: mitral valve prolapse)	◯ Yes ◯ No If yes, explain:
51	Coronary heart disease	◯ Yes ◯ No If yes, explain:
52	Heart attack (also called myocardial infarction)	◯ Yes ◯ No If yes, explain:
53	High blood pressure	◯ Yes ◯ No If yes, explain:
54	Low blood pressure	◯ Yes ◯ No If yes, explain:
55	Skin diseases (other than cancer)	◯ Yes ◯ No If yes, explain:
56	Cancer (other than skin)	◯ Yes ◯ No If yes, explain:
57	Skin cancer	◯ Yes ◯ No If yes, explain:

NAME		DOD ID NUMBER	

2. JOINT, SPINE, & MUSCULO-SKELETAL SYSTEM

#	Question	Response
During qualifying military service, have you ever experienced pain and/or injury in the following:		
1	Head and Neck	◯ Yes ◯ No If yes, explain:
2	Back and Chest	◯ Yes ◯ No If yes, explain:
3	Shoulder/Arm	◯ Yes ◯ No If yes, explain:
4	Elbow/Forearm	◯ Yes ◯ No If yes, explain:
5	Wrist/Hand/Fingers	◯ Yes ◯ No If yes, explain:
6	Hip/Thigh	◯ Yes ◯ No If yes, explain:
7	Leg/Knee	◯ Yes ◯ No If yes, explain:
8	Ankle/Foot/Toes	◯ Yes ◯ No If yes, explain:

3. HEALTH & WELLNESS

#	Question	Response
1	Do you currently use tobacco products (cigarettes, cigars, pipes, etc.), electronic nicotine products (e-cigarette/JUUL, e-hookah, vape-pen, vaporizer, tank system, other similar nicotine products), smokeless tobacco products (chewing tobacco, snuff, dip, snus (pronounced as “snoose”), or dissolvable tobacco)?	◯ Yes ◯ No If yes, explain:
2	Have you smoked at least 100 cigarettes in your entire life? (Note: A pack typically contains 20 cigarettes)	◯ Yes ◯ No If no, skip to question 5.
3	During the past 12 months, have you ever tried to stop smoking?	◯ Yes ◯ No ◯ Not Applicable If yes, explain:
4	Have you ever had a serious health problem that was caused or made worse by smoking?	◯ Yes ◯ No If yes, explain:

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5	During the past 12 months, how often were you exposed to secondhand smoke indoors (home, work, vehicle, etc.), a mixture of smoke that comes from the burning end of a tobacco product (cigarettes, cigars, pipes, etc.), or vapor indoors from a person using an e-cigarette/JUUL, ehookah, vape-pen, vaporizer, tank system, or other similar nicotine product?	◯ Daily ◯ Less than daily ◯ Not at all
6	Do you have any ongoing health concerns with past use of recreational drugs or misuse of prescription drugs?	◯ Yes ◯ No If yes, explain:

4. HEARING

#	Question	Response
1	During qualifying military service have you ever had, or do you now have, persistent or recurring noises in your head or ears? (for example: ringing, buzzing, humming)	◯ Yes ◯ No If yes, explain:
2	During qualifying military service have you ever had, or do you now have, a change in your hearing that impacts duty performance?	◯ Yes ◯ No If yes, explain:
3	Do you currently, or have you ever worn, a hearing aid?	◯ Yes ◯ No If yes, explain:
4	During your deployment or during military training, were you exposed to loud noises, to include blasts, that resulted in a temporary or permanent decrease in hearing and/or ringing, humming, buzzing sounds in your ears or head?	◯ Yes ◯ No If yes, how many times? For how long? Describe exposure and any symptoms you are still experiencing.

5. VISION

#	Question	Response
1	Do you wear corrective lenses (glasses or contacts)?	◯ Yes ◯ No If yes, explain:
During qualifying military service, have you ever experienced:		
2	Eye disorder or trouble	◯ Yes ◯ No If yes, explain:
3	Surgery to correct vision	◯ Yes ◯ No If yes, explain:
4	Loss of vision in either eye	◯ Yes ◯ No If yes, explain:
5	Double vision (diplopia)	◯ Yes ◯ No If yes, explain:

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6	Change in your vision that impacts your duty performance	◯ Yes ◯ No If yes, explain:

6. HEAD INJURY

#	Question	Response
During qualifying military service:		
1	As a result of any injury or event, did you receive a jolt or blow to your head that IMMEDIATELY resulted in losing consciousness; losing memory of events before or after the injury; or seeing stars, becoming disoriented, functioning differently, or nearly blacking out?	◯ Yes ◯ No ◯ Not Applicable If yes, check all that apply: ☐ Losing consciousness ("knocked out")? ☐ Losing memory of events before or after the injury? ☐ Seeing stars, becoming disoriented, functioning differently, or nearly blacking out?
2	How many total times did you receive a jolt or blow to your head?	
3	Have you ever experienced a head injury, concussion, or Traumatic Brain Injury (TBI)?	◯ Yes ◯ No If yes, explain:
4	As a result of any injury or event, where you received a jolt or blow to your head, or were diagnosed with a TBI:	
	Have you had prolonged symptoms that have not resolved?	◯ Yes ◯ No If yes, explain:
	Are you currently experiencing any prolonged symptoms that have not resolved?	◯ Yes ◯ No If yes, explain:

7. ENVIRONMENTAL/OCCUPATIONAL

This section covers various potentially hazardous occupational and environmental exposures during qualifying military service. Exposures may have occurred while deployed, in training, or during other assignments. Consider your potential exposure to: burn pits, oil well fires, burning trash, dust storms, air pollution, explosions, fuels/fumes, pesticides/insecticides, cleaning agents, solvents, heavy metals/depleted uranium, nerve agents/gases, protective medication and vaccines (for example: Pyridostigmine Bromide (PB), Lariam (Mefloquine) pills), persistent chemicals such as PCBs, asbestos, radiation, unusual food/drinking water exposures, contaminated water, and personal hygiene exposures (for example: swimming, showering, etc.).

#	Question	Response
1	Were you potentially exposed to any occupational/ environmental hazards (described above) while in a qualifying military duty service?	◯ Yes ◯ No ◯ Unsure If yes or unsure, provide details here:
2	Have you been based or stationed at a location where an open burn pit was used?	◯ Yes ◯ No ◯ Unsure If yes or unsure, provide details here:

NAME		DOD ID NUMBER
3	Have you been potentially exposed to toxic airborne chemicals or other airborne contaminants?	◯ Yes ◯ No ◯ Unsure If yes or unsure, provide details here:
4	If 2 or 3 is “Yes” or “Unsure,” have you enrolled in the Airborne Hazards and Open Burn Pit Registry?	◯ Yes ◯ No ◯ Not Applicable
5	Federal law requires eligible members to enroll in the Airborne Hazards and Open Burn Pit Registry or to opt-out. If eligible choose one: (See page 11 for more information on the registry.)	I wish to: ◯ enroll ◯ opt out ◯ Not Applicable
6	While deployed, were you potentially exposed to other deployment-related hazards?	◯ Yes ◯ No ◯ Unsure If yes or unsure, provide details here:
7	During any part of your qualifying military service, were you exposed to any of the following? (check all that apply)	☐ Medications to prevent malaria/malaria prophylaxis, including Mefloquine ☐ A vaccine with a possible complication ☐ Firefighting foam ☐ Solvents or other chemicals that may have caused skin reactions, breathing problems, or other concerns ☐ Fuels ☐ Contaminated water ☐ Radiation (include any possible exposure to depleted uranium) ☐ Other exposures of possible concern not listed here ☐ Embedded shrapnel ☐ Unsure
8	If you checked any exposures, including “unsure,” listed in question 7, please explain your exposure concerns in the right column, being as specific as possible.	Provide details of exposure concerns here:
9	Are you currently participating in any specialty occupational exposure examinations?	◯ Yes ◯ No If yes, explain:
During qualifying military service, have you ever experienced:		
10	A blast or explosion?	◯ Yes ◯ No If yes, explain:
11	A vehicular accident/crash (any vehicle including aircraft)?	◯ Yes ◯ No If yes, explain:
12	A fragment wound or bullet wound?	◯ Yes ◯ No If yes, explain:

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The Airborne Hazards and Open Burn Pit Registry (AHOBPR)

Are you eligible to participate? AHOBPR is open to Service members and Veterans who deployed to contingency operations in the Southwest Asia theater of operations at any time on or after August 2, 1990, or Afghanistan or Djibouti on or after September 11, 2001. The Southwest Asia theater includes the following countries, bodies of water, and the airspace above these locations: Iraq, Kuwait, Saudi Arabia, Bahrain, Gulf of Aden, Gulf of Oman, Oman, Qatar, and the United Arab Emirates; and waters of the Persian Gulf, Arabian Sea, Red Sea, Uzbekistan, and Syria. The VA will use deployment data provided by DoD to determine your eligibility. You can join the AHOBPR even if:
• You do not think you were exposed to specific airborne hazards.
• You are not experiencing symptoms or illnesses you think are related to exposures.
• You have not filed a VA claim for compensation and benefits or applied for VA health care.
• You are still an active duty Service member, reservist, or have returned to active service.

Visit www.publichealth.VA.gov/airbornehazards to learn more about airborne hazards and the AHOBPR.

If you are not eligible for the AHOBPR but are concerned about your exposures, you can still apply for VA health care and file a claim for compensation and benefits.

8. DENTAL

#	Question	Response
1	Do you currently have any dental problems that need to be evaluated?	◯ Yes ◯ No If yes, explain:
2	Have you ever been diagnosed or treated for oral cancer?	◯ Yes ◯ No If yes, explain:
During qualifying military service, have you ever experienced:		
3	A dental examination where you were told you had a Temporomandibular Disorder (TMD) or Temporomandibular Joint (TMJ) problem?	◯ Yes ◯ No If yes, explain:
4	Your jaw locked open and you could not close the jaw?	◯ Yes ◯ No If yes, explain:
5	Loss of a portion of the bone in your upper or lower jaw due to trauma or disease such as osteomyelitis or necrosis?	◯ Yes ◯ No If yes, explain:
6	Loss of any teeth because of service-related trauma?	◯ Yes ◯ No If yes, explain:
7	Physical (anatomical) loss or injury to your mouth, lips, or tongue?	◯ Yes ◯ No If yes, explain:

NAME _____ **DOD ID NUMBER** _____

9. WOMEN'S HEALTH / FEMALE REPRODUCTIVE ORGANS ☐ Not Applicable

#	Question	Response
During qualifying military service, have you ever:		
1	Been diagnosed with and/or treated for any of the following disorders? (check all that apply)	☐ Fibroids (leiomyomas) ☐ Endometriosis Date (YYYYMMDD): _____ Diagnosed by laparoscopy? ◯ Yes ◯ No ◯ Unsure ☐ Rectocele or cystocele ☐ Polycystic Ovarian Syndrome (PCOS) ☐ Infertility/difficulty getting pregnant ☐ Recurrent miscarriage (2 or more pregnancy losses) ☐ Ovarian cancer ☐ Cervical cancer ☐ Uterine/endometrial cancer ☐ Breast cancer ☐ Bone loss or osteoporosis ☐ Frequent urinary tract infections ☐ Urinary or fecal incontinence (leaking urine or stool)
2	Please provide additional details for all marked disorders in question 1 (for example: date diagnosed, treatment, medications, and treatment center).	
3	Had any of the following surgeries or injuries? (check all that apply)	☐ Breast surgery or breast biopsy ☐ Hysterectomy (uterus removed) ☐ Other uterine surgery (C-section, dilation and curettage (D&C), endometrial ablation, removal of fibroids, or other uterine surgery) ☐ Oophorectomy (ovaries removed) ◯ One ovary ◯ Both ovaries ☐ Other ovarian surgery ☐ Removal of ovarian cyst ☐ Treatment of ovarian torsion (twisting) ☐ Tubal surgery including tubal ligation ☐ Surgery for urinary/ fecal incontinence (leaking urine/stool) ☐ LEEP or cervical cone biopsy ☐ Vaginal/vulvar surgery or injury
4	Please provide additional detail for all marked surgeries in question 3 (for example: date diagnosed, treatment center).	
5	Pregnancy. List all pregnancies and associated outcomes and conditions.	

Date (YYYYMMDD)	Vaginal Delivery	C-Section	Miscarriage (loss before 20 weeks)	Stillbirth (loss at or after 20 weeks)	Ectopic (Tubal)	Termin-ation (Abortion)	Complications* (Depression or Anxiety)	Other**
_____	☐	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐	☐

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List dates, outcomes, treatment location, and complications, if any.
*Complications include, but are not limited to: depression, anxiety, high blood pressure in pregnancy, preeclampsia, etc.
**Provide additional information, as necessary (for example: gestational diabetes).

Have you ever had:

6	A breast cancer screening (mammogram)?	◯ Yes ◯ No ◯ Unsure (if no or unsure, skip to question 8)
	If yes, when was your last screening?	(YYYYMM)
7	An abnormal mammogram result?	◯ Yes ◯ No ◯ Unsure (if no or unsure, skip to question 8)
	If yes, when did the abnormal result occur? What was the abnormal result?	(YYYYMM)/Result
	If applicable, when did you receive treatment or follow-up care? What was the treatment or follow-up care?	(YYYYMM)/Treatment or Follow-up Care
8	A cervical cancer screening (Pap and/or HPV test):	◯ Yes ◯ No ◯ Unsure (if no or unsure, skip to question 10)
	If yes, when was your last screening?	(YYYYMM)
9	An abnormal result showing cancer or pre-cancer or a positive HPV test?	◯ Yes ◯ No ◯ Unsure (if no or unsure, skip to question 10)
	If yes, when did the abnormal result occur? What was the abnormal result?	(YYYYMM)/Result
	If applicable, when did you receive treatment or follow-up care? What was the treatment or follow-up care?	(YYYYMM)/Treatment or Follow-up Care

Are you currently:

	Still having menses (periods)?	◯ Yes (Enter the date of your last menstrual period and skip to question 11.) (YYYYMMDD) ◯ No ◯ Unsure
10	If no or unsure, why are you not having menses (periods)?	☐ Postmenopausal (no periods for 12 months or more) ☐ Hysterectomy ☐ Hormonal suppression (pills/ring/patch/shot/ IUD) ☐ Pregnant ☐ Lactating (breastfeeding) ☐ Unsure ☐ Other
	If you remember, what was the date of your last menstrual period?	(YYYYMM)
11	Experiencing any of the following? (check all that apply)	☐ Pelvic pain ☐ Current or recent genital lesions (sores on or near your vaginal area) ☐ Pelvic inflammatory disease, uterus prolapse, or displacement ☐ Pain during intercourse ☐ Leakage of urine affecting work/ social activities ☐ Leakage of stool ☐ Low libido (reduced interest in sex) ☐ Bleeding after menopause ☐ No If yes, explain:

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10. MENTAL HEALTH SCREENING QUESTIONNAIRES

NOTE TO THE SERVICE MEMBER: Please respond to the following screening questionnaires. Your responses will be reviewed by the Examining Clinician, and additional questions may be asked.

10.1. POST-TRAUMATIC STRESS DISORDER (PTSD) SCREEN

#	Question	Response
Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. In the past month, have you...		
1	Had nightmares about the event(s) or thought about the event(s) when you did not want to?	◯ Yes ◯ No
2	Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?	◯ Yes ◯ No
3	Been constantly on guard, watchful, or easily startled?	◯ Yes ◯ No
4	Felt numb or detached from people, activities, or your surroundings?	◯ Yes ◯ No
5	Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?	◯ Yes ◯ No

10.2 DEPRESSION SCREEN

#	Question	Response
Over the last 2 weeks, how often have you been bothered by any of the following problems?		
1	Little interest or pleasure in doing things?	◯ Not At All ◯ Several Days ◯ More Than Half the Days ◯ Nearly Every Day
2	Feeling down, depressed, or hopeless?	◯ Not At All ◯ Several Days ◯ More Than Half the Days ◯ Nearly Every Day

10.3. ALCOHOL USE SCREEN

#	Question	Response
1	How often did you have a drink containing alcohol in the past year?	◯ Never (Proceed to signature) ◯ Monthly or less ◯ 2-4 times a month ◯ 2-3 times per week ◯ 4 or more times a week
2	How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?	◯ 1 or 2 ◯ 3 or 4 ◯ 5 or 6 ◯ 7 to 9 ◯ 10 or more
3	For men: How often did you have six or more drinks on one occasion in the past year?	◯ Never ◯ Less than monthly ◯ Monthly ◯ Weekly ◯ Daily, or almost daily ◯ Not Applicable
4	For women: How often did you have four or more drinks on one occasion in the past year?	◯ Never ◯ Less than monthly ◯ Monthly ◯ Weekly ◯ Daily, or almost daily ◯ Not Applicable

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Before submitting, please review your responses to ensure they are accurate and complete.

Space for additional response(s). Note the question number before each response (for example, 3.1).

Signature of Service member	Date of signature (YYYYMMDD)

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]