



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)

J o h n A D o e

3. SOCIAL SECURITY NUMBER (SSN)

1 1 1 - 1 1 - 1 1 1 1

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)

0 1 - 0 1 - 1 9 4 9

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

1 1 1 1 1 1 1 1

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

-

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

1 2 3 - 2 4 5 - 7 8 9 0

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 1 2 3 V e t e r a n R d

Apt./Unit Number City H o u s t o n

State/Province T X Country U S ZIP Code/Postal Code 1 2 3 4 5 -

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

J o h n d o e @ g m a i l . c o m

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

SECTION II: CHANGE OF ADDRESS

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

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

☐ TEMPORARY ☐ PERMANENT

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

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code -

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

Month Day Year Month Day Year
BEGINNING DATE: - - ENDING DATE: - -

SECTION III: HOMELESS INFORMATION

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

14A. ARE YOU CURRENTLY HOMELESS?

- ☐ YES (If "Yes," complete Item 14B regarding your living situation)
- ☐ NO

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

- ☐ LIVING IN A HOMELESS SHELTER
- ☐ NOT CURRENTLY IN A SHELTERED ENVIRONMENT (e.g., living in a car or tent)
- ☐ STAYING WITH ANOTHER PERSON
- ☐ FLEEING CURRENT RESIDENCE
- ☐ OTHER (Specify) _____

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

- ☐ YES (If "Yes," complete Item 14D regarding your living situation)
- ☐ NO

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

- ☐ HOUSING WILL BE LOST IN 30 DAYS
- ☐ LEAVING PUBLICLY FUNDED SYSTEM OF CARE (e.g., homeless shelter)
- ☐ OTHER (Specify) _____

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

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

 - -
 Enter International Phone Number (If applicable)
SECTION IV: EXPOSURE INFORMATION

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

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

15B. DID YOU SERVE IN ANY OF THE FOLLOWING GULF WAR HAZARD LOCATIONS?

Iraq; Kuwait; Saudi Arabia; the neutral zone between Iraq and Saudi Arabia; Bahrain; Qatar; the United Arab Emirates; Oman; Yemen; Lebanon; Somalia; Afghanistan; Israel; Egypt; Turkey; Syria; Jordan; Djibouti; Uzbekistan; the Gulf of Aden; the Gulf of Oman; the Persian Gulf; the Arabian Sea; and the Red Sea.

- ☐ YES ☐ NO

WHEN DID YOU SERVE IN THESE LOCATIONS? (MM-YYYY)

Note: Please provide an approximate time frame (month and year).

 FROM: - TO: -

15C. DID YOU SERVE IN ANY OF THE FOLLOWING HERBICIDE (e.g., Agent Orange) LOCATIONS?

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

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

- ☒ YES ☐ NO

Served in Vietnam

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

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 WORSENERD
1.	Pancreatic Cancer	Pancreatic cancer linked to Agent Orange exposure	Medical records confirm pancreatic cancer linked to service-related duties	July 2019
2.	Diabetes Mellitus (Type 2)	Due to Pancreatic Cancer	linked to agent orange exposure	Aug 2022
3.	Depression & Anxiety	Due to Pancreatic Cancer	Difficulty dealing with Pancreatic Cancer	May 2023
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
dark urine: Ft. Bragg Medical Facility, North Carolina	0 7 - 2 0 1 9	<input type="checkbox"/> Don't have date
loss of appetite: Ft. Bragg Medical Facility, North Carolina	0 9 - 2 0 1 9	<input type="checkbox"/> Don't have date
dark urine: Ft. Bragg Medical Facility, North Carolina	1 1 - 2 0 1 9	<input type="checkbox"/> 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

SECTION VI: SERVICE INFORMATION

18A. DID YOU SERVE UNDER ANOTHER NAME? <input type="checkbox"/> YES (If "Yes," complete Item 18B) <input checked="" type="checkbox"/> NO (If "No," skip to Item 19A)		18B. LIST THE OTHER NAME(S) YOU SERVED UNDER: 	
19A. BRANCH OF SERVICE <input checked="" type="checkbox"/> ARMY <input type="checkbox"/> NAVY <input type="checkbox"/> MARINE CORPS <input type="checkbox"/> AIR FORCE <input type="checkbox"/> COAST GUARD <input type="checkbox"/> SPACE FORCE <input type="checkbox"/> NOAA <input type="checkbox"/> USPHS		19B. COMPONENT <input checked="" type="checkbox"/> ACTIVE <input type="checkbox"/> RESERVES <input type="checkbox"/> NATIONAL GUARD	
20A. MOST RECENT ACTIVE SERVICE DATES ENTRY DATE: Month Day Year 0 1 - 0 1 - 1 9 6 9 EXIT DATE: Month Day Year 0 1 - 0 1 - 1 9 9 0		20B. PLACE OF LAST OR ANTICIPATED SEPARATION <div style="border: 1px solid black; padding: 2px; display: inline-block;"> F t K n o x K Y </div>	
20C. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20D. ADDITIONAL PERIODS OF SERVICE (Indicate enlistment and discharge date(s), if applicable) 		
21A. ARE YOU CURRENTLY SERVING OR HAVE YOU EVER SERVED IN THE RESERVES OR NATIONAL GUARD? <input type="checkbox"/> YES (If "Yes," complete Items 21B through 21F) <input type="checkbox"/> NO (If "No," skip to Item 22A)		21B. COMPONENT <input type="checkbox"/> NATIONAL GUARD <input type="checkbox"/> RESERVES	21C. OBLIGATION TERM OF SERVICE FROM: Month Day Year <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> TO: Month Day Year <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
21D. CURRENT OR LAST ASSIGNED NAME AND ADDRESS OF UNIT: 45th BN 124 Veteran Blvd., Ft. Knox, KY 12345		21E. CURRENT OR ASSIGNED PHONE NUMBER OF UNIT (Include Area Code) (123)456-7979	21F. ARE YOU CURRENTLY RECEIVING INACTIVE DUTY TRAINING PAY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
22A. ARE YOU CURRENTLY ACTIVATED ON FEDERAL ORDERS WITHIN THE NATIONAL GUARD OR RESERVES? <input type="checkbox"/> YES (If "Yes," complete Items 22B & 22C) <input checked="" type="checkbox"/> NO	22B. DATE OF ACTIVATION: Month Day Year <div style="border: 1px solid black; padding: 2px; display: inline-block;"> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div>		22C. ANTICIPATED SEPARATION DATE: Month Day Year <div style="border: 1px solid black; padding: 2px; display: inline-block;"> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div>
23A. HAVE YOU EVER BEEN A PRISONER OF WAR? <input type="checkbox"/> YES (If "Yes," complete Item 23B) <input checked="" type="checkbox"/> NO	23B. DATES OF CONFINEMENT FROM: Month Day Year TO: Month Day Year <div style="border: 1px solid black; padding: 2px; display: inline-block;"> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> FROM: Month Day Year TO: Month Day Year <div style="border: 1px solid black; padding: 2px; display: inline-block;"> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div>		

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

24A. ARE YOU RECEIVING MILITARY RETIRED PAY? <input checked="" type="checkbox"/> YES (If "Yes," complete Items 24C and 24D) <input type="checkbox"/> NO	24B. WILL YOU RECEIVE MILITARY RETIRED PAY IN THE FUTURE? <input type="checkbox"/> YES (If "Yes," explain below (e.g. future Reserve/National Guard retirement, pending MEB/PEB and also complete Items 24C and 24D)) <input type="checkbox"/> NO		
24C. BRANCH OF SERVICE <input checked="" type="checkbox"/> ARMY <input type="checkbox"/> NAVY <input type="checkbox"/> MARINE CORPS <input type="checkbox"/> AIR FORCE <input type="checkbox"/> COAST GUARD <input type="checkbox"/> SPACE FORCE <input type="checkbox"/> NOAA <input type="checkbox"/> USPHS	24D. MONTHLY AMOUNT \$ <input type="text"/> <input type="text"/> 3 , <input type="text"/> 2 0 0 .00		25. RETIRED STATUS <input checked="" type="checkbox"/> RETIRED <input type="checkbox"/> PERMANENT DISABILITY RETIRED LIST <input type="checkbox"/> 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.**

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

☐ ARMY
 ☐ NAVY
 ☐ MARINE CORPS
 ☐ AIR FORCE
 ☐ COAST GUARD
 ☐ SPACE FORCE
 ☐ NOAA
 ☐ USPHS

27D. AMOUNT RECEIVED (Provide pre-tax amount)

\$

IMPORTANT INFORMATION ON INACTIVE DUTY TRAINING PAY:

You may elect to keep the active or inactive duty training pay you received from the military service department. However, to be legally entitled to keep your training pay, you must waive VA benefits for the number of days equal to the number of days for which you received training pay. In most instances, it will be to your advantage to waive your VA benefits and keep your training pay.

If you waive VA benefits to receive training pay by checking the box in **Item 28**, VA will retroactively adjust your VA award to withhold benefits equal to the total number of training days waived and at the monthly rate in effect for the fiscal year period for which you received training pay. This action may result in an overpayment of compensation, which **may** be subject to collection.

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

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

SECTION VIII: DIRECT DEPOSIT INFORMATION

(Note: If you have already signed up for direct deposit, skip to Section IX)

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

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

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

Account No.: **0 1 2 7 8 7 7 7 3 2 1 4 5 5 6**

☒ CHECKING
 ☐ SAVINGS

31. NAME OF FINANCIAL INSTITUTION (Provide the name of the bank where you want your direct deposit)

Bank of America

32. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)

0 1 0 2 3 4 4 5 5

SECTION IX: CLAIM CERTIFICATION AND SIGNATURE

VETERAN/SERVICEMEMBER CERTIFICATION AND SIGNATURE

I certify and authorize the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me. For the limited purpose of providing VA with this information as it may relate to my claim, I waive any privilege that may apply and would otherwise make the information confidential and not discloseable.

I certify I have received the notice attached to this application titled, **Notice to Veteran/Service Member of Evidence Necessary to Substantiate a Claim for Veterans Disability Compensation and Related Compensation Benefits.**

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility such as a VA medical center; **OR**, I have no information or evidence to give VA to support my claim; **OR**, I have checked the box in Item 1, on page 9, indicating I want my claim processed under the standard claim process because I plan to submit additional evidence in support of my claim.

33A. VETERAN/SERVICE MEMBER SIGNATURE (REQUIRED)

John A. Doe

33B. DATE SIGNED (MM-DD-YYYY)

0 2 - 0 2 - 2 0 2 5

SECTION X: WITNESSES TO SIGNATURE

34A. SIGNATURE OF WITNESS (Note: Only sign if veteran signed in Item 33A using an "X")

34B. PRINTED NAME AND ADDRESS OF WITNESS

35A. SIGNATURE OF WITNESS (Note: Only sign if veteran signed in Item 33A using an "X")

35B. PRINTED NAME AND ADDRESS OF WITNESS

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)

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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.

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 WORSENER
1.				
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3.				
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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) Doe, John A		2. BRANCH AND COMPONENT ARMY		3. DOD ID NUMBER 11111111	4. SERIAL NUMBER: 11111111	
5a. GRADE, RATE OR RANK E-7		b. PAY GRADE E-7		6. DATE OF BIRTH (YYYYMMDD) 19490101		
7a. MILITARY SERVICE OBLIGATION TERMINATION DATE (YYYYMMDD) 19900101	b. RESERVE STATUS FOR OBLIGATION (SELRES/IRR)		c. CONTACT PHONE NUMBER (Civilian) (123)456-7890		d. CONTACT EMAIL ADDRESS (Civilian) johndoe@gmail.com	
8a. PLACE OF ENTRY INTO ACTIVE DUTY HOUSTON, TX		b. HOME OF RECORD AT TIME OF ENTRY (City and state, or complete address if known) 123 Veteran Rd., Houston, TX 12345				
9a. LAST DUTY ASSIGNMENT AND MAJOR COMMAND 18th Airborne Corps			b. STATION WHERE SEPARATED Ft. Knox, KY 45852			
10. COMMAND TO WHICH TRANSFERRED 99th Ready Reserve, Ft. Knox KY 45852					11. SGLI COVERAGE <input type="checkbox"/> NONE AMOUNT: \$	
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 TO AD THIS PERIOD		1969	01	01
		b. SEPARATION DATE THIS PERIOD		1990	01	01
		c. NET ACTIVE SERVICE THIS PERIOD		0020	00	00
		d. TOTAL PRIOR ACTIVE SERVICE		0000	00	00
		e. TOTAL ACTIVE SERVICE		0020	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		1986	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 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
18. RETIREMENT SYSTEM OPTION <input type="checkbox"/> FINAL <input type="checkbox"/> HIGH-3 <input checked="" type="checkbox"/> REDUX <input type="checkbox"/> BRS		19. DD214-1 (Accompanies this DD214) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
20. REMARKS SERVED IN A DESIGNATED IMMINENT DANGER PAY AREA/ SERVICE IN VEITNAM 19690101-19700101// 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// ARMED FORCES SERVICE MEDAL (AFSM)//VIETNAM 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) 123 Veteran Rd., Houston, TX 12345		21b. NEAREST RELATIVE (Name and address - include ZIP code) Mary Doe 123 Veteran Rd., Houston, Tx 12345				
22. MEMBER REQUESTS DATA SHARE WITH (Specify state/locality)		OFFICE OF VETERANS AFFAIRS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
23a. MEMBER SIGNATURE		b. DATE (YYYYMMDD)	24. OFFICIAL AUTHORIZED TO SIGN			
			a. NAME, GRADE AND TITLE			
			b. SIGNATURE			
			c. DATE (YYYYMMDD)			

INJURY STATEMENT

March 11, 2025

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

TO: Department of Veterans Affairs

SUBJECT: Injury Statement for VA Disability Claim – Pancreatic Cancer and Secondary Conditions

Background:

I, **John A. Doe**, am submitting this injury statement in support of my VA disability claim for **pancreatic cancer**, which I developed due to **exposure to Agent Orange during my service in Vietnam**. Additionally, I am seeking recognition of **diabetes mellitus (Type 2) and depression/anxiety** as secondary disabilities resulting from my primary condition.

I served in Vietnam from January 1969 to January 1970.

Symptoms and Diagnosis:

I first began experiencing symptoms in **Ft. Bragg, North Carolina**, where I noticed **dark urine and a loss of appetite**. After seeking medical attention, I was officially **diagnosed with pancreatic cancer in July 2019**.

Treatment History:

I was initially diagnosed in July 2019 and have been receiving treatment since which includes.

Treatment Location and Methods:

I have received all my treatments at **Ft. Bragg Medical Facility**, where I have undergone:

Surgery and chemotherapy to combat pancreatic cancer

Nutritional support to maintain weight and strength

Insulin treatments for diabetes mellitus (Type 2)

Psychotherapy and antidepressant medication (mirtazapine) to manage depression and anxiety

Impact on Daily Life:

Since the onset of my illness, my ability to live a normal life has been severely impacted. My **loss of appetite and chronic fatigue** have left me with **limited energy**, making even simple tasks exhausting. To avoid overexertion, I have had to **restrict my daily activities**, which has significantly affected my **independence and quality of life**. Additionally, my **difficulty focusing and completing tasks in a timely manner** has further hindered my ability to function on a daily basis.

Conclusion:

My **pancreatic cancer, diabetes, and mental health conditions** have drastically altered my life, leaving me physically and emotionally strained. Given my **exposure to Agent Orange in Vietnam and the medical evidence linking my conditions to my military service**, I respectfully request that my **VA disability claim be granted** based on these service-connected disabilities.

If any additional information is required, I am available to provide further details.

Sincerely,

John A. Doe

John A. Doe

NEXUS STATEMENT

[Physician's Letterhead]

Houston Medical Group
124 Bronson Street
Houston, TX
Phone: (718) 242-5254

DATE: March 11, 2025

TO: Department of Veterans Affairs

RE: Medical Nexus Statement for John A. Doe
123 Veteran Rd.
Houston, TX 12345

SUBJECT: Nexus Letter in Support of VA Disability Claim for Pancreatic Cancer and Related Conditions

To Whom It May Concern,

I am **Dr. William Stryker, MD, Orthopedic Specialist**, currently practicing at **Houston Medical Group**, and I am writing this letter in support of **John A. Doe's** VA disability claim for **pancreatic cancer**, which I believe is **directly related to his exposure to Agent Orange during his service in Vietnam**. Additionally, I am supporting his claim for **diabetes mellitus (Type 2) and depression/anxiety** as secondary conditions to his primary disability.

Medical History and Diagnosis

Mr. Doe has been under my medical care for **pancreatic cancer**, which was diagnosed in **July 2019** following symptoms including **dark urine and loss of appetite** while residing in **Ft. Bragg, North Carolina**. His **treatment began immediately** and has included:

- **Surgery and chemotherapy** to manage the cancer
- **Nutritional support** to maintain weight and strength
- **Insulin therapy** for diabetes mellitus (Type 2)
- **Psychotherapy and mirtazapine** for depression and anxiety

His treatment continues at **Ft. Bragg Medical Facility**, where he has been receiving ongoing medical care since **March 2021 to the present**.

Link Between Military Service and Pancreatic Cancer

Mr. Doe was **deployed in Vietnam**, where he was **exposed to Agent Orange**, a well-documented risk factor for **pancreatic cancer and Type 2 diabetes**. The Institute of Medicine (IOM) and the VA have recognized an **association between herbicide exposure and various cancers**, including **pancreatic cancer**. Given his history of **Agent Orange exposure**, **lack of**

significant alternative risk factors, and the timeframe of his diagnosis, it is **more likely than not ($\geq 50\%$ probability)** that Mr. Doe's pancreatic cancer is service-connected.

Secondary Disabilities – Diabetes Mellitus and Depression/Anxiety

Due to his **pancreatic cancer**, Mr. Doe developed **diabetes mellitus (Type 2)**, which is a known complication of pancreatic diseases. Given the **onset of diabetes following his pancreatic cancer diagnosis**, I strongly believe that **his diabetes is at least as likely as not ($\geq 50\%$ probability) secondary to his pancreatic cancer**.

Furthermore, Mr. Doe has experienced **significant depression and anxiety** as a result of his illness, treatment burden, and the limitations it has placed on his daily life. He has been undergoing **psychotherapy and pharmacological treatment with mirtazapine** to manage his mental health symptoms. Given his cancer diagnosis, chronic illness, and the profound impact on his quality of life, it is **at least as likely as not ($\geq 50\%$ probability) that his depression and anxiety are secondary to his service-connected pancreatic cancer and its complications**.

Impact on Quality of Life

Since the onset of **pancreatic cancer, diabetes, and depression**, Mr. Doe has faced **severe physical, emotional, and cognitive impairments**. He reports:

- **Significant fatigue and weakness**, limiting his ability to perform daily activities
- **Loss of appetite and unintended weight loss**, leading to reduced energy and stamina
- **Cognitive difficulties**, including trouble focusing on tasks and completing them efficiently
- **Emotional distress and social withdrawal**, affecting his ability to maintain relationships and engage in social interactions

Due to these factors, Mr. Doe has been forced to **restrict his daily activities** to avoid exhaustion and manage his health.

Conclusion

Based on my medical evaluation, review of Mr. Doe's military service, and his current health conditions, it is my **professional medical opinion** that:

1. **Mr. Doe's pancreatic cancer is at least as likely as not ($\geq 50\%$ probability) caused by his military exposure to Agent Orange in Vietnam.**
2. **His diabetes mellitus (Type 2) is at least as likely as not ($\geq 50\%$ probability) secondary to his pancreatic cancer.**
3. **His depression and anxiety are at least as likely as not ($\geq 50\%$ probability) secondary to his pancreatic cancer and its complications.**

I respectfully request that the VA consider this medical evidence in support of Mr. Doe's disability claim. If any further information or clarification is required, I am available for consultation.

Sincerely,

William Stryker

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

BUDDY STATEMENT #1

Victor Ratcliffe

2345 Foster Rd.

Seattle, WA 98040

Email: victorratcliffe@gmail.com

Phone: (206) 432-6451

March 3, 2025

Department of Veterans Affairs

To Whom It May Concern,

I, **Victor Ratcliffe**, am writing this letter in support of my friend, **John A. Doe's**, VA disability claim for **Pancreatic Cancer, Diabetes, Depression, and Anxiety**. I have known John for many years, and I have personally witnessed the struggles he has endured due to these conditions.

From **May 2018 to December 2024**, I observed John experiencing **significant difficulty living a normal life due to Pancreatic Cancer and its associated conditions**. Over time, I noticed a drastic decline in his **energy levels, appetite, and overall physical health**. He frequently appeared fatigued and weak, often unable to complete basic daily activities without taking breaks or resting.

As his health declined, **diabetes became another major challenge for him**. I have seen him **struggle with maintaining stable blood sugar levels, requiring constant monitoring and insulin therapy**. His diabetes has further drained his energy and made it even harder for him to stay active or maintain his weight.

Beyond the physical struggles, I have also observed the **emotional toll** that these conditions have taken on John. Over the years, he has **become more withdrawn, avoiding social interactions and struggling with depression and anxiety**. I have had conversations with him where he expressed **feelings of frustration, sadness, and hopelessness** about his declining health. I have seen how his **motivation to engage in activities he once enjoyed has diminished**, and he often struggles to concentrate or stay engaged in conversations.

John's conditions have completely altered his life, limiting his ability to function independently and diminishing his quality of life. I am submitting this letter as a firsthand witness to his 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 **(206) 432-6451** or victorratcliffe@gmail.com if any further information is needed.

Sincerely,

Victor Ratcliffe

Victor Ratcliffe

BUDDY STATEMENT #2

Chantelle Doe

10 Providence Road

Dallas, TX 75287

Email: frankboyd@gmail.com

Phone: (214) 411-9797

March 3, 2025

Department of Veterans Affairs

To Whom It May Concern,

I, **Chantelle Doe**, am writing this letter in support of my brother, **John A. Doe's**, VA disability claim for **Pancreatic Cancer, Diabetes, Depression, and Anxiety**. I have personally witnessed how these conditions have severely impacted his ability to live a normal life.

Since **July 2019 to the present**, I have observed John struggling with **extreme fatigue, loss of appetite, and significant weight loss** due to his pancreatic cancer. One specific instance that stands out occurred during our family gathering in **December 2022**. John, who used to be the center of attention and full of energy, **barely had the strength to engage in conversation**. He sat quietly in the corner, visibly exhausted, and barely ate anything from his plate. When I asked if he was okay, he admitted that **chewing was exhausting and that he constantly felt weak due to his lack of appetite**. He had to leave early because he was too tired to stay for the evening.

His **diabetes has further complicated his health**, making even small daily tasks difficult. I recall visiting him in **March 2023**, when I saw him **struggling to check his blood sugar** due to shaky hands. He also mentioned that his **energy crashes throughout the day make it hard to even get through basic activities like cooking or running errands**.

Beyond his physical struggles, I have also seen a **drastic change in his emotional well-being**. Over the past few years, John has **become withdrawn, often avoiding family events and isolating himself**. When I spoke to him on the phone in **July 2024**, he expressed that he felt **overwhelmed with his health issues, constantly anxious about his condition, and deeply depressed**. I have noticed that he no longer has the same motivation or enthusiasm for life that he once had, and his **mental health has continued to decline** due to the overwhelming burden of his illnesses.

John has always been a strong and independent person, but **his conditions have taken away so much of his ability to live a normal life**. I am submitting this letter as a firsthand witness to his 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 **(214) 411-9797** or frankboyd@gmail.com if any further information is needed.

Sincerely,

Chantelle Doe

Chantelle Doe

**ADD MEDICAL
DOCUMENTS
HERE**

DBQ

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

DBQ's can be found here:

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