Department of Veterans Affairs

FIBROMYALGIA DISABILITY BENEFITS QUESTIONNAIRE

IMPORTANT - THE DEPARTMENT OF VETERANS AFFAIRS (VA) ***WILL NOT PAY*** OR ***REIMBURSE*** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER
Mark Lee	TRA-72-4820

NOTE TO PHYSICIAN - Your patient is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the veteran's claim.

SECTION I - DIAGNOSIS

NOTE - Fibromyalgia may also be called fibrositis or primary fibromyalgia syndrome.

1A. DOES THE VETERAN NOW HAVE OR HAS HE/SHE EVER BEEN DIAGNOSED WITH FIBROMYALGIA? (This is the condition the veteran is claiming or for which an exam has been requested)

☒ YES ☐ NO *(If "Yes," complete Item 1B)*

1B. SELECT THE VETERAN'S CONDITION (check all that apply)

☒ FIBROMYALGIA ICD code : 729.1 Date of diagnosis: Unk

☐ OTHER (specify)

OTHER DIAGNOSIS #1_____ ICD code :_____ Date of diagnosis:_____

OTHER DIAGNOSIS #2_____ ICD code :_____ Date of diagnosis:_____

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO FIBROMYALGIA, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL RECORD REVIEW

2. INDICATE MEDICAL RECORDS REVIEWED IN PREPARATION OF THIS REPORT:

☒ C-FILE (VA ONLY)

☐ OTHER, DESCRIBE:_____

SECTION III - MEDICAL HISTORY

3A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S FIBROMYALGIA CONDITION:

The Veteran developed symptoms of fibromyalgia about a year ago and sought treatment from his private Dr.

3B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF FIBROMYALGIA SYMPTOMS?

☒ YES ☐ NO *(If "Yes," list only those medications required for the veteran's fibromyalgia condition):*

Cymbalta

3C. IS THE VETERAN CURRENTLY UNDERGOING TREATMENT FOR THIS CONDITION?

☒ YES ☐ NO *(If "Yes," describe):* The Veteran's private physician has prescribed Cymbalta

3D. ARE THE VETERAN'S FIBROMYALGIA SYMPTOMS REFRACTORY TO THERAPY?

☒ YES ☐ NO *(If "Yes," describe):*

SECTION IV - FINDINGS, SIGNS AND SYMPTOMS

4. DOES THE VETERAN CURRENTLY HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO FIBROMYALGIA?

☒ YES ☐ NO *(If "Yes," complete items 4A thru 4C)*

A. FINDINGS, SIGNS AND SYMPTOMS (Check all that apply)

☒ WIDESPREAD MUSCULOSKELETAL PAIN (**NOTE**: For VA purposes widespread musculoskeletal pain means that pain occurs in both sides of the body, both above and below the waist and affecting both the axial skeleton (i.e., cervical spine, anterior chest, thoracic spine or low back) and the extremities)

☒ STIFFNESS

☐ MUSCLE WEAKNESS (If checked, describe):_____

☒ FATIGUE

☐ SLEEP DISTURBANCES

☐ PARESTHESIAS

☐ HEADACHE

☐ DEPRESSION

☐ ANXIETY

☐ IRRITABLE BOWEL SYMPTOMS

☐ RAYNAUD'S-LIKE SYMPTOMS

☐ OTHER

(For all checked conditions, describe): Veteran experienced these for the last 6 months or more and the symptoms are constant

SECTION IV - FINDINGS, SIGNS AND SYMPTOMS *(Continued)*

NOTE - If Mental Health conditions, such as depression due to fibromyalgia are identified, a VA Form 21-0960P-2, Mental Disorders (Other than PTSD) Disability Benefits Questionnaire must ALSO be completed.

B. FREQUENCY OF FIBROMYALGIA SYMPTOMS (check all that apply)

- ☐ NO SYMPTOMS
- ☐ EPISODIC WITH EXACERBATIONS
- ☐ PRESENT MORE THAN ONE-THIRD OF THE TIME
- ☒ CONSTANT OR NEARLY CONSTANT
- ☐ OFTEN PRECIPITATED BY ENVIRONMENTAL OR EMOTIONAL STRESS OR OVEREXERTION (If checked, describe):_____
- ☐ OTHER (describe):_____

C. TENDER POINTS (trigger points) FOR PAIN (check all that apply)

- ☐ None
- ☒ All bilaterally
- ☐ Low cervical region: at anterior aspect of the interspaces between transverse processes of C5-C7 (If checked, indicate side): ☐ Right ☐ Left ☐ Both
- ☐ Second rib: at second costochondral junction (If checked, indicate side): ☐ Right ☐ Left ☐ Both
- ☐ Occiput: at suboccipital muscle insertion (If checked, indicate side): ☐ Right ☐ Left ☐ Both
- ☐ Trapezius muscle: midpoint of upper border (If checked, indicate side): ☐ Right ☐ Left ☐ Both
- ☐ Supraspinatus muscle: above medial border of the scapular spine (If checked, indicate side): ☐ Right ☐ Left ☐ Both
- ☐ Lateral epicondyle: 2 cm distal to lateral epicondyle (If checked, indicate side): ☐ Right ☐ Left ☐ Both
- ☐ Gluteal: at upper outer quadrant of buttocks (If checked, indicate side): ☐ Right ☐ Left ☐ Both
- ☐ Greater trochanter: posterior to greater trochanteric prominence (If checked, indicate side): ☐ Right ☐ Left ☐ Both
- ☐ Knee: medial joint line (If checked, indicate side): ☐ Right ☐ Left ☐ Both
- ☐ Other, specify:_____ (If checked, indicate side): ☐ Right ☐ Left ☐ Both

SECTION V - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS

5. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

☐ YES ☒ NO (If "Yes," describe - brief summary):

SECTION VI - DIAGNOSTIC TESTING

NOTE - If diagnostic test results are in the medical record and reflect the veteran's current condition, repeat testing is not required.

6. ARE THERE ANY SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

☐ YES ☒ NO (If "Yes," provide type of test or procedure, date and results - brief summary);

SECTION VII - FUNCTIONAL IMPACT

7. DOES THE VETERAN'S FIBROMYALGIA IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☒ NO (If "Yes," describe impact of the veteran's fibromyalgia and provide one or more examples)

SECTION VIII - REMARKS

8. REMARKS (If any)

The Veteran reported that the Cymbalta has been effective in controlling his fibromyalgia.

SECTION IX - PHYSICIAN'S CERTIFICATION AND SIGNATURE

CERTIFICATION - To the best of my knowledge, the information contained herein is accurate, complete and current.

9A. PHYSICIAN'S SIGNATURE	9B. PHYSICIAN'S PRINTED NAME	9C. DATE SIGNED
Gregory House	Gregory House	02/18/2017

9D. PHYSICIAN'S PHONE AND FAX NUMBER	9E. PHYSICIAN'S MEDICAL LICENSE NUMBER	9F. PHYSICIAN'S ADDRESS
888-888-8888	54321	1234 Cute St Georgetown, KY 47012 (US)

NOTE - VA may request additional medical information, including additional examinations if necessary to complete VA's review of the veteran's application.

IMPORTANT - Physician please fax the completed form to: 777-777-7777

(VA Regional Office FAX No.)

NOTE - A list of VA Regional Office FAX Numbers can be found at www.vba.va.gov/disabilityexams or obtained by calling 1-800-827-1000.

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN : We need this information to determine entitlement to benefits (38 U.S.C. 501). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete a form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain . If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

This 33 y. o. veteran presents for an evaluation of symptoms of persistent fatigue, aching muscles and joints and insomnia for the past ten months. He takes ibuprofen to relieve his discomfort and it helps for about 4 hours, then recurs causing him to wake up. He wakes in the morning not feeling refreshed and has stiffness of his muscles and joints. His stiffness improves with movement throughout the day.

He also complains of nausea, bloating and alternating constipation and diarrhea 3-4 times per week. Diet doesn't seem to affect these symptoms. No blood or mucus is noted in the stool.

The veteran served in combat during the Gulf War.

P.E. B.P. 120/82 Ht 70 “ Wt 190 lbs. HR 80

HEENT – Within normal limits

Lungs – Normal inspiration and expiration without wheezing

Cardiovascular – Regular rhythm without murmurs, no peripheral edema

Abdomen – soft, bowel sounds normal, no tenderness to palpation

GU – deferred

Extremities –

- Upper extremities - normal sensation (light and sharp touch), normal temperature, vibratory and position sensation, deep tendon reflexes are 2+ bilaterally
- Lower extremities – normal sensation (light and sharp touch), normal temperature, vibratory and position sensation, deep tendon reflexes are 2+ bilaterally

Diagnostic Tests

CBC and chemistry-12 panel – WNL

ANA, Rheumatoid factor, FM/a – all are negative

Imp: Fibromyalgia

Plan: Rx Cymbalta, 20 milligrams BID

/ES/ Dr. Capazzolini 03/15/2016

OMB Control No. 2900-0747
Respondent Burden: 25 minutes
Expiration Date: 11/30/2017

Department of Veterans Affairs

APPLICATION FOR DISABILITY COMPENSATION AND RELATED COMPENSATION BENEFITS

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)
01/14/2017

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 10 before completing the form.

SECTION I: IDENTIFICATION AND CLAIM INFORMATION

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

Mark Lee

2. VETERAN'S SOCIAL SECURITY NUMBER

TRA – 72 – 4820

3. HAVE YOU EVER FILED A CLAIM WITH VA?

☐ YES ☒ NO *(If "Yes," provide your file number in Item 4)*

4. VA FILE NUMBER

TRA72482O

5. DATE OF BIRTH (MM,DD,YYYY)

Month 02 – Day 06 – Year 1983

6. SEX

☒ MALE ☐ FEMALE

7. VETERAN'S SERVICE NUMBER *(If applicable)*

8A. ARE YOU CURRENTLY HOMELESS OR AT RISK OF BECOMING HOMELESS?

☐ YES ☒ NO *(If "Yes," complete Items 8B & 8C)*

8B. POINT OF CONTACT *(Name of person that VA can contact in order to get in touch with you)*

8C. POINT OF CONTACT TELEPHONE NUMBER *(Include Area Code)*

9A. SERVICE *(Check all that apply)*

☐ ARMY ☐ NAVY ☐ MARINE CORPS ☒ AIR FORCE ☐ COAST GUARD

9B. COMPONENT *(Check all that apply)*

☒ ACTIVE ☐ RESERVES ☐ NATIONAL GUARD

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

No. & Street: 2512 410th Avenue S.W.

Apt./Unit Number: | City: Georgetown

State/Province: KY | Country: US | ZIP Code/Postal Code: 47012 –

10B. FORWARDING ADDRESS AND EFFECTIVE DATE *(Provide the date you will be living at this address)*

No. & Street:

Apt./Unit Number: | City:

State/Province: | Country: | ZIP Code/Postal Code: –

EFFECTIVE DATE:

Month 01 – Day 14 – Year 2017

11. PREFERRED TELEPHONE NUMBER

371 – 555 – 0112

12A. PREFERRED E-MAIL ADDRESS *(If applicable)*

mark5@my-case.com

12B. ALTERNATE E-MAIL ADDRESS *(If applicable)*

VETERANS SOCIAL SECURITY NO. T R A – 7 2 – 4 8 2 0

13. LIST THE DISABILITY(IES) YOU ARE CLAIMING *(If applicable, identify whether a disability is due to a service-connected disability, is due to confinement as a Prisoner of War, is due to exposure to Agent Orange, Asbestos, Mustard Gas, Ionizing Radiation, or Gulf War Environmental Hazards, or is related to benefits under 38 U.S.C. 1151).*

Please list your contentions below. See the following examples, for more information:

- Example 1: Hearing loss
- Example 2: Diabetes-Agent Orange (exposed 12/72, Da Nang)
- Example 3: Left knee - secondary to right knee

DISABILITIES	
1.	Fibromyalgia
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
16.	
17.	
18.	
19.	
20.	

14. 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) AND PROVIDE TREATMENT DATES:

A. NAME *AND* LOCATION	B. DATE(S) OF TREATMENT
Louisville VAMC	

VETERANS SOCIAL SECURITY NO. T R A – 7 2 – 4 8 2 0

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):*
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
Post-Traumatic Stress Disorder	VA Form 21-0781 and 21-0781a
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 II: SERVICE INFORMATION

15A. DID YOU SERVE UNDER ANOTHER NAME?
☐ YES *(If "Yes," complete Item 15B)* ☒ NO *(If "No," skip to Item 16A)*

15B. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER:

16A. MOST RECENT ACTIVE SERVICE ENTRY DATE (MM,DD,YYYY)
Month 0 2 – Day 2 1 – Year 2 0 0 6

16B. RELEASE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE SERVICE (MM,DD,YYYY)
Month 0 2 – Day 2 1 – Year 2 0 1 0

16C. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001?
☐ YES ☒ NO

16D. PLACE OF LAST OR ANTICIPATED SEPARATION

17A. ARE YOU CURRENTLY SERVING OR HAVE YOU EVER SERVED IN THE RESERVES OR NATIONAL GUARD?
☐ YES ☒ NO *(If "Yes," complete Items 17B thru 17F)* *(If "No," skip to Item 18A)*

17B. COMPONENT
☐ NATIONAL GUARD
☐ RESERVES

17C. OBLIGATION TERM OF SERVICE
Month Day Year
From: – –
To: – –

17D. CURRENT OR LAST ASSIGNED NAME AND ADDRESS OF UNIT:

17E. CURRENT OR ASSIGNED PHONE NUMBER OF UNIT *(Include Area Code)*
( )

17F. ARE YOU CURRENTLY RECEIVING INACTIVE DUTY TRAINING PAY?
☐ YES ☐ NO

18A. ARE YOU CURRENTLY ACTIVATED ON FEDERAL ORDERS WITHIN THE NATIONAL GUARD OR RESERVES?
☐ YES ☒ NO *(If "Yes," complete Items 18B & 18C)*

18B. DATE OF ACTIVATION: (MM,DD,YYYY)
Month – Day – Year

18C. ANTICIPATED SEPARATION DATE: (MM,DD,YYYY)
Month – Day – Year

19A. HAVE YOU EVER BEEN A PRISONER OF WAR?
☐ YES ☒ NO *(If "Yes," complete Item 19B)*

19B. DATES OF CONFINEMENT (MM,DD,YYYY)

From:	To:
Month – Day – Year	Month – Day – Year

SECTION III: SERVICE PAY

20A. DID/DO YOU RECEIVE ANY TYPE OF SEPARATION/SEVERANCE/RETIRED PAY?
☐ YES ☒ NO *(If "Yes," complete Items 20B and 20C)*

20B. LIST AMOUNT *(If known)*
$

20C. LIST TYPE *(If known)*

IMPORTANT: Submission of this application constitutes an election of VA compensation in lieu of military retired pay if it is determined you are entitled to both benefits. If you are entitled to receive military retired pay, your retired pay may be reduced by the amount of any VA compensation that you are awarded. VA will notify the Military Retired Pay Center of all benefit changes. Receipt of military retired pay or Voluntary Separation Incentive (VSI) and VA compensation at the same time may result in an overpayment, which may be subject to collection. However, if you ***do not*** want to receive VA compensation in lieu of military retired pay, you should check the box in **Item 21**. Please note that if you check the box in **Item 21**, you ***will not*** receive VA compensation, if granted.

☐ **21. I want military retired pay instead of VA compensation**

IMPORTANT: You may elect to keep the training pay for inactive duty training days 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 22**, VA will adjust your VA award to withhold future benefits equal to the total number of inactive duty for training days waived and at the monthly rate in effect for the fiscal year period for which you received training pay. Your normal VA rate will be restored when the sufficient numbers of days' benefits have been withheld.

☐ **22. I elect to waive VA benefits for the days I accrued inactive duty training pay in order to retain my inactive duty training pay.**

VETERANS SOCIAL SECURITY NO. T R A – 7 2 – 4 8 2 0

SECTION IV: DIRECT DEPOSIT INFORMATION

The Department of Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. Please attach a voided personal check or deposit slip or provide the information requested below in **Items 23, 24 and 25** to enroll in direct deposit. If you do not have a bank account, you must receive your payment through Direct Express Debit MasterCard. To request a Direct Express Debit MasterCard you must apply at www.usdirectexpress.com or by telephone at 1-800-333-1795. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

23. ACCOUNT NUMBER *(Check the appropriate box and provide the account number, or simply write "Established" if you have a direct deposit with VA)*

☐ CHECKING ☐ SAVINGS ☐ I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

Account No.: _____ Account No.: _____

24. NAME OF FINANCIAL INSTITUTION *(Please provide the name of the bank where you want your direct deposit)*	25. ROUTING OR TRANSIT NUMBER *(The first nine numbers located at the bottom left of your check)*

SECTION V: CLAIM 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, and I waive any privilege which makes the information confidential.
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 26**, indicating that I do not want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.

ALTERNATE SIGNER: By signing on behalf of the claimant, I certify 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 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.

26. The FDC Program is designed to rapidly process compensation or pension claims received with the evidence necessary to decide the claim. VA will automatically consider a claim submitted on this form for rapid processing under the FDC Program. Check the box below **ONLY if you DO NOT want your claim considered for rapid processing** under the FDC Program because you plan on submitting further evidence in support of your claim.

☐ **I DO NOT want my claim considered for rapid processing** under the FDC Program because I plan to submit further evidence in support of my claim.

27A. VETERAN/SERVICE MEMBER/ALTERNATE SIGNER SIGNATURE (**REQUIRED**)	27B. DATE SIGNED
Mark Lee	01/10/2017

SECTION VI: WITNESSES TO SIGNATURE

28A. SIGNATURE OF WITNESS *(If veteran signed above using an "X")*	28B. PRINTED NAME AND ADDRESS OF WITNESS
29A. SIGNATURE OF WITNESS *(If veteran signed above using an "X")*	**29B. PRINTED NAME AND ADDRESS OF WITNESS**

SECTION VII: POWER OF ATTORNEY (POA) SIGNATURE

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

30A. POA/AUTHORIZED REPRESENTATIVE SIGNATURE	30B. DATE SIGNED

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 Vocational Rehabilitation 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 obligation to respond 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: We need this information to determine your eligibility for compensation. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 25 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

NO. OF ATTACHED SHEETS:

MEDICAL RECORD	REPORT OF MEDICAL HISTORY	DATE OF EXAM
		02/18/2010

NOTE: This information is for official and medically-confidential use only and will not be released to unauthorized persons

1. NAME OF PATIENT (Last, first, middle)	2. IDENTIFICATION NUMBER	3. GRADE
Mark Lee	TRA-72-4820	O-2

4a. HOME STREET ADDRESS (Street or RFD; City or Town; State; and ZIP Code)	5. EXAMINING FACILITY
2512 410th Avenue S.W.	Travis AFB MTF

4b. CITY	4c. STATE	4d. ZIP CODE
Georgetown	KY	47012

6. PURPOSE OF EXAMINATION

Separation

7. STATEMENT OF PATIENT'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Use additional pages if necessary)

a. PRESENT HEALTH	b. CURRENT MEDICATION	REGULAR OR INTERM.
Good		
c. ALLERGIES (Include insect bites/stings and common foods)		
	d. HEIGHT	e. WEIGHT
	5' 11"	168

8. PATIENT'S OCCUPATION	9. ARE YOU (Check one)
Police	[X] RIGHT HANDED [ ] LEFT HANDED

10. PAST/CURRENT MEDICAL HISTORY

CHECK EACH ITEM	YES	NO	DON'T KNOW	CHECK EACH ITEM	YES	NO	DON'T KNOW	CHECK EACH ITEM	YES	NO	DON'T KNOW
Household contact with anyone with tuberculosis		X		Shortness of breath		X		Bone, joint or other deformity		X	
				Pain or pressure in chest		X		Loss of finger or toe		X	
Tuberculosis or positive TB test		X		Chronic cough		X		Painful or "trick" shoulder or elbow		X	
Blood in sputum or when coughing		X		Palpitation or pounding heart		X					
				Heart trouble		X		Recurrent back pain or any back injury		X	
Excessive bleeding after injury or dental work		X		High or low blood pressure		X					
				Cramps in your legs		X		"Trick" or locked knee		X	
Suicide attempt or plans		X		Frequent indigestion		X		Foot trouble		X	
Sleepwalking		X		Stomach, liver or intestinal trouble		X		Nerve Injury		X	
Wear corrective lenses		X		Gall bladder trouble or gallstones		X		Paralysis (including infantile)		X	
Eye surgery to correct vision		X						Epilepsy or seizure		X	
Lack vision in either eye		X		Jaundice or hepatitis		X		Car, train, sea or air sickness		X	
Wear a hearing aid		X		Broken bones		X		Frequent trouble sleeping		X	
Stutter or stammer		X		Adverse reaction to medication		X		Depression or excessive worry	X		
Wear a brace or back support		X		Skin diseases		X		Loss of memory or amnesia		X	
Scarlet fever		X		Tumor, growth, cyst, cancer		X		Nervous trouble of any sort		X	
Rheumatic fever		X		Hernia		X		Periods of unconsciousness		X	
Swollen or painful joints		X		Hemorrhoids or rectal disease		X		Parent/sibling with diabetes, cancer, stroke or heart disease		X	
Frequent or severe headaches		X		Frequent or painful urination		X					
Dizziness or fainting spells		X		Bed wetting since age 12		X		X-ray or other radiation therapy		X	
Eye trouble		X		Kidney stone or blood in urine		X		Chemotherapy		X	
Hearing loss		X		Sugar or albumin in urine		X		Asbestos or toxic chemical exposure		X	
Recurrent ear infections		X		Sexually transmitted diseases		X					
Chronic or frequent colds		X		Recent gain or loss of weight		X		Plate, pin or rod in any bone		X	
Severe tooth or gum trouble		X		Eating disorder (anorexia bulimia, etc.)		X		Easy fatigability		X	
Sinusitis		X						Been told to cut down or criticized for alcohol use		X	
Hay fever or allergic rhinitis		X		Arthritis, Rheumatism, or Bursitis		X					
Head injury		X						Used illegal substances		X	
Asthma		X		Thyroid trouble or goiter		X		Used tobacco		X	

11. FEMALES ONLY

CHECK EACH ITEM	YES	NO	DON'T KNOW	DATE OF LAST MENSTRUAL PERIOD	DATE OF LAST PAP SMEAR	DATE OF LAST MAMMO-GRAM
Treated for a female disorder						
Change in menstrual pattern						

CHECK EACH ITEM. IF "YES" EXPLAIN IN BLANK SPACE TO RIGHT. LIST EXPLANATION BY ITEM NUMBER.

ITEM	YES	NO
12. Have you been refused employment or been unable to hold a job or stay in school because of:		
a. Sensitivity to chemicals, dust, sunlight, etc.		X
b.Inability to perform certain motions.		X
c. Inability to assume certain positions.		X
d.Other medical reasons (If yes, give reasons.)		X
13. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details.)		X
14. Have you ever been denied life insurance? (If yes, state reason and give details.)		X
15. Have you had, or have you been advised to have, any operation. (If yes, describe and give age at which occurred.)		X
16. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)		X
17. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)		X
18. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection.)		X
19. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)		X
20. Have you ever received, is there pending, or have you ever applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.)		X
21. Have you ever been arrested or convicted of a crime, other than minor traffic violations. (If yes, provide details.)		X
22. Have you ever been diagnosed with a learning disability? (If yes, give type, where, and how diagnosed.)		X

23. LIST ALL IMMUNIZATIONS RECEIVED

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

24a. TYPED OR PRINTED NAME OF EXAMINEE	24b. SIGNATURE	24c. DATE
Mark Lee	Mark Lee	02/18/2010

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY".

25. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (Physician shall comment on all positive answers in Items 7 through 11. Physician may develop by interview any additional medical history deemed important, and record any significant findings here.)

Service member reported worrying about leaving military service and adjusting to civilian life. - NCD

26a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	26b. SIGNATURE	26c. DATE
Adelle Tyler	Adelle Tyler	02/18/2010

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REPORT OF MEDICAL EXAMINATION

1. LAST NAME - FIRST NAME - MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
Mark Lee	O-2	TRA-72-4820

4. HOME ADDRESS *(Number, street or RFD, city or town, State and ZIP Code)*	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
2512 410th Avenue S.W. Georgetown, KY 47012 (US)	Separation	02/18/2010

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
Male	White	4		USAF	

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
02/06/1983	Georgetown	Christa Lee, Sister 2501 Madeira LN, Pleasantville, OH 43148 (US)

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
Travis AFB MTF	

17. RATING OR SPECIALTY	TIME IN THIS CAPACITY *(Total)*	LAST SIX MONTHS
MD - General Practitioner		

CLINICAL EVALUATION

NORMAL	*(Check each item in appropriate column, enter "NE" if not evaluated.)*	ABNORMAL
×	18. HEAD, FACE, NECK AND SCALP	
×	19. NOSE	
×	20. SINUSES	
×	21. MOUTH AND THROAT	
×	22. EARS-GENERAL *(INTERNAL CANALS) (Auditory) acuity under items 70 and 71)*	
×	23. DRUMS *(Perforation)*	
×	24. EYES-GENERAL *(Visual acuity and refraction under items 59, 60 and 67)*	
×	25. OPHTHALMOSCOPIC-	
×	26. PUPILS (Equality and reaction)	
×	27. OCULAR MOTILITY (Associated parallel movements nysingmus)	
×	28. LUNGS AND CHEST *(Include breasts)*	
×	29. HEART *(Thrust, size, rhyhm, sounds)*	
×	30. VASCULAR SYSTEM *(Varicosities, etc.)*	
×	31. ABDOMEN AND VISCERA *(Include hernia)*	
×	32. ANUS AND RECTUM *(Hemorrhoids, Fistular) (Prostate, if indicated)*	
×	33. ENDOCRINE SYSTEM	
×	34. G-U SYSTEM	
×	35. UPPER EXTREMITIES *(Strength, range of motion)*	
×	36. FEET	
×	37. LOWER EXTREMITIES *(Except feet) (Strength, range of motion)*	
×	38. SPINE, OTHER MUSCULOSKELETAL	
×	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
×	40. SKIN, LYMPHATICS	
×	41. NEUROLOGIC *(Equilibrium tests under item 72)*	
×	42. PSYCHIATRIC *(Specify any personality deviation)*	
	43. PELVIC *(Females only) (Check how done)* ☐ VAGINAL ☐ RECTAL	

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary)

38. lumbar strain

(Continue in item 73)

44. DENTAL *(Place appropriate symbols, shown in examples, above or below numer of upper and lower teeth.)*

	Restorable Teeth	Non-Restorable Teeth	Missing Teeth	Replaced by Dentures	Fixed Partial dentures
Examples	0 / 123 / 32 31 30 / 0	/ / 123 / 32 31 30 / /	x x 123 / 32 31 30 / x	xxx / 123 / 32 31 30 / xxx	(x) / 123 / 32 31 30 / (x)

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
	x															x	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY	1.018	46. CHEST X-RAY *(Place, date, film number and result)*
B. ALBUMIN	Neg	Travis AFB MTF 349 Negative
C. SUGAR	Neg	
D. MICROSCOPIC		

47. SEROLOGY *(Specify test used and result)*	48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS
Negative	-	AB+	None

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD:	56. TEMPERATURE
5' 11"	168	Brown	Brown	☐ SLENDER ☒ MEDIUM ☐ HEAVY ☐ OBESE	98.6

57. BLOOD PRESSURE *(Arm at heart level)*						58. PULSE *(Arm at heart level)*				
A. SITTING	SYS. 130 / DIAS. 78	B. RECUMBENT	SYS. 120 / DIAS. 72	C. STANDING *(5 min.)*	SYS. 124 / DIAS. 76	A. SITTING	B. AFTER EXERCISE	C. 2 MIN. AFTER	D. RECUMBENT E.	AFTER STANDING 3 MIN.
						72	84	78	68	76

59. DISTANT VISION				60. REFRACTION			61. NEAR VISION		
RIGHT 20/	20	CORR. TO 20/	20	BY	S.	CX	20/20	CORR. TO	BY
LEFT 20/	20	CORR. TO 20/	20	BY	S.	CX	20/20	CORR. TO	BY

62. HETEROPHORIA *(Specify distance)*

ES°	EX°	R.H.	L.H.	PRISM DIV.	PRISM CONV. CT	PC	PD

63. ACCOMMODATION		64. COLOR VISION *(Test used and result)*	65. DEPTH PERCEPTION *(Test used and score)*	UNCORRECTED
RIGHT	LEFT	Cover test Normal 10 ft		CORRECTED
66. FIELD OF VISION		65. TEST VISION *(Test used and score)*	66. RED LENS TEST	69. INTRAOCULAR TENSION
Normal		Isthara Normal	NotRequired	

70. HEARING			71. AUDIOMETER								72. PSYCHOLOGICAL AND PSYCHOMOTOR *(Test used and score)*
RIGHT WV	/15 SV	/15		250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
LEFT WV	/15 SV	/15	RIGHT	5	5	0	10	10	10	10	10	
			LEFT	10	15	20	10	20	10	10	10	

73. NOTES *(Continued)* AND SIGNIFICANT OR INTERVAL HISTORY

(Use additional sheets if necessary)

74. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnosis with item numbers)*

75. RECOMMENDATIONS-FURTHER SPECIALIST EXAMINATIONS INDICATED *(Specify)*

76. A. PHYSICAL PROFILE					
P	U	L	H	E	S

77. EXAMINEE *(Check)*

A. ☒ IS QUALIFIED FOR separation

B. ☐ IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

79. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
Meredith Gray	Meredith Gray
80. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)*	SIGNATURE
82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE / NUMBER OF ATTACHED SHEETS

*U.S. Government Printing Office: 1991 - 281-782/40135

REPORT OF MEDICAL EXAMINATION

1. LAST NAME - FIRST NAME - MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
Mark Lee		TRA-72-4820

4. HOME ADDRESS *(Number, street or RFD, city or town, State and ZIP Code)*	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
2512 410th Avenue S.W. Georgetown, KY 47012 (US)	Enlistment	02/20/2006

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
Male	White	4		USAF	

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
02/06/1983	Georgetown	Christa Lee, Sister 2501 Madeira LN, Pleasantville, OH 43148 (US)

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
Georgetown MEPS, Kentucky	

17. RATING OR SPECIALTY	TIME IN THIS CAPACITY *(Total)*	LAST SIX MONTHS
MD - General Practitioner		

CLINICAL EVALUATION

NORMAL	*(Check each item in appropriate column, enter "NE" if not evaluated.)*	ABNORMAL
×	18. HEAD, FACE, NECK AND SCALP	
×	19. NOSE	
×	20. SINUSES	
×	21. MOUTH AND THROAT	
×	22. EARS-GENERAL *(INTERNAL CANALS) (Auditory) acuity under items 70 and 71)*	
×	23. DRUMS *(Perforation)*	
×	24. EYES-GENERAL *(Visual acuity and refraction under items 59, 60 and 67)*	
×	25. OPHTHALMOSCOPIC-	
×	26. PUPILS (Equality and reaction)	
×	27. OCULAR MOTILITY (Associated parallel movements nystagmus)	
×	28. LUNGS AND CHEST *(Include breasts)*	
×	29. HEART *(Thrust, size, rhyhm, sounds)*	
×	30. VASCULAR SYSTEM *(Varicosities, etc.)*	
×	31. ABDOMEN AND VISCERA *(Include hernia)*	
×	32. ANUS AND RECTUM *(Hemorrhoids, Fistular) (Prostate, if indicated)*	
×	33. ENDOCRINE SYSTEM	
×	34. G-U SYSTEM	
×	35. UPPER EXTREMITIES *(Strength, range of motion)*	
×	36. FEET	
×	37. LOWER EXTREMITIES *(Except feet) (Strength, range of motion)*	
×	38. SPINE, OTHER MUSCULOSKELETAL	
×	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
×	40. SKIN, LYMPHATICS	
×	41. NEUROLOGIC *(Equilibrium tests under item 72)*	
×	42. PSYCHIATRIC *(Specify any personality deviation)*	
	43. PELVIC *(Females only) (Check how done)* ☐ VAGINAL ☐ RECTAL	

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary)

(Continue in item 73)

44. DENTAL *(Place appropriate symbols, shown in examples, above or below numer of upper and lower teeth.)*

	Restorable Teeth	Non-Restorable Teeth	Missing Teeth	Replaced by Dentures	Fixed Partial dentures
	0 / 1 2 3 / 32 31 30 / 0	/ 1 2 3 / 32 31 30 /	x 1 2 3 / 32 31 30 / x	xxx 1 2 3 / 32 31 30 / xxx	(x) 1 2 3 / 32 31 30 / (x)

RIGHT																	LEFT
	x															x	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
	x															x	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

Good Oral Hygiene

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY	1.017	46. CHEST X-RAY *(Place, date, film number and result)*
B. ALBUMIN	Neg	Neg
C. SUGAR	Neg	
D. MICROSCOPIC	Neg	

47. SEROLOGY *(Specify test used and result)*	48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS
Not Required		AB+	Not Required

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD:	56. TEMPERATURE
5' 11"	168	Brown	Brown	☐ SLENDER ☒ MEDIUM ☐ HEAVY ☐ OBESE	98.6

57. BLOOD PRESSURE *(Arm at heart level)*						58. PULSE *(Arm at heart level)*				
A. SITTING	SYS. 142 / DIAS. 78	B. RECUMBENT	SYS. 130 / DIAS. 72	C. STANDING *(5 min.)*	SYS. 128 / DIAS. 70	A. SITTING	B. AFTER EXERCISE	C. 2 MIN. AFTER	D. RECUMBENT E.	AFTER STANDING 3 MIN.
						72	88	68	72	76

59. DISTANT VISION		60. REFRACTION			61. NEAR VISION		
RIGHT 20/ 20	CORR. TO 20/	BY	S.	CX	20/20	CORR. TO	BY
LEFT 20/ 20	CORR. TO 20/	BY	S.	CX	20/20	CORR. TO	BY

62. HETEROPHORIA *(Specify distance)*

ES°	EX°	R.H.	L.H.	PRISM DIV.	PRISM CONV. CT	PC	PD

63. ACCOMMODATION		64. COLOR VISION *(Test used and result)*	65. DEPTH PERCEPTION *(Test used and score)*	UNCORRECTED
RIGHT	LEFT	Cover Test Normal 10ft	Normal	CORRECTED
66. FIELD OF VISION		65. TEST VISION *(Test used and score)*	66. RED LENS TEST	69. INTRAOCULAR TENSION
Normal			Not Required	

70. HEARING			71. AUDIOMETER								72. PSYCHOLOGICAL AND PSYCHOMOTOR *(Test used and score)*
RIGHT WV	15 /15 SV	15 /15		250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
LEFT WV	15 /15 SV	15 /15	RIGHT	0	0	0	0	0	0	0	0	
			LEFT	0	0	0	0	0	0	0	0	

73. NOTES *(Continued)* AND SIGNIFICANT OR INTERVAL HISTORY

Essentially Negative

(Use additional sheets if necessary)

74. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnosis with item numbers)*

75. RECOMMENDATIONS-FURTHER SPECIALIST EXAMINATIONS INDICATED *(Specify)*	76. A. PHYSICAL PROFILE					
	P	U	L	H	E	S

77. EXAMINEE *(Check)*	B. PHYSICAL CATEGORY
A. ☒ IS QUALIFIED FOR Entry into service	
B. ☐ IS NOT QUALIFIED FOR	

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER	A	B	C	E

79. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
Meredith Gray	Meredith Gray
80. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)*	SIGNATURE
82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE / NUMBER OF ATTACHED SHEETS

*U.S. Government Printing Office: 1991 - 281-782/40135

NO. OF ATTACHED SHEETS:

MEDICAL RECORD	REPORT OF MEDICAL HISTORY	DATE OF EXAM
		02/12/2006

NOTE: This information is for official and medically-confidential use only and will not be released to unauthorized persons

1. NAME OF PATIENT (Last, first, middle)	2. IDENTIFICATION NUMBER	3. GRADE
Mark Lee	TRA-72-4820	

4a. HOME STREET ADDRESS (Street or RFD; City or Town; State; and ZIP Code)	5. EXAMINING FACILITY
2512 410th Avenue S.W.	Georgetown MEPS, Kentucky

4b. CITY	4c. STATE	4d. ZIP CODE
Georgetown	KY	47012

6. PURPOSE OF EXAMINATION

Enlistment

7. STATEMENT OF PATIENT'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Use additional pages if necessary)

a. PRESENT HEALTH	b. CURRENT MEDICATION	REGULAR OR INTERM.
Good		
c. ALLERGIES (Include insect bites/stings and common foods)		
	d. HEIGHT	e. WEIGHT
	5' 11"	168

8. PATIENT'S OCCUPATION	9. ARE YOU (Check one)
	[X] RIGHT HANDED [ ] LEFT HANDED

10. PAST/CURRENT MEDICAL HISTORY

CHECK EACH ITEM	YES	NO	DON'T KNOW	CHECK EACH ITEM	YES	NO	DON'T KNOW	CHECK EACH ITEM	YES	NO	DON'T KNOW
Household contact with anyone with tuberculosis		X		Shortness of breath		X		Bone, joint or other deformity		X	
				Pain or pressure in chest		X		Loss of finger or toe		X	
Tuberculosis or positive TB test		X		Chronic cough		X		Painful or "trick" shoulder or elbow		X	
Blood in sputum or when coughing		X		Palpitation or pounding heart		X					
				Heart trouble		X		Recurrent back pain or any back injury		X	
Excessive bleeding after injury or dental work		X		High or low blood pressure		X					
				Cramps in your legs		X		"Trick" or locked knee		X	
Suicide attempt or plans		X		Frequent indigestion		X		Foot trouble		X	
Sleepwalking		X		Stomach, liver or intestinal trouble		X		Nerve Injury		X	
Wear corrective lenses		X		Gall bladder trouble or gallstones		X		Paralysis (including infantile)		X	
Eye surgery to correct vision		X						Epilepsy or seizure		X	
Lack vision in either eye		X		Jaundice or hepatitis		X		Car, train, sea or air sickness		X	
Wear a hearing aid		X		Broken bones		X		Frequent trouble sleeping		X	
Stutter or stammer		X		Adverse reaction to medication		X		Depression or excessive worry		X	
Wear a brace or back support		X		Skin diseases		X		Loss of memory or amnesia		X	
Scarlet fever		X		Tumor, growth, cyst, cancer		X		Nervous trouble of any sort		X	
Rheumatic fever		X		Hernia		X		Periods of unconsciousness		X	
Swollen or painful joints		X		Hemorrhoids or rectal disease		X		Parent/sibling with diabetes, cancer, stroke or heart disease		X	
Frequent or severe headaches		X		Frequent or painful urination		X					
Dizziness or fainting spells		X		Bed wetting since age 12		X		X-ray or other radiation therapy		X	
Eye trouble		X		Kidney stone or blood in urine		X		Chemotherapy		X	
Hearing loss		X		Sugar or albumin in urine		X		Asbestos or toxic chemical exposure		X	
Recurrent ear infections		X		Sexually transmitted diseases		X					
Chronic or frequent colds		X		Recent gain or loss of weight		X		Plate, pin or rod in any bone		X	
Severe tooth or gum trouble		X		Eating disorder (anorexia bulimia, etc.)		X		Easy fatigability		X	
Sinusitis		X						Been told to cut down or criticized for alcohol use		X	
Hay fever or allergic rhinitis		X		Arthritis, Rheumatism, or Bursitis		X					
Head injury		X						Used illegal substances		X	
Asthma		X		Thyroid trouble or goiter		X		Used tobacco		X	

11. FEMALES ONLY

CHECK EACH ITEM	YES	NO	DON'T KNOW	DATE OF LAST MENSTRUAL PERIOD	DATE OF LAST PAP SMEAR	DATE OF LAST MAMMO-GRAM
Treated for a female disorder						
Change in menstrual pattern						

CHECK EACH ITEM. IF "YES" EXPLAIN IN BLANK SPACE TO RIGHT. LIST EXPLANATION BY ITEM NUMBER.

ITEM	YES	NO
12. Have you been refused employment or been unable to hold a job or stay in school because of:		
a. Sensitivity to chemicals, dust, sunlight, etc.		X
b.Inability to perform certain motions.		X
c. Inability to assume certain positions.		X
d.Other medical reasons (If yes, give reasons.)		X
13. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details.)		X
14. Have you ever been denied life insurance? (If yes, state reason and give details.)		X
15. Have you had, or have you been advised to have, any operation. (If yes, describe and give age at which occurred.)		X
16. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)		X
17. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)		X
18. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection.)		X
19. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)		X
20. Have you ever received, is there pending, or have you ever applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.)		X
21. Have you ever been arrested or convicted of a crime, other than minor traffic violations. (If yes, provide details.)		X
22. Have you ever been diagnosed with a learning disability? (If yes, give type, where, and how diagnosed.)		X

23. LIST ALL IMMUNIZATIONS RECEIVED

Usual childhood immunizations

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

24a. TYPED OR PRINTED NAME OF EXAMINEE	24b. SIGNATURE	24c. DATE
Mark Lee	Mark Lee	02/20/2006

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY".

25. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (Physician shall comment on all positive answers in Items 7 through 11. Physician may develop by interview any additional medical history deemed important, and record any significiant findings here.)

26a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	26b. SIGNATURE	26c. DATE
Adelle Tyler	Adelle Tyler	02/20/2006

STANDARD FORM 93 (REV. 6-96) BACK

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 RELEASE OR DISCHARGE FROM ACTIVE DUTY

1. NAME *(Last, First, Middle)*	2. DEPARTMENT, COMPONENT AND BRANCH	3. SOCIAL SECURITY NUMBER
Lee, Mark	**Air Force**	**TRA-72-4820**

4a. GRADE, RATE OR RANK	b. PAY GRADE	5. DATE OF BIRTH *(YYYYMMDD)*	6. RESERVE OBLIGATION TERMINATION DATE *(YYYYMMDD)*
First Lieutenant	**O-2**	**19830206**	**NA**

7a. PLACE OF ENTRY INTO ACTIVE DUTY	b. HOME OF RECORD AT TIME OF ENTRY *(City and State, or complete address if known)*
Georgetown, KY	**2512 410th Avenue S.W. Georgetown, KY 47012 (US)**

8a. LAST DUTY ASSIGNMENT AND MAJOR COMMAND	b. STATION WHERE SEPARATED
Ali Al Salem Air Base	**Travis Air Force Base**

9. COMMAND TO WHICH TRANSFERRED	10. SGLI COVERAGE
NA	[X] NONE AMOUNT:

11. PRIMARY SPECIALTY *(List number, title and years and months in specialty. List additional speciality numbers and titles involving periods of one or more years.)*

8111 - Security Police Commander (3 years)

12. RECORD OF SERVICE	YEAR(S)	MONTH(S)	DAY(S)
a. DATE ENTERED AD THIS PERIOD	**06**	**02**	**21**
b. SEPARATION DATE THIS PERIOD	**10**	**02**	**21**
c. NET ACTIVE SERVICE THIS PERIOD	**04**	**00**	**01**
d. TOTAL PRIOR ACTIVE SERVICE	**00**	**00**	**00**
e. TOTAL PRIOR INACTIVE SERVICE	**00**	**00**	**00**
f. FOREIGN SERVICE	**01**	**06**	**00**
g. SEA SERVICE	**00**	**00**	**00**
h. EFFECTIVE DATE OF PAY GRADE	**08**	**12**	**13**

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

Air Force Achievement Medal
Global War on Terrorism Expeditionary Medal
Iraq Campaign Medal
National Defense Service Medal

14. MILITARY EDUCATION *(Course title, number of weeks, and months and years completed)*

Security Police Commander (52 weeks)

15a. MEMBER CONTRIBUTED TO VETERAN'S EDUCATION ASSISTANCE PROGRAM		YES	X	NO
b. HIGH SCHOOL GRADUATE OR EQUIVALENT	X	YES		NO

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. REMARKS

Service in Southwest Asia Theatre of Operations (Iraq, Kawait) from 06/12/2008 to 12/15/2009.

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.

19a. MAILING ADDRESS AFTER SEPERATION *(Include Zip Code)*	b. NEAREST RELATIVE *(Name and Address - include Zip Code)*
2512 410th Avenue S.W. Georgetown, KY 47012 (US)	**Christa Lee 2501 Madeira LN, Pleasantville, OH 43148 (US)**

20. MEMBER REQUESTS COPY 6 BE SENT TO _____ DIRECTOR OF VETERANS AFFAIRS		YES		NO
	X	YES		NO

21. SIGNATURE OF MEMBER BEING SEPARATED	22. OFFICIAL AUTHORIZED TO SIGN *(Type name, grade, title and signature)*
Mark Lee	**Capt. Samuel D. Hawkins ADMINO** Samuel D. Hawkins

SPECIAL ADDITIONAL INFORMATION *(For use by authorized agencies only)*

23. TYPE OF SEPARATION	24. CHARACTER OF SERVICE *(Include upgrades)*	
VOLUNTARY	**HONORABLE**	
25. SEPARATION AUTHORITY	26. SEPARATION CODE	27. REENTRY CODE
AR-15F	**JBK**	**73D**

28. NARRATIVE REASON FOR SEPARATION

COMPLETION OF REQUIRED ACTIVE SERVICE

29. DATES OF TIME LOST DURING THIS PERIOD	30. MEMBER REQUESTS COPY 4 *(Initials)*
0	

DD FORM 214
(PPYFF - WHS/DIOR)

Previous editions are obsolete.

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