Department of Veterans Affairs

CHRONIC FATIGUE SYNDROME 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 INFORMATION BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER
Rudolph J. Dillon Sr.	TRA-44-9456

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

1A. DOES THE VETERAN NOW HAVE OR HAS HE/SHE EVER BEEN DIAGNOSED WITH CHRONIC FATIGUE SYNDROME?

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

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

☒ CHRONIC FATIGUE SYNDROME ICD code - 780.71 DATE OF DIAGNOSIS - 04/03/2017

☐ 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 CHRONIC FATIGUE SYNDROME, LIST USING ABOVE FORMAT:

NOTE - For VA purposes, the diagnosis of chronic fatigue syndrome requires:
(A) New onset of debilitating fatigue severe enough to reduce daily activity to less than 50 percent of the usual level for at least 6 months; and
(B) The exclusion, by history, physical examination, and laboratory tests, of all other clinical conditions that may produce similar symptoms; and
(C) Six or more of the following:

1. Acute onset of the condition
2. Low grade fever
3. Non-exudative pharyngitis
4. Palpable or tender cervical or axillary lymph nodes
5. Generalized muscle aches or weakness
6. Fatigue lasting 24 hours or longer after exercise
7. Headaches (of a type, severity or pattern that is different from headaches in the pre-morbid state)
8. Migratory joint pains
9. Neuropsychological symptoms
10. Sleep disturbance

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 CHRONIC FATIGUE SYNDROME:

The Veteran described a three year history of flu like symptoms, headache, chills, swollen lymph nodes in his neck and groin, fatigue, and generalized muscle and joint pain.

3B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF CHRONIC FATIGUE SYNDROME?

☒ YES ☐ NO

(If "Yes," are the veteran's symptoms controlled by continuous medication?)

☒ Yes ☐ No

(If "Yes," list only those medications required for the veteran's chronic fatigue syndrome)

ibuprophen, sertraline

3C. HAVE OTHER CLINICAL CONDITIONS THAT MAY PRODUCE SIMILAR SYMPTOMS BEEN EXCLUDED BY HISTORY, PHYSICAL EXAMINATION AND/OR LABORATORY TESTS TO THE EXTENT POSSIBLE?

☒ YES ☐ NO *(If "No," describe):*

3D. DID THE VETERAN HAVE AN ACUTE ONSET OF CHRONIC FATIGUE SYNDROME?

☒ YES ☐ NO

3E. HAS THE DEBILITATING FATIGUE REDUCED DAILY ACTIVITY LEVEL TO LESS THAN 50% OF PRE-ILLNESS LEVEL?

☒ YES ☐ NO

(If "Yes," specify length of time daily activity level has been reduced to less than 50% of pre-illness level):

☐ Less than 6 months ☒ 6 months or longer

SECTION IV - FINDINGS, SIGNS AND SYMPTOMS

4A. DOES THE VETERAN NOW HAVE OR HAS THE VETERAN HAD ANY FINDINGS, SIGNS AND SYMPTOMS ATTRIBUTABLE TO CHRONIC FATIGUE SYNDROME?

☒ YES ☐ NO

(If "Yes," check all that apply):

- ☒ Debilitating fatigue
- ☒ Low grade fever
- ☐ Nonexudative pharyngitis
- ☒ Palpable or tender cervical or axillary lymph nodes
- ☒ Generalized muscle aches or weakness
- ☐ Fatigue lasting 24 hours or longer after exercise
- ☒ Headaches (of a type, severity or pattern that is different from headaches in the pre-morbid state)
- ☒ Migratory joint pain
- ☐ Neuropsychologic symptoms
- ☒ Sleep disturbance
- ☐ Other

(Note : Describe all checked conditions in Item 4B)

4B. PROVIDE A DESCRIPTION OF THE CONDITION(S):

The Veteran's symptoms respond to medication, however they do not resolve

4C. DOES THE VETERAN NOW HAVE OR HAS THE VETERAN HAD ANY COGNITIVE IMPAIRMENT ATTRIBUTABLE TO CHRONIC FATIGUE SYNDROME?

☒ YES ☐ NO

(If "Yes," check all that apply):

- ☒ Poor attention
- ☒ Inability to concentrate
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Other cognitive impairments

(Note : Describe all checked conditions in Item 4D)

4D. PROVIDE A DESCRIPTION OF THE CONDITION(S):

Poor attention and inability to concentrate during exacerbations.

4E. SPECIFY FREQUENCY OF SYMPTOMS:

- ☒ Symptoms wax and wane
- ☐ Symptoms are nearly constant
- ☐ Other

(Note : Describe frequency in Item 4F)

4F. PROVIDE A DESCRIPTION OF THE FREQUENCY:

Periods of incapacitation of at least one but less than two weeks total duration per year

4G. DO THE VETERAN'S SYMPTOMS DUE TO CHRONIC FATIGUE SYNDROME RESTRICT ROUTINE DAILY ACTIVITIES AS COMPARED TO THE PRE-ILLNESS LEVEL?

☐ YES ☒ NO

(If "Yes," specify % of restriction (check all that apply))

- ☐ Symptoms restrict routine daily activities by less than 25 % of the pre-illness level (more than 75% of the pre-illness level of activities are not restricted)
- ☐ Symptoms restrict routine daily activities to 50 % to 75% of the pre-illness level
- ☐ Symptoms restrict routine daily activities to less than 50 % of the pre-illness level
- ☐ Symptoms are so severe as to restrict routine daily activities almost completely
- ☐ Symptoms are so severe as to occasionally preclude self-care (If checked, describe frequency with which this occurs):_____
- ☐ Other (describe):_____

NOTE: For VA purposes, chronic fatigue syndrome is considered incapacitating only while it requires bed rest and treatment by a physician.

4H. DO THE VETERAN'S SYMPTOMS DUE TO CHRONIC FATIGUE SYNDROME RESULT IN PERIODS OF INCAPACITATION?

☒ YES ☐ NO

(If "Yes," indicate total duration of periods of incapacitation over the past 12 months):

- ☐ Less than 1 week
- ☒ At least 1 but less than 2 weeks
- ☐ At least 2 but less than 4 weeks
- ☐ At least 4 but less than 6 weeks
- ☐ At least 6 weeks total duration per year
- ☐ Other (describe):_____

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

5A. DOES THE VETERAN HAVE ANY SCARS (surgical or otherwise) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

☐ YES ☒ NO

(If "Yes," are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)

☐ Yes ☐ No

(If "Yes," ALSO complete VA Form 21-0960F-1, Scars/Disfigurement Disability Benefits Questionnaire)

5B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS OF CHRONIC FATIGUE SYNDROME?

☐ YES ☒ NO

(If "Yes," describe - brief summary):

SECTION VI - DIAGNOSTIC TESTING

NOTE: If testing has been performed and reflects 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 CHRONIC FATIGUE SYNDROME IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☒ NO *(If "Yes," describe the impact the veteran's chronic fatigue syndrome, providing one or more examples)*

SECTION VIII - REMARKS

8. REMARKS *(If any)*

The Veteran's symptoms meet the criteria for a diagnosis of chronic fatigue syndrome. The symptoms are controlled by continuous medication and have persisted for the last three years.

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
Peter Wilder	Peter Wilder	04/03/2017

9D. PHYSICIAN'S PHONE AND FAX NUMBER	9E. PHYSICIAN'S MEDICAL LICENSE NUMBER	9F. PHYSICIAN'S ADDRESS
(888) 888-8888	073195	23 Nice Street, Vancour, WY 86543 (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: _____

(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, 58/VA21/22/28, 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 the 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.

Gulf War General Medical Examination
Disability Benefits Questionnaire

** Internal VA or DoD Use Only**

Name of patient/Veteran: Rudolph J. Dillon Sr. SSN: TRA-44-9456

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.

DEFINITIONS: VA statutes and regulations provide for service connecting certain chronic disability patterns based on exposure to environmental hazards experienced during military service in Southwest Asia. The environmental hazards may have included: exposure to smoke and particles from oil well fires; exposure to pesticides and insecticides; exposure to indigenous infectious diseases; exposure to solvent and fuel fumes; ingestion of pyridostigmine bromide tablets, as a nerve gas antidote; the combined effect of multiple vaccines administered upon deployment; and inhalation of ultra fine-grain sand particles. In addition, there may have been exposure to smoke and particles from military installation "burn pit" fires that incinerated a wide range of toxic waste materials.

The chronic disability patterns associated with these Southwest Asia environmental hazards have two distinct outcomes. One is referred to as "undiagnosed illnesses" and the other as "diagnosed medically unexplained chronic multisymptom illnesses **".** An undiagnosed illness is established when findings are present that cannot be attributed to a known, clearly defined diagnosis, after all likely diagnostic possibilities for such abnormalities have been ruled out. Examples of medically unexplained chronic multi-symptom illnesses include, but are not limited to: (1) chronic fatigue syndrome, (2) fibromyalgia, and (3) irritable bowel syndrome. Diseases of "partially explained etiology," such as diabetes or multiple sclerosis, are not considered by VA to be in the category of medically unexplained chronic multisymptom illnesses.

The following list of signs and symptoms may represent an "undiagnosed illness" or "diagnosed medically unexplained chronic multisymptom illness **"** for which a Gulf War Veteran may be presumptively service connected:

- Fatigue
- Signs or symptoms involving the skin
- Headache
- Muscle pain
- Joint pain
- Neurological signs and symptoms
- Neuropsychological signs or symptoms
- Upper or lower respiratory system signs or symptoms
- Sleep disturbances
- Gastrointestinal signs or symptoms
- Cardiovascular signs or symptoms
- Abnormal weight loss
- Menstrual disorders

1. Medical record review

Indicate medical records reviewed in preparation of this report:

☒ C-file (VA only)
☐ Other, describe: _____

2. Medical history

Identify each affected system/area (This is the system/area/condition the Veteran is claiming or for which an exam has been requested). In particular, identify all systems/areas for any conditions the Veteran has claimed as secondary to Southwest Asia exposure or that could represent "undiagnosed illness" or "diagnosed medically unexplained chronic multisymptom illness."

Gulf War General Medical Examination
Disability Benefits Questionnaire

** Internal VA or DoD Use Only**

Under each identified system/area, select the appropriate associated Questionnaires (check all that apply). Complete the associated Questionnaires as part of this General Medical exam report.

☐ a. No symptoms, abnormal findings or complaints

☐ b. Skin and scars
- ☐ Skin Diseases
- ☐ Scars

☐ c. Hematologic/lymphatic
- ☐ Hematologic (including Anemia) and Lymphatic (Including Non-Hodgkin's Lymphoma)
- ☐ Hairy Cell & Other B-Cell Leukemias

☐ d. Eye

Note: Vision evaluations must be conducted by a specialist.

☐ e. Hearing loss, tinnitus and ear
- ☐ Hearing Loss and Tinnitus
- ☐ Ear Conditions

Note: Audio evaluations must be conducted by a specialist.

☐ f. Sinus, nose, throat, dental and oral
- ☐ Dental and Oral Conditions (including mouth, lips and tongue)
- ☐ Loss of Sense of Smell and/or Taste
- ☐ Sinusitis/Rhinitis and Other Conditions of the Nose, Throat, Larynx and Pharynx
- ☐ Temporomandibular Joint

☐ g. Breast

☐ h. Respiratory
- ☐ Respiratory Conditions (other than tuberculosis and sleep apnea)
- ☐ Sleep Apnea
- ☐ Tuberculosis

☐ i. Cardiovascular
- ☐ Artery & Vein Conditions (vascular diseases including varicose veins)
- ☐ Hypertension
- ☐ Heart Disease (including arrhythmias, valvular disease, and cardiac surgery)
- ☐ Ischemic Heart Disease

☐ j. Digestive and abdominal wall
- ☐ Abdominal, Inguinal, and Femoral Hernias
- ☐ Esophageal Disorders (GERD and Hiatal Hernia)
- ☐ Gallbladder and Pancreas
- ☐ Infectious Intestinal Conditions
- ☐ Intestinal Conditions (other than Surgical and Infectious)
- ☐ Intestinal Surgery
- ☐ Liver Conditions, including hepatitis and cirrhosis
- ☐ Peritoneal Adhesions
- ☐ Rectum and Anus (Including Hemorrhoids)
- ☐ Stomach and Duodenal Conditions

Gulf War General Medical Examination
Disability Benefits Questionnaire

** Internal VA or DoD Use Only**

☐ k. Kidney and urinary tract
- ☐ Kidney Conditions
- ☐ Urinary Tract (including Bladder and Urethral) Conditions

☐ l. Reproductive
- ☐ Gynecological Conditions
- ☐ Male Reproductive Organs
- ☐ Prostate Cancer

☐ m. Musculoskeletal

Spine
- ☐ Back (Thoracolumbar Spine) Conditions
- ☐ Neck (Cervical Spine) Conditions

Joints and extremities
- ☐ Ankle
- ☐ Elbow and Forearm
- ☐ Hands and Fingers
- ☐ Hip and Thigh
- ☐ Knee and Lower Leg
- ☐ Shoulder and Arm
- ☐ Wrist

Feet
- ☐ Flatfeet
- ☐ Foot (other than Flatfeet)

Miscellaneous musculoskeletal
- ☐ Amputations
- ☐ Arthritis (non-degenerative arthritis, including inflammatory, autoimmune, crystalline and infectious arthritis) and dysbaric osteonecrosis)
- ☐ Bone conditions, miscellaneous, including osteomyelitis
- ☐ Fibromyalgia
- ☐ Muscle Injuries
- ☐ Osteoporosis/osteopenia

  If checked, provide DexaScan results: _____ Date of scan: _____

  If checked, are there joint manifestations of osteoporosis/osteopenia (Osteoporosis may or may not present as spine or joint disease)?

  ☐ Yes ☐ No

  If yes, complete appropriate Questionnaire for affected joint(s)/spine.

☐ n. Endocrine
- ☐ Diabetes Mellitus
- ☐ Endocrine Diseases (other than Thyroid, Parathyroid, or Diabetes Mellitus)
- ☐ Thyroid and Parathyroid

☐ o. Neurologic
- ☐ Amyotrophic Lateral Sclerosis (ALS)
- ☐ Cranial Nerves Diseases
- ☐ Diabetic Sensory-Motor Peripheral Neuropathy
- ☐ Disease of the Central Nervous System
- ☐ Fibromyalgia
- ☐ Headaches (including Migraine Headaches)
- ☐ Narcolepsy
- ☐ Multiple Sclerosis (MS)

Gulf War General Medical Examination
Disability Benefits Questionnaire
** Internal VA or DoD Use Only**

- ☐ Parkinson's disease
- ☐ Peripheral Nerves
- ☐ Seizure Disorder (Epilepsy)
- ☐ Traumatic Brain Injury (Initial or Review)

(The Initial and Review TBI Questionnaire may only be completed by a VA clinician who has completed the TBI C&P certification. The initial diagnosis of TBI must be made by a specialist, but a certified generalist can complete the disability exam for TBI.)

☐ p. Psychiatric
- ☐ Eating Disorders
- ☐ Mental Disorders (Other Than PTSD)
- ☐ PTSD (Initial or Review)

Note: Mental disorder evaluations must be conducted by a specialist

☒ q. Infectio us disease, immune disorder or nutritional deficiency
- ☒ Chronic Fatigue Syndrome
- ☐ HIV and Related Illnesses
- ☐ Infectious Diseases
- ☐ Nutritional Deficiencies
- ☐ Persian Gulf and Afghanistan Infectious Diseases
- ☐ Systemic Lupus Erythematosus or other Immune Disorders
- ☐ Tuberculosis

☐ r. Miscellaneous conditions
- ☐ Cold Injury Residuals
- ☐ Former Prisoner of War (POW) Protocol

3. Diagnosed illnesses with no etiology

From the conditions identified and for which Questionnaires were completed, are there any diagnosed illnesses for which no etiology was established?

☐ Yes ☒ No

If yes, list diagnoses for diagnosed illnesses for which no etiology was established:

Diagnosis #1: _____
ICD code(s): _____
Date of diagnosis: _____
Name of Questionnaire: _____

Diagnosis #2: _____
ICD code(s): _____
Date of diagnosis: _____
Name of Questionnaire: _____

Diagnosis #3: _____
ICD code(s): _____
Date of diagnosis: _____
Name of Questionnaire: _____

If there are additional diagnoses, list using above format: _____

Gulf War General Medical Examination
Disability Benefits Questionnaire

** Internal VA or DoD Use Only**

4. Additional signs and/or symptoms that may represent an "undiagnosed illness" or "diagnosed medically unexplained chronic multisymptom illness"

Does the Veteran report any additional signs and/or symptoms not addressed through completion of DBQs identified in the above sections?

☐ Yes ☒ No

If yes, check all that apply

- ☐ Fatigue
- ☐ Signs or symptoms involving the skin
- ☐ Headache
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Neurological signs and symptoms
- ☐ Neuropsychological signs or symptoms
- ☐ Upper or lower respiratory system signs or symptoms
- ☐ Sleep disturbances
- ☐ Gastrointestinal signs or symptoms
- ☐ Cardiovascular signs or symptoms
- ☐ Abnormal weight loss
- ☐ Menstrual disorders
- ☐ Other, describe: _____

For all checked signs and symptoms in this section, provide pertinent information related to each (e.g. frequency, duration, severity, precipitating/relieving factors, physical exam, studies):

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5. Physical Exam

- ☐ Normal PE
- ☒ Normal PE, except as noted on additional Questionnaires included as part of this report
- ☐ Other, describe: _____

6. Functional impact of additional signs and/or symptoms that may represent an "undiagnosed illness" or "diagnosed medically unexplained chronic multisymptom illness"

Does the Veteran have any additional signs and/or symptoms checked above in question 4 that impact his or her ability to work (and that are not addressed in other Questionnaires)?

☐ Yes ☒ No

If yes, describe the impact of each additional sign and/or symptom that impacts his or her ability to work, providing one or more examples: _____

7. Remarks, if any: _____

Physician signature: John Carter Date: 03/05/2017

Physician printed name: Dr. John Carter

Medical license #: 12345 Physician address: 123 Best St, Vancour, WY 86543 (US)

Phone: (888) 888-8888 Fax: (777) 777-7777

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

Rudolph J. Dillon Sr.
TRA-44-9456

Priority processing GWOT. Please expedite.

Date of claim: 02/28/2017

Attention C&P clinical staff — This exam request was scheduled at your location based on the claimant's residing zip code and ERRA instructions

An in-person examination is required for the following exam(s). ACE process must not be used to complete the DBQ.

DBQ General Medical Gulf War

DBQ General Medical Gulf War:

Please review the Veteran's electronic folder in VBMS and state that it was reviewed in your report.

Please examine and evaluate this Veteran with Southwest Asia service for any chronic disability pattern. Please review the claims file as part of your evaluation and state that it was reviewed. The Veteran has claimed a disability pattern related to Fatigue.

Please provide a medical statement explaining whether the Veteran's disability pattern is:

1. an undiagnosed illness
2. a diagnosable but medically unexplained chronic multi-symptom illness of unknown etiology
3. a diagnosable chronic multi-symptom illness with a partially explained etiology, or
4. a disease with a clear and specific etiology and diagnosis

If, after examining the Veteran and reviewing the claims file, you determine that the Veteran's disability pattern is either (1) an undiagnosed illness; or (2) a diagnosable but medically unexplained chronic multi-symptom illness of unknown etiology, then no medical opinion or rationale is required as these conditions are presumed to be caused by service in the Southwest Asia theater of operations.

If, after examining the Veteran and reviewing the claims file, you determine that the Veteran's disability pattern is either (3) a diagnosable chronic multi-symptom illness with a partially explained etiology, or (4) a disease with a clear and specific etiology and diagnosis, then please provide a medical opinion, with supporting rational, as to whether it is at least as likely as not that the disability pattern or diagnosed disease is related to a specific exposure event experienced by the Veteran during service in Southwest Asia.

Please see the attached Notice to Examiner and Gulf War Fact Sheets regarding Exposure to Environmental Hazards.

FACT sheet
Burn Pits in Iraq, Afghanistan, and the Horn of Africa

NOTICE TO VA EXAMINERS
VA Considers this Veteran Exposed to Burn Pit Toxins

Large burn pits have been used throughout the operations in Iraq and Afghanistan to dispose of nearly all forms of waste. It is estimated that such pits, some nearly as large as 20 acres, are or have been located at every military forward operating base (FOB). The pit at Joint Base Balad, also known as Logistic Support Area (LSA) Anaconda, has received the most attention. The burned waste products include, but are not limited to: plastics, metal/aluminum cans, rubber, chemicals (such as, paints, solvents), petroleum and lubricant products, munitions and other unexploded ordnance, wood waste, medical and human waste, and incomplete combustion by-products. Jet fuel (JP-8) is used as the accelerant. The pits do not effectively burn the volume of waste generated, and smoke from the burn pit blows over bases and into living areas.

DoD has performed air sampling at Joint Base Balad, Iraq and Camp Lemonier, Djibouti. Subsequently, DoD has indicated that most of the air samples have not shown individual chemicals that exceed military exposure guidelines (MEG). Nonetheless, DoD further concluded that the confidence level in their risk estimates is low to medium due to lack of specific exposure information, other routes/sources of environmental hazards not identified; and uncertainty regarding the synergistic impact of multiple chemicals present, particularly those affecting the same body organs/systems.

The air sampling performed at Balad and discussed in an unclassified 2008 assessment tested and detected all of the following: (1) Particulate matter (PM-10) (and PM 2.5); (2) Polycyclic Aromatic Hydrocarbons (PAHs); (3) Volatile Organic Compounds (VOCs); and (4) Toxic Organic Halogenated Dioxins and Furans (dioxins). Each of the foregoing is discussed below.

Some of the PAHs that were tested for and detected are listed below. These results are from DoD testing from January through April 2007.

Acenaphthene	Acenaphthylene
Anthracene	Benzo(a)anthracene
Benzo(a)pyrene	Benzo(b)fluoroanthene
Benzo(b)fluoroanthene	Benzo(g,h,i)perylene
Benzo(k)fluoroanthene	Chrysene
Dibenz(a,h)anthracene	Fluoranthene
Fluorene	Indeno(1,2,3-cd)pyrene
Naphthalene	Phenanthrene
Pyrene	

The following list reveals some of the VOCs that were tested for and detected at Balad. These results are from DoD testing from January through April 2007.

Acetone	Acrolein*
Benzene	Carbon Disulfide
Chlorodifluoromethane	Chloromethane
Ethylbenzene	Hexane
Hexachlorobutadiene*	m/p-Xylene
Methylene Chloride	Pentane
Propylene	Styrene
Toluene	

* Acrolein and Hexachlorobutadiene were, although seldomly, detected far above the MEG ratio-once over 1800 percent above the MEG for Acrolein and over 500 percent above the MEG for Hexachlorobutadiene.

Below is a list of the dioxins and furans detected, all reportedly at low doses.

1,2,3,4,6,7,8 HPCDD	1,2,3,4,6,7,8 HPCDF
1,2,3,4,7,8,9 HPCDF	1,2,3,4,7,8 HXCDD
1,2,3,4,7,8 HXCDF	1,2,3,6,7,8 HXCDD
1,2,3,6,7,8 HXCDF	1,2,3,7,8,9 HXCDD
1,2,3,7,8,9 HXCDF	1,2,3,7,8 PECDD
1,2,3,7,8 PECDF	2,3,4,6,7,8 HXCDF
2,3,4,7,8 PECDF	2,3,7,8 TCDD
2,3,7,8 TCDF	octachlorodibenzodioxin
octachlorodibenzofuran	

For examination purposes, 22 of the VORs and PAHs, affect the respiratory system; 20 affect the skin; at least 12 affect the eyes; and others affect the liver, kidneys, central nervous system, cardiovascular system, reproductive system, peripheral nervous system, and GI tract. In at least seven, dermal exposure can greatly contribute to overall dosage. Therefore, when considering total potential exposure, please consider the synergistic affect of all combined toxins, primarily through inhalation and dermal exposure, but also through ingestion.

This information is not meant to influence examiners rendering opinions concerning the etiology of any particular disability; but rather to ensure that such opinions are fully informed based on all known objective facts. Therefore, when rendering opinions requested by rating authorities for a disability potentially related to such exposure, please utilize this information objectively and together with the remaining evidence, including lay evidence, in the Veteran's record.

Adjudication Authority

FACT sheet
Particulate Matter throughout Iraq and Afghanistan

NOTICE TO VA EXAMINERS
VA Considers this Veteran Exposed to High Levels of Particulate Matter

"Particulate matter"(PM), is a complex mixture of extremely small particles and liquid droplets made up of a number of components, including acids (such as nitrates and sulfates), organic chemicals, metals, and soil or dust particles. The PM levels in Southwest Asia are naturally higher than most of the world and may present a health risk to service members. There are two sizes of particles in the air that are a health concern-particles with a 10-micron (PM10) diameter or smaller, and those 2.5 microns (PM2.5) and smaller. The size is directly linked to potential for causing health problems. Once inhaled, 10-micron sized particles or smaller can affect the heart and lungs and cause serious health effects.

Primary sources of PM in Southwest Asia include dust storms and emissions from local industries. The DoD conducted a year-long sampling survey to characterize the chemistry and mineralogy of the PM at 15 sites in OIF and OEF. These results were published by the Desert Research Institute in 2008 and are being reviewed by the National Academy of Sciences Committee on Toxicology. DoD stated in their 2008 Balad assessment, that emission from burns pits, among other things, "may increase localized concentration of 2.5 micrometer PM and other potentially toxic air pollutants."

Most studies relate PM exposure data to respiratory and cardiopulmonary health effects in specific susceptible general population subgroups to include young children, the elderly, and especially those with existing asthma or cardiopulmonary disease. Many variables influence the probability of health outcomes. The key variables are the size-fraction and chemical make up of the PM, the concentration levels, the duration of exposures, and various human factors to include age, health status, existing medical conditions, and genetics. These variables combined with scientific data gaps limit the medical community's ability to estimate health impacts to relatively healthy troops. Another key factor is that most studies have been on older or less healthy groups. Several studies to determine potential health effects/outcomes are currently underway.

DoD collected approximately 60 air samples at Balad from January to April 2007 and assessed for PM. The samples were taken from five different locations around Balad. The heaviest measured concentration of PM was taken in April 2007-the concentration level was 299 ug/m3 of PM10 sized particles. In total, 50 of the 60 samples registered above the military exposure guidelines.

This information is not meant to influence examiners rendering opinions concerning the etiology of any particular disability; but rather to ensure that such opinions are fully informed based on all known objective facts. Therefore, when rendering opinions requested by rating authorities for a disability potentially related to such exposure, please utilize this information objectively and together with the remaining evidence, including lay evidence, in the Veteran's record.

Adjudication Authority

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)
02/28/2017

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)*

Rudolph J Dillon

2. VETERAN'S SOCIAL SECURITY NUMBER

TRA – 44 – 9456

3. HAVE YOU EVER FILED A CLAIM WITH VA?

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

4. VA FILE NUMBER

TRA44945 6

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

Month 03 – Day 26 – Year 1980

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)*

722 – 555 – 0169

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: 595 Burning Street

Apt./Unit Number:

City: Vancour

State/Province: WY

Country: US

ZIP Code/Postal Code: 86543 –

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 02 – Day 28 – Year 2016

11. PREFERRED TELEPHONE NUMBER

722 – 555 – 0169

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

rudolph0@my-case.com

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

VETERANS SOCIAL SECURITY NO. T R A – 4 4 – 9 4 5 6

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.	Chronic Fatigue
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
BAYJI MTF (IRAQ)	

VETERANS SOCIAL SECURITY NO. T R A – 4 4 – 9 4 5 6

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 1 0 – Day 0 2 – Year 2 0 0 8

16B. RELEASE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE SERVICE (MM,DD,YYYY)
Month 1 1 – Day 0 2 – Year 2 0 1 4

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 – 4 4 – 9 4 5 6

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
Rudolph J. Dillon Sr.	02/28/2017

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.

Offices of Michael Roberts M.D.
123456 Main Street
Anywhere town USA

Date of Exam: 10/04/2016

This 35 y. o. Veteran relates a history of having a generalized petechial, non-itchy rash one year ago noted after he went hiking in Wyoming. The rash spontaneously resolved within eight months.

He complained at the time of having symptoms like the flu with headache, chills, swollen lymph nodes in his neck and groin. He does not now have those flu-like complaints. He has however, continued fatigue and generalized muscle and joint pain, particularly bilateral knee pain for the past eighteen months.

P.E. B.P. 130/78 Ht 73 " Wt 182 lbs. HR 80

General – Veteran appears well-groomed, appropriate affect, cooperative and pleasant. No evidence of rash on skin.

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, Chemistry-12 panel - negative

ELISA and Western Blot tests – negative

Sedimentation rate - 28

ANA, Rheumatoid factor – negative

Imp: Possible Lyme disease, R/O Chronic Fatigue Syndrome

REPORT OF MEDICAL EXAMINATION

1. LAST NAME - FIRST NAME - MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
Rudolph J. Dillon Sr.	O-3	TRA-44-9456

4. HOME ADDRESS *(Number, street or RFD, city or town, State and ZIP Code)*	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
595 Burning Street Vancour, WY 86543 (US)	Separation	10/30/2014

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
Male	an/Pacific Islan	6		USA	

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
03/26/1980	Vancour	Erin M. Dillon, Sister 25001 Montague Expressway, Milpitas, CA 95035 (US)

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
Fort Huachuca 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 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*
Example	0 / 1 2 3 / 32 31 30 / 0 /		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

LABORATORY FINDINGS

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

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

NSN 7540-00-634-4038
88-122

STANDARD FORM 88 (REV. 3-89)
General Services Administration
Interagency Comm. on Medical Records
FIRMR (41 CFR) 201-45.505

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD:	56. TEMPERATURE
6' 1"	182	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	0	0	5	5	5	5	10	10	
			LEFT	5	0	0	0	5	5	5	5	

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

NO. OF ATTACHED SHEETS:

MEDICAL RECORD	REPORT OF MEDICAL HISTORY	DATE OF EXAM
		10/30/2014

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
Rudolph J. Dillon Sr.	TRA-44-9456	O-3

4a. HOME STREET ADDRESS (Street or RFD; City or Town; State; and ZIP Code)	5. EXAMINING FACILITY
595 Burning Street	Fort Huachuca MTF

4b. CITY	4c. STATE	4d. ZIP CODE
Vancour	WY	86543

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
	6' 1"	182

8. PATIENT'S OCCUPATION	9. ARE YOU (Check one)
Physician	[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
Rudolph J. Dillon Sr.	Rudolph J. Dillon Sr.	10/30/2014

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.)

Service member reports difficulty hearing on the telephone, ringing in the ears, and back pain.

26a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	26b. SIGNATURE	26c. DATE
Adelle Tyler	Adelle Tyler	10/30/2014

REPORT OF MEDICAL EXAMINATION

1. LAST NAME - FIRST NAME - MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
Rudolph J. Dillon Sr.		TRA-44-9456

4. HOME ADDRESS *(Number, street or RFD, city or town, State and ZIP Code)*	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
595 Burning Street Vancour, WY 86543 (US)	Enlistment	09/29/2008

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
Male	an/Pacific Islan	6			

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
03/26/1980	Vancour	Erin M. Dillon, Sister 25001 Montague Expressway, Milpitas, CA 95035 (US)

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
Vancour MEPS, Wyoming	

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
Upper	0 / 1 2 3 / 32 31 30	/ 1 2 3 / 32 31 30	x 1 2 3 / 32 31 30	xxx 1 2 3 / 32 31 30	(x) 1 2 3 / 32 31 30
Lower	0	/	x	xxx	(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

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		O-	Not Required

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD:	56. TEMPERATURE
6' 1"	182	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
		09/29/2008

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
Rudolph J. Dillon Sr.	TRA-44-9456	

4a. HOME STREET ADDRESS (Street or RFD; City or Town; State; and ZIP Code)	5. EXAMINING FACILITY
595 Burning Street	Vancour MEPS, Wyoming

4b. CITY	4c. STATE	4d. ZIP CODE
Vancour	WY	86543

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
	6' 1"	182

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
Rudolph J. Dillon Sr.	Rudolph J. Dillon Sr.	09/29/2008

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	09/29/2008

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
Dillon Sr., Rudolph J.	**Army**	**TRA-44-9456**

4a. GRADE, RATE OR RANK	b. PAY GRADE	5. DATE OF BIRTH *(YYYYMMDD)*	6. RESERVE OBLIGATION TERMINATION DATE *(YYYYMMDD)*
Captain	**O-3**	**19800326**	

7a. PLACE OF ENTRY INTO ACTIVE DUTY	b. HOME OF RECORD AT TIME OF ENTRY *(City and State, or complete address if known)*
Vancour, WY	**595 Burning Street Vancour, WY 86543 (US)**

8a. LAST DUTY ASSIGNMENT AND MAJOR COMMAND	b. STATION WHERE SEPARATED
Army	**Fort Huachuca**

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

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.)*

3150 - Battalion Aide Surgeon (5 years)

12. RECORD OF SERVICE	YEAR(S)	MONTH(S)	DAY(S)
a. DATE ENTERED AD THIS PERIOD	**08**	**10**	**02**
b. SEPARATION DATE THIS PERIOD	**14**	**11**	**02**
c. NET ACTIVE SERVICE THIS PERIOD	**06**	**02**	**01**
d. TOTAL PRIOR ACTIVE SERVICE	**00**	**00**	**00**
e. TOTAL PRIOR INACTIVE SERVICE	**00**	**00**	**00**
f. FOREIGN SERVICE	**02**	**00**	**00**
g. SEA SERVICE	**00**	**00**	**00**
h. EFFECTIVE DATE OF PAY GRADE	**13**	**08**	**24**

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

Army Achievement Medal
Global War on Terrorism Expeditionary Medal
Iraqi Campaign Medal
National Defense Service Medal

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

Battalion Aide Surgeon (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

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)*
595 Burning Street Vancour, WY 86543 (US)	**Erin M. Dillon 25001 Montague Expressway, Milpitas, CA 95035 (US)**

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

21. SIGNATURE OF MEMBER BEING SEPARATED	22. OFFICIAL AUTHORIZED TO SIGN *(Type name, grade, title and signature)*
Rudolph J. Dillon Sr.	**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)*	
RELEASED FROM ACTIVE DUTY	**HONORABLE**	
25. SEPARATION AUTHORITY	26. SEPARATION CODE	27. REENTRY CODE
AR-15F	**63JK**	**58RT**

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.

SERVICE - 2

For Training Purposes Only