CAUTION: NOT TO BE USED FOR IDENTIFICATION PURPOSES. THIS IS AN IMPORTANT RECORD. SAFEGUARD IT. // ALTERATIONS IN SHADED AREAS RENDER FORM VOID.

CERTIFICATE OF RELEASE OR DISCHARGE FROM ACTIVE DUTY

For *Training Purposes Only*

1. NAME (*Last, First, Middle*)	2. DEPARTMENT, COMPONENT AND BRANCH	3. SOCIAL SECURITY No.
Case, Test	Army/RA	000 00 0000

4.a GRADE, RATE OR RANK	4.b PAY GRADE	5. DATE OF BIRTH (YYMMDD)	6. RESERVE OBLIG. TERM. DATE
SGT	E05	19770214	000 000 000

7.a PLACE OF ENTRY INTO ACTIVE DUTY	7.b HOME OF RECORD AT TIME OF ENTRY (City and state, or complete address if known)
Bedrock, USA	301 Cobblestone Way, Bedrock, USA
8.a LAST DUTY ASSIGNMENT AND MAJOR COMMAND WT CO D (WARRIORS) MC	8.b STATION WHERE SEPARATED FORT CARSON, CO 80913-2965
9. COMMAND TO WHICH TRANSFERRED USAR CON GP (RETRES) 1 RESERVE WAY, ST LOUIS, MO 63132	10. SGLI COVERAGE ☐None Amount: $400,000.00

11. PRIMARY SPECIALTY (*List number, title and years and months in specialty. List additional specialty numbers and titles involving periods of one or more years.*)
11B10 INFANTRYMAN -- 7 YRS 0 MOS//NOTHING FOLLOWS

12. RECORD OF SERVICE	Year(s)	Month(s)	Day(s)
a. Date Entered AD This Period	1998	11	25
b. Separation Date This Period	2005	11	24
c. Net Active Service This Period	07	00	01
d. Total Prior Active Service	00	00	00
e. Total Prior Inactive Service			
f. Foreign Service			
g. Sea Service			
h. Effective Date of Pay Grade	2003	09	06

13. DECORATIONS, MEDALS, BADGES, CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED (*All periods of service*) (*training purposes only*)
ARMY GOOD CONDUCT MEDAL//GLOBAL WAR ON TERRIORISM SERVICE MEDAL//IRAQ CAMPAIGN MEDAL W/ CAMPAIGN STAR//OVERSEAS SERVICE RIBBON//NOTHING FOLLOWS

14. MILITARY EDUCATION (*Course title, number of weeks, and month and year completed*)
COMABT LIST SAVERS CRS, 1 WEEK, 2006//NOTHING FOLLOWS

15.a MEMBER CONTRIBUTED TO POST-VIETNAM ERA VETERAN'S EDUCATIONAL ASSISTANCE PROGRAM	Yes	No	15.b HIGH SCHOOL GRADUATE OR EQUIVALENT	Yes	No	16. DAYS ACCRUED LEAVE PAID
B. HIGH SCHOOL GRADUATE OR EQUIVALENT	X			X		Paid 0

17. MEMBER WAS PROVIDED COMPLETE DENTAL EXAMINATION AND ALL APPROPRIATE DENTAL SERVICES AND TREATMENT WITHIN 90 DAYS PRIOR TO SEPARATION — Yes: X — No:
DENTAL SERVICES AND TREATMENT WITHIN 90 DAYS PRIOR TO SEPARATION

18. REMARKS
//////////////////////////////////ENLISTMENT BONUS PAID: $20000.00, 20060107//SERVED IN A DESIGNATED IMMINENT DANGER PAY AREA//SERVICE IN IRAQ 20031010-20050228//MEMBER

19 a. MAILING ADDRESS AFTER SEPARATION (Include Zip Code)	19.b NEAREST RELATIVE (Name and address -- Include Zip Code)
301 Cobblestone Way, Bedrock, USA	Liz Case, Same as 19
20. MEMBER REQUESTS COPY — Yes: ☐ No: ☐	22. OFFICIAL AUTHORIZED TO SIGN (Type name, grade, title and signature)
21. SIGNATURE OF MEMBER BEING SEPARATED Fred Flintstone	Barney Rubble, Branch Chief, PERS PROC

SPECIAL ADDITIONAL INFORMATION (*for use for training purpose only*)

23. TYPE OF SEPARATION	24. CHARACTER OF SERVICE (*include upgrades*)	
End of Service	HONORABLE	
25. SEPARATION AUTHORITY	26. SEPARATION CODE	27. REENTRY CODE
AR 635-40, PARA 4-24B	SFK	4R
28. NARRATIVE REASON FOR SEPARATION Disability, Temporary		
29. DATES OF TIME LOST DURING THIS PERIOD	30. MEMBER REQUESTS	
None	FJF	Initials

DD Form 214, NOV 88, EG For Training Purposes Only

LOCAL TITLE: C&P CAPRI EXAMINATION
STANDARD TITLE: C & P EXAMINATION NOTE
DATE OF NOTE: December 5, 2009 ENTRY DATE: December 5, 2009@18:47:15
AUTHOR: EXP COSIGNER:
INSTITUTION:
DIVISION: Any town VAMC
URGENCY: STATUS: COMPLETED

COMPENSATION AND PENSION EXAMINATION REPORT (FREE TEXT)
==========

Reference #: 256617 Initial examination for Cervical spine condition

The veteran is a 32 year-old male who is appointed for a Compensation Examination per CAPRI-2507 request. The veteran's claims file was available and was reviewed. For pertinent past medical history and findings of record, please see the claims folder.

The current evaluation is a review evaluation for the veteran, who is asked to be evaluated for a cervical spine condition

MILITARY HISTORY: The veteran enlisted in the Army on November 25, 1998, and was discharged November 24, 2005 due to the downsizing of his unit.

PHYSICAL EXAMINATION:

VITAL SIGNS:

Height: 67.5 inches Weight: 190 lbs Pulse: 64/min. The three blood pressure readings were as follows: 118/70, 110/60 and 110/76. The claimants uncorrected visual acuity with Snellen chart reading is right 20/13 and left 20/13. The claimant is well developed, well nourished and is in no acute distress.

EYES:

There is no icterus. Extraocular muscle movements are intact. Pupils are round and reactive to light. Funduscopic examination reveals no retinal hemorrhages or exudates.

HEAD EARS NOSE AND THROAT:

The head is normocephalic and atraumatic. The nasal septum is at midline. The oral cavity reveals no lesion and dentition is grossly intact. Throat reveals: mucosa is intact, no pharyngeal Erythema or exudates. Ear lobe and cartilage are normal. External auditory canal reveals no exudates or lesion any tympanic membranes are intact. Examination of the nose reveals no nasal obstruction, no deviated septum, no partial loss of the nose, no partial loss of the ala, no nasal polyps, no scar and no disfigurement. There is no rhinitis or sinusitis present.

SKIN:

Clear of rashes and lesions. There are no scars present.

LYMPHATIC SYSTEM:

There is no lymphadenopathy.

NECK:

Supple with trachea midline. No jugular venous distention or thyroid enlargement.

LUNG:

Breath sounds are symmetric. No rhonchi or rales. Expiratory phase is within normal limits.

HEART:

Normal S1 and S2. No S3, S4 regular rate and rhythm. No heaves or thrills. No murmurs or gallops.

ABDOMEN:

No tenderness. Liver and spleen are not palpable. Bowel sounds are normal. There are no ascites.

EXTREMITIES:

There is no ulceration, edema or stasis dermatitis. There is no clubbing or cyanosis. There is no evidence of hand tremor on examination. Vascular examination is within normal limits.

MUSCULOSKELETAL SYSTEM:

Cervical Spine

There was no overt deformity noted. There is tenderness to palpation throughout the cervical vertebrae. Strength throughout the upper extremities 5/5 throughout grossly. Deep tendon reflexes 1+ and symmetrical. Cervical flexion 0 to 36 degrees, lateral flexion right and left 0 to 20 degrees, rotation right and left 0 to 40 degrees and cervical extension 0 to 30 degrees. With repetitive use times three the range of motion was not additionally limited by pain, fatigue, weakness or lack of endurance. You denied any flare-ups in regards to your cervical condition. There was no additional loss of function of the cervical spine on today's physical examination. There was also minimal spasm, and tenderness with no weakness.

KNEE: On the right there is tenderness. The right shows no signs of edema, effusion, weakness, redness, heat and guarding or movement. There is no subluxation.

Range of motion of the right knee joint is as follows:

	Normal ROM	**Right** ROM in degree	Degree that pain occurs
Flexion	140	140	140
Extension	0	0	

On the right, the joint function is additionally limited by the following after repetitive use: pain and pain has the major functional impact. The joint function on the right is not additionally limited by the following after repetitive use: fatigue, weakness, lack of endurance and incoordination. There is no additional limitation in degree.

The anterior and posterior cruciate ligaments stability test of the right knee is within normal limits. The medial and lateral collateral ligaments stability test of the right knee is within normal limits. The medial and lateral meniscus test of the right knee is within normal limits. The anterior and posterior cruciate ligaments stability test of the left knee is within normal limits. The medial and lateral collateral ligaments stability test of the left knee is within normal limits. The medial and lateral meniscus test of the left knee is within normal limits.

RECTAL:

The rectal exam was decline.

MALE GENITAL:

The genital exam was decline.

PERIPHERAL PULSES:

Examination of the left and right peripheral pulses reveals femoral pulse 2+, popliteal pulse 2+, dorsalis pedis pulse 2+ and anterior tibial pulse 2+.

NEUROLOGICAL:

Examination of the cranial nerves reveals normal findings.
Coordination is within normal limits.

Neurological examination of the upper extremities: Motor function is within normal limits. Sensory function is within normal limits. The right and left upper extremity reflexes reveal biceps jerk 2+ and triceps jerk 2+.

Neurological examination of the lower extremities: Motor function is within normal limits. Sensory function is within normal limits. The right and left lower extremity reflexes reveal knee jerk 2+ and ankle jerk 2+.

DIAGNOSTIC TESTS:

Right knee x-ray was normal.
Cervical spine showed degenerative changes of the cervical spine

DIAGNOSIS:

For the claimants claimed condition of RIGHT KNEE PATELLOFEMORAL SYNDROME, the diagnosis is right knee patellofemoral syndrome. The objective factors are right knee pain.

For the claimants claimed condition of degenerative changes of the cervical spine with limitation of motion secondary to pain.

Dr. Green

DEPARTMENT OF VETERANS AFFAIRS
123 Slate Way
Sandstone, USA 12345

Test Case
301 COBBLESTONE WAY
BEDROCK USA 00000

In reply, refer to:
000/XXX/xx
File Number: 00000000
Test Case

IMPORTANT -- reply needed

Dear Mr. Case:

We are working on your claim for:

- Degenerative changes of the cervical spine
- Right knee condition

This letter tells you what we will do with your claim and what you can do to help us. Please read the enclosure to this letter entitled, "Veteran Claims Assistance Act (VCAA)." The enclosure explains how we obtain evidence related to your claim and the legal requirements for supporting your claim.

What Do We Still Need from You?

We need additional evidence from you. ***Please put your VA file number on the first page of every document you send us.***

- We need evidence showing that the following condition(s) existed from military service to the present time:

  degenerative changes of the cervical spine, and your right knee condition

- We are requesting your service treatment records from the service department. You do not need to contact the service department yourself. If you have your service treatment records already in your possession, please submit them. Original records are preferable to copies.

- Send us any treatment records related to your claimed condition(s). This includes reports or statements from doctors, hospitals, laboratories, medical facilities, mental health clinics, x-rays, physical therapy records, surgical reports, etc. These should include the dates of treatment, findings, and diagnoses. If you want us to try to obtain any doctor, hospital or medical reports on your behalf, please complete and return the attached *VA Form 21-4142, Authorization and Consent to Release Information.*

- If you have received treatment at a Department of Veterans Affairs (VA) facility or treatment authorized by VA, please tell us the dates and places of treatment. We will then obtain the necessary records if you give us enough information to locate them.

- You may also send us your own statement, or statements from people who have witnessed how your claimed disabilities affect you. All statements submitted on your behalf should conclude with the following certification: "I hereby certify that the information I have given is true to the best of my knowledge and belief."

- **We have enclosed a "VCAA Notice Response." We encourage you to return this document, as it may expedite a decision on your claim.**

Where Should You Send What We Need?

Please send what we need to this address:

Department of Veterans Affairs
123 Slate Way
Sandstone, USA 12345

How Soon Should You Send What We Need?

We strongly encourage you to send any information or evidence as soon as you can. If we do not hear from you, we may make a decision on your claim after 30 days. However, you have up to one year from the date of this letter to submit the information and evidence necessary to support your claim. If we decide your claim before one year from the date of this letter, you will still have the remainder of the one-year period to submit additional information or evidence necessary to support your claim.

What Have We Received?

- Your claim for benefits, which we received on August 1, 2006.
- Certified copy of your DD Form 214.

What Have We Done?

- We have requested service treatment records from our office in St. Louis, Missouri.

How Can You Contact Us?

If you are looking for general information about benefits and eligibility, you should visit our web site at http://www.va.gov. Otherwise, you can contact us in several ways. Please give us your VA file number, **000000000**, when you do contact us.

- Call us at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the number is 1-800-829-4833.
- Send us an inquiry using the Internet at https://iris.va.gov.
- Write to us at the address at the top of this letter.

We look forward to resolving your claim in a fair and timely manner. We have also enclosed information on how Veterans' Service Organizations can help you.

Sincerely yours,

Enclosures:
VA Form 21-4138
VA Form 21-4142 (2)
Veterans' Service Organization Information
Veterans Claims Assistance Act (VCAA)
What the Evidence Must Show - Service connected comp
VCAA Notice Response

Veterans Claims Assistance Act (VCAA)

What the Evidence Must Show for Service Connection

To support your claim for service-connection, the evidence must show:

1. You had an injury in military service, or a disease that began in or was made permanently worse during military service, or there was an event in service that caused an injury or disease; **AND**
2. You have a current physical or mental disability. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that are visible or observable; **AND**
3. A relationship exists between your current disability and an injury, disease, or event in military service. Medical records or medical opinions are generally required to establish this relationship. However, under certain circumstances, VA may presume that certain current disabilities were caused by service, even if there is no specific evidence proving this in your particular claim. The cause of a disability is presumed for the following veterans who have certain diseases:
   - Former prisoners of war;
   - Veterans who have certain chronic or tropical diseases that become evident within a specific period of time after discharge from service;
   - Veterans who were exposed to ionizing radiation, mustard gas, or Lewisite while in service;
   - Veterans who were exposed to certain herbicides, such as by serving in Vietnam; or
   - Veterans who served in the Southwest Asia theater of operations during the Gulf War.

VA is Responsible for Getting the Following Evidence:

- Relevant records that you adequately identify and authorize VA to obtain from any Federal agency. These may include records from the military, VA medical centers (including private facilities where VA authorized treatment), or the Social Security Administration.
- VA will provide a medical examination for you, or get a medical opinion, if we determine it is necessary to decide your compensation claim.

On Your Behalf, VA Will Make Reasonable Efforts to Get the Following Evidence:

Relevant records not held by a Federal agency that you adequately identify and authorize VA to obtain. These may include records from State or local governments, private doctors and hospitals, or current or former employers.

How Can You Help: If you have any information or evidence that you have not previously told us about or given to us, please tell us or give us that evidence now. If the evidence is not in your possession, you must give us enough information about the evidence so that we can request it from the person or agency that has it. If the holder of the evidence declines to give it to us,

asks for a fee to provide it, or VA otherwise cannot get the evidence, we will notify you. *It is your responsibility to make sure we receive all requested records that are not in the possession of a Federal department or agency.*

How VA Determines the Disability Rating: When we find disabilities to be service connected, we assign a disability rating for compensation purposes. That rating can be changed if your condition changes. Depending on the disability and diagnostic code involved, we will assign a rating from 0 percent to as much as 100 percent. VA uses a schedule for evaluating disabilities that is published as Title 38, Code of Federal Regulations, Part 4. Under certain circumstances, a disability rating may be assigned based on the result of a specific test or measurement. In exceptional cases, we can assign a disability rating based on factors not found in the schedule for a specific condition if your impairment is not adequately covered by the schedule. Additional payment of compensation may be assigned under special circumstances for certain disabilities, or disabilities that affect activities of daily living.

We consider the following evidence in determining the disability rating:

- Nature and symptoms of the condition;
- Severity and duration of the symptoms;
- Impact of the condition upon employment and daily life; and
- Specific test or measurement results, such as pulmonary function tests for certain respiratory ailments, treadmill exercise tests for certain types of heart disease, audiometric tests for hearing loss, optometric tests for visual loss, and range of motion tests for some joint or muscle conditions.

Examples of evidence that are relevant to assigning a disability rating include the following:

- Private, VA, or other Federal treatment and hospitalization records, including medical statements;
- Recent Social Security determinations;
- Statements from employers regarding how your condition(s) affect(s) your ability to work;
- Job application rejections;
- Statements from people who have witnessed how the symptoms of your disabilities affect you; or
- Any other evidence showing the extent of your disability or exceptional circumstances relating to it.

How VA Determines the Effective Date: If we grant your claim, the beginning date of your entitlement or increased entitlement to benefits will generally be based on the following factors:

- When we received your claim; or
- When the evidence shows a level of disability that supports a certain rating under the rating schedule or other applicable standards.

If VA received your claim within one year of your separation from the military, entitlement will be from the day following the date of your separation.

Examples of evidence that are relevant to determining the effective date of any benefits we award include the following:

- Information about continuous treatment or when treatment began;
- Service treatment records in your possession that you may not have sent us; or
- Reports of treatment for your condition while attending training in the Guard or Reserve.

What Are Veterans Service Organizations and How Can They Help You?

- Veterans Service Organizations (VSOs) are not part of VA. VSOs are recognized national and state organizations that help veterans and their dependents and survivors with their claims. These services are provided without charge.

- VSOs can help you with questions about your claim. They can also act on your behalf regarding your claim with VA. Ask your VA representative or a VSO for more specific information about what VSOs do.

What Is an Example of a VSO?

Below is a list of recognized national organizations that can assist with your claim. Other recognized state and local organizations can also help you. A more complete list of recognized VSOs can be found at http://www.va.gov/vso.

American Legion	Disabled American Veterans	Paralyzed Veterans of America, Inc.
American Red Cross	Marine Corps League	Veterans of Foreign Wars of the US
AMVETS	Military Order of the Purple Heart	Vietnam Veterans of America

How Can You Contact a VSO?

To contact a particular VSO, consult your local telephone book.

VCAA NOTICE RESPONSE

We provided a notice to you about the evidence and information VA needs to support your claim for benefits. At this time, you may choose to indicate whether you intend to submit additional information or evidence that would help support your claim.

Your signed response will let us know whether to decide your claim without waiting 30 days, or whether we should give you the full 30 days from the date of the letter sent with this notice response before deciding your claim.

Your signature on this response will not affect:

- Whether or not you are entitled to VA benefits;
- The amount of benefits to which you may be entitled;
- The assistance VA will provide you in obtaining evidence to support your claim; or
- The date any benefits will begin if your claim is granted.

RESPONSE

I elect *one* of the following: (Whichever box you check, you have one year from the date of the notice to give VA any other information or evidence you think will support your claim.)

☐ I have enclosed all the remaining information or evidence that will support my claim, or I have no other information or evidence to give VA to support my claim. Please decide my claim as soon as possible.

☐ I will send more information or evidence to VA to support my claim. VA will wait the full 30 days from the date of the letter sent with this notice response before deciding my claim.

_____ _____

Claimant/Representative Signature Date

VA Department of Veterans Affair

Respondent Burden: 1 hour, 30 Minutes
(DO NOT WRIRE IN THIS SPACE)

Received August 1, 2009

VETERAN'S APPLICATION FOR COMPENSATION AND/OR PENSION

VA Form 21-526, Part A: General Information

Please read the attached "General Instructions" before you fill out the form.

SECTION I Tell us what you are applying for

Check the box that says what you are applying for. Be sure to complete the other Parts you need.

1. What are you applying for? If you are unsure please refer to the "General Instructions", page 2

Section 1: Preparing your application

XXX Compensation — Fill out Part A of VA Form 21-526, and PARTS B and C

___ Pension — Fill out Part A of VA Form 21-526, and PARTS C and D

___ Compensation and Pension — Fill out Part A of VA Form 21-526, and PARTS B, C, and D

2a. Have you ever filed a claim with VA?

XXX No *(If No, skip item 2b and go to item 3)*

(If yes, provide file number below)

___ Yes _____

2b. I filed a claim for:

___ Compensation ___ Pension

___ Other _____

SECTION II Tell us about you

We need information about you to process your claim faster.

3. What is your name?

Test **Case**

First Middle Last Suffix (if applicable)

4. What is your Social Security Number?

111-11-1111

5. What is your sex?

XXX Male ___ Female

6a. Did you serve under another name?

___ Yes *(If Yes, go to Item 6b)*

XXX No *(If No, go to item 7)*

6b. Please list the other name(s) you served under

Give us your correct mailing address in the space provided. If it will change within the next three months, give us the new address in block 29 "Remarks." Also in block 29, give us the date you think you will be at the new address.

7. What is your address?

59 Evergreen Terrace

Street address, Rural Route, or P.O. Box Apt Number

Springfield **USA** **11111**

City State ZIP Code Country

8. What are your telephone numbers?

989-444-0000

Daytime _____

989-444-0000

Evening _____

9. What is your email address?

Not setup yet

10. What is your date of birth?

02/14/1977

11. Where were you born? *(City, State, Count.)*

Springfield USA

OWCP used to be called the U.S. Bureau of Employees Compensation

12a. Are you receiving disability benefits from the Office of Workers' Compensation (OWCP)?

___Yes XXX No

(If Yes, answer 12b and 12c also)

12b. When was the claim filed?

12c. What disability are you receiving benefits for?

13a. What is the name of your nearest relative or other person we could contact if necessary/

Bob Case

13b. What is his/her telephone number?

989-444-0000

Daytime _____

989-444-0000

Evening _____

13c. What is the person's address?

Same as noted in box 7

13d. How is this person related to you?

Father

TRAINING PURPOSES ONLY

SECTION III Tell us about your active duty

1. Enter complete information for all periods of service. If more space is needed, use Item 29 "Remarks".

2. Attach your original DD214 or a certified copy to this form. (We will return original documents to you.)

The VA has a registry of Veterans who served in the Gulf War. This area has also been called the "Persian Gulf." If you served there, we will include your name in the registry. If you want your medical information included, you must check "Yes" in Item 16b. For more information about the registry, see page 4 of the General Instructions for VA Form 21-526.

SECTION IV Tell us about your reserve duty

14a. I entered active service the **first** time... **11/25/1998** _____ mo day yr	14b. Place: **NY, NY**	14c. My service number was ... **111-11-1111**	
14d. I left active service ... **11/24/2005** _____ mo day yr	14e. Place: **NY, NY**	14f. Branch of Service **Army**	14g, Grade, rank, or rating.... **E-5**
14h. I entered my **second** period of active service .... _____ mo day yr	14i. Place:	14j. My service number was	
14k. I left this active service..... _____ mo day yr	14l. Place:	14m. Branch of Service	14n, Grade, rank, or rating....
15a. Did you serve in Vietnam? ___ Yes **XXX** No *(If yes, answer Item 15b also)*		15b. When were you in Vietnam? *from* _____ mo day yr | *to* _____ mo day yr	
16a. Were you in the Gulf after August 1, 1990? **__X__**Yes ____No *(If Yes, answer 16b also)*		16b. Do you want to have medical and other information about you included in the "Gulf War Veterans' Health Registry" _____ Yes **XXX** No	
17 a. Have you ever been a Prisoner of War? ___ Yes **XXX** No *(If yes, answer Items 17b, 17c, and 17d also)*		17b. What country or government imprisoned you?	
17c. When were you confined? *from* _____ mo day yr | *to* _____ mo day yr		17d. What was the name of the camp or sector and what are the names of the city and country near its location?	
18a. Are you currently assigned to an active reserve unit? ___ Yes **XXX** No *(If Yes, answer 18b also)*		18b. What is the name, mailing address, and telephone number of your current unit?	
18c. Were you previously assigned to an active reserve unit within the last 2 years? ___ Yes **XXX** No *(If Yes, answer 18d also)*		18d. What is the name, mailing address, and telephone number of that unit?	

SECTION IV (Continued) **Tell us about your reserve duty**	18e. Do you have an inactive reserve obligation? (You perform no active duty, but you could be activated if there was a national emergency) ___ Yes **XXX** No ___ Don't know *(If Yes, answer Item 18f also)*	48f. What is your reserve obligation termination date? _____ mo day yr
Instructions 18g-18K *If you are currently or have ever been a full time reservist for operational or support duty:* *1. Complete 18g – 18k for that service only* *2.Aattach proof of service*	18g. I entered reserve service… _____ | Place: mo day yr |	18h. My service number was…
	18i. I left reserve service… _____ | Place: mo day yr |	18j, Branch of Service 18k. Grade, rank, or rating
Instructions 18l – 18p *If your disability occurred or was aggravated during any period of reserve duty:* *1. Complete 18l – 18p for the period when your disability occurred* *2. Attach proof that your disability occurred during reserve service*	18l. I entered reserve service… _____ | Place: mo day yr |	18m. My service number was…
	18n. I left reserve service… _____ | Place: mo day yr |	18o, Branch of Service 18p. Grade, rank, or rating
SECTION V **Tell us about your National Guard duty**	19a. Are you currently a member of the National Guard? ___ Yes **XXX** No ___ Not Assigned *(If Yes, answer Item 19b also)*	19b. What is the name, mailing address, and telephone number of your current unit?
	19c. Were you previously assigned to a guard unit within the last 2 years? ___ Yes ___ No *(If Yes, answer Item 19d also)*	19d. What is the name, mailing address, and telephone number of this unit?
Instructions 19e – 19i *If you were activated to Federal Active Duty under the Authority of Title 10, United States Code* *1. Complete 19e – 19i for that service only* *2. Attach proof of Federal Active Duty*	19e. I entered reserve service… _____ | Place: mo day yr |	19f. My service number was…
	19g. I left reserve service… _____ | Place: mo day yr |	19h, Branch of Service 19i. Grade, rank, or rating
Instructions 19j – 19n *If your disability occurred or was aggravated during any period of guard duty:* *1. Complete 19j – 19n for the period when your disability occurred* *2. Attach proof that your disability occurred during National Guard Service*	19j. I entered reserve service… _____ | Place: mo day yr |	19k. My service number was…
	19l. I left reserve service… _____ | Place: mo day yr |	19m, Branch of Service 19n. Grade, rank, or rating

SECTION VI Tell us about your travel status	20a. were you injured while traveling to or from your military assignment? ___ Yes XXX No *(If Yes, answer Items 20b thru 20e and Section I of Part B: Compensation)*	20b. When did your injury occur? _____ mo day yr	20c. Where did your injury occur? *(City, State, Country)*	20d. Where were you treated? *(Provide name and address of physician's office or hospital)*	20e. What agency did you file an accident report with?

SECTION VII Tell us about your military benefits	21a. Are you receiving or will you receive retired or retainer pay that is based on your military service? ___ Yes XXXX No *(If Yes, answer Items 21b thru 21f. If No, skip to Item 22).*	21b. What branch of service is paying or will pay your retired or retained pay?	21c. What is the monthly amount? _____

When you file this application, you are telling us that you want to get VA compensation instead of military retired pay. If you currently receive military retired pay, you should be aware that we will reduce your retired pay by the amount of any compensation that you are awarded. VA will notify the Military Retired Pay Center of all benefit changes.

You must sign 21e if you want to keep getting military retired pay instead of VA compensation.

Please see page 4 of the General Instructions for VA Form 21-526.

If you have gotten both military retired pay and VA compensation, some of the amount you get may be recouped by VA, or in the case of VSI, the Department of Defense.

21d. What is your retirement based on?

XXX Length of service ___ Disability ___ TDRL (Temporary Disability Retired List)

21e. Sign here if you want to receive military retired pay instead of VA compensation

_____

21f. Have you received or will you receive any of the following military benefits?
(Please check the appropriate boxes and tell us the amount)

Benefit	*Amount*
(1) ___ Lump Sum Readjustment Pay	$
(2) ___ Separation Pay under 10 USC 1174	$
(3) ___ Special Separation Benefit (SSB)	$
(4) ___ Voluntary Separation incentive (VSI)	$
(5) ___ Disability Severance Pay (name of disability _____)	$
(6) ___ Other (tell us the type of benefit _____)	$

SECTION VIII Give us direct deposit information

If benefits are awarded we will need more information in order to process any payments to you. Please read the paragraph starting with, "All federal payments..." and then either:

1. Attach a voided check, or

2. Answer questions 22-24 to the right.

All federal payments beginning January 2, 1999, must 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 Item 22, 23, and 24 to enroll in Direct Deposit. If you do not have a bank account we will give you a waiver from Direct Deposit, just check the box below in Item 22. The Treasury Department is working on making bank accounts available to you. Once these accounts are available, you will be able to decide whether you wish to sign-up for one of the accounts or continue to receive a paper check. You can also request a waiver

22. Account number (Please check the appropriate box and provide that account number, if applicable)

___ Checking

XXX Savings

___ I certify that I do not have an account with a financial institution or certified payment agent

Account number: _____

23. Name of Financial institution:

Bank of Springfield USA

_____

24. Routing or transit number:

0

_____

SECTION IX **Give us your signature**

1. Read the box that starts, " I certify and authorize the release of information:"

2. Sign the box that says, "Your signature".

3. If you sign with an "X", then you must have 2 people you know to witness you as you sign. They must sign the form and print their names and addresses also.

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 except protected health information, and I waive any privileges which makes the information confidential.

25. Your signature	26. Today's date

27a. Signature of witness (if claimant signed above using an "X")	27b. Printed name and address of witness

28a. signature of witness (if claimant signed above using an "X")	28b. Printed name and address of witness

SECTION X

Remarks – Use this space for any additional statement that you would like to make concerning your application for Compensation and/or Pension.

IMPORTANT:
Penalty: The law provides severe penalties, which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment which you are not entitled to.

29. Remarks. ***(If you need more space to answer a question or have a comment about a specific item number on this form, please identify your answer or statement by the part and item number). (See page 5, "Tips for filling out VA Form 21-526")***

VA Department of Veteran Affairs

VA Form 21-526, Part B: Compensation

Use this form to apply for compensation. Remember that you must fill out a VA Form 21-526, Part A: General information, for your application to be processed. Be sure to write your name and Social Security number in the space provided on page 2.

SECTION I Tell us about your disability

In the table below, tell us more about your disability or disabilities. Be sure to:

- List all disabilities you believe are related to military service
- List all the treatments you received for your disabilities, including
  1. Treatments you received in the military facility before and after discharge
  2. Treatments you received from civilian and VA sources before, during, and after your service

1. What disability are you claiming?	2. When did your disability begin?	3. When were you treated?	4a. What medical facility or doctor treated you?	4b. What is the address of that medical facility or doctor?
Degenerative changes of the cervical spine	mo day yr	From mo day yr To mo day yr		staff
Right knee condition	mo day yr	From mo day yr To mo day yr		staff
	mo day yr	From mo day yr To mo day yr		
	mo day yr	From mo day yr To mo day yr		
	mo day yr	From mo day yr To mo day yr		
	mo day yr	From mo day yr To mo day yr		
	mo day yr	From mo day yr To mo day yr		
	mo day yr	From mo day yr To mo day yr		
	mo day yr	From mo day yr To mo day yr		

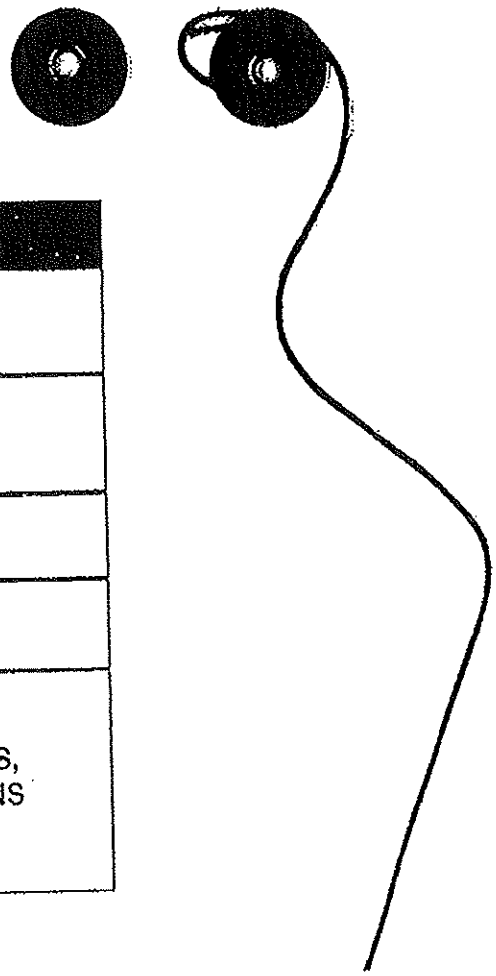
SECTION II	**Tell us if any of the disabilities you listed on Page 1 were because of exposures**	5a. Were you exposed to Agent Orange or other herbicides? ___ Yes XXX No	5b. What is your disability?	5c. In what country were you exposed?
		6a. Were you exposed to asbestos? ___ Yes XXX No *(If Yes, answer Item 6b and 6c also)*	6b. What is your disability? 6c. When and how were you exposed?	
		7a. Were you exposed to mustard gas? ___ Yes XXX No *(If Yes, answer Item 7b and 7c also)*	7b. What is your disability? 7c. When and how were you exposed?	
		8a. Were you exposed to ionizing radiation? ___ Yes XXX No *(If Yes, answer Items 8b, 8c, and 8d also)*	8b. What is your disability?	8c. When was your last exposure? _____ mo day yr
		9a. Were you exposed to an environmental hazard in the Gulf War? ___ Yes XXX No *(If Yes, answer Items 9b and 9c)*	9b What is your disability?	9c. What was the hazard?
		10a. Did you have a separation or retirement physical examination? XXX Yes ___ No *(If Yes, answer Items 10b and 10c also)*	10b. When was the exam? _____ mo day yr	10c. Where did the exam occur?
SECTION III	**Tell us how your disabilities listed on page 1 are related to your military service.**	11. Explanation		

Your Name: Test Case	**Your Social Security Number**

FOR TRAINING PURPOSES ONLY

DO NOT OVERFILL

IF 1/2 INCH THICK OR MORE USE ANOTHER ENVELOPE



Department of Veterans Affairs

SERVICE DEPARTMENT RECORDS ENVELOPE

NAME - FIRST NAME - MIDDLE INITIAL OF VETERAN

NUMBER	SOCIAL SECURITY NUMBER
	SERVICE NUMBER

THE ENCLOSED SERVICE RECORDS, PHYSICAL EXAMINATIONS, ETC., LOANED OR FURNISHED THE DEPARTMENT OF VETERANS AFFAIRS, MUST BE PROTECTED AGAINST MUTILATION, DEFACEMENT OR LOSS.

FORM 21-4582 2003 EXISTING STOCKS OF VA FORM 21-4582, JAN 1990, WILL BE USED.

NO. OF ATTACHED SHEETS:

MEDICAL RECORD | **REPORT OF MEDICAL HISTORY** | DATE OF EXAM: 11/15/05

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)*: CASE TEST 1
2. IDENTIFICATION NUMBER:
3. GRADE: E-5
4a. HOME STREET ADDRESS *(Street or RFD; City or Town; State; and ZIP Code)*: Any Street
4b. CITY: Any Street City
4c. STATE: WV
4d. ZIP CODE:
5. EXAMINING FACILITY:
6. PURPOSE OF EXAMINATION: Discharge

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

a. PRESENT HEALTH: Good

b. CURRENT MEDICATION: Multivitamin - Tylenol/motrin/sleepers | REGULAR OR INTERM.: By interm as Needed

c. ALLERGIES *(Include insect bites/stings and common foods)*:

d. HEIGHT:

e. WEIGHT:

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
Household contact with anyone with tuberculosis		✓	
Tuberculosis or positive TB test		✓	
Blood in sputum or when coughing		✓	
Excessive bleeding after injury or dental work		✓	
Suicide attempt or plans		✓	
Sleepwalking		✓	
Wear corrective lenses		✓	
Eye surgery to correct vision		✓	
Lack vision in either eye		✓	
Wear a hearing aid		✓	
Stutter or stammer		✓	
Wear a brace or back support			
Scarlet fever			
Rheumatic fever			
Swollen or painful joints	✓		
Frequent or severe headaches	✓		
Dizziness or fainting spells			
Eye trouble		✓	
Hearing loss		✓	
Recurrent ear infections		✓	
Chronic or frequent colds		✓	
Severe tooth or gum trouble		✓	
Sinusitis		✓	
Hay fever or allergic rhinitis		✓	
Head injury	✓		
Asthma		✓	

CHECK EACH ITEM	YES	NO	DON'T KNOW
Shortness of breath		✓	
Pain or pressure in chest		✓	
Chronic cough		✓	
Palpitation or pounding heart		✓	
Heart trouble		✓	
High or low blood pressure		✓	
Cramps in your legs		✓	
Frequent indigestion		✓	
Stomach, liver or intestinal trouble		✓	
Gall bladder trouble or gallstones		✓	
Jaundice or hepatitis		✓	
Broken bones		✓	
Adverse reaction to medication		✓	
Skin diseases		✓	
Tumor, growth, cyst, cancer		✓	
Hernia		✓	
Hemorrhoids or rectal disease		✓	
Frequent or painful urination		✓	
Bed wetting since age 12		✓	
Kidney stone or blood in urine		✓	
Sugar or albumin in urine		✓	
Sexually transmitted diseases		✓	
Recent gain or loss of weight		✓	
Eating disorder (anorexia bulimia, etc.)		✓	
Arthritis, Rheumatism, or Bursitis	✓		
Thyroid trouble or goiter		✓	

CHECK EACH ITEM	YES	NO	DON'T KNOW
Bone, joint or other deformity	✓		
Loss of finger or toe		✓	
Painful or "trick" shoulder or elbow	✓		
Recurrent back pain or any back injury	✓		
"Trick" or locked knee		✓	
Foot trouble		✓	
Nerve injury		✓	
Paralysis *(including infantile)*		✓	
Epilepsy or seizure		✓	
Car, train, sea or air sickness		✓	
Frequent trouble sleeping		✓	
Depression or excessive worry		✓	
Loss of memory or amnesia		✓	
Nervous trouble of any sort		✓	
Periods of unconsciousness		✓	
Parent/sibling with diabetes, cancer, stroke or heart disease		✓	
X-ray or other radiation therapy		✓	
Chemotherapy		✓	
Asbestos or toxic chemical exposure		✓	
Plate, pin or rod in any bone		✓	
Easy fatigability		✓	
Been told to cut down or criticized for alcohol use		✓	
Used illegal substances		✓	
Used tobacco		✓	

11. FEMALES ONLY

CHECK EACH ITEM	YES	NO	DON'T KNOW	DATE OF LAST MENSTRUAL PERIOD	DATE OF LAST PAP SMEAR	DATE OF LAST MAMMOGRAM
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.		✓
b. Inability to perform certain motions.	✓	
c. Inability to assume certain positions.		✓
d. Other medical reasons *(If yes, give reasons.)*		✓
13. Have you ever been treated for a mental condition? *(If yes, specify when, where, and give details.)*		✓
14. Have you ever been denied life insurance? *(If yes, state reason and give details.)*		✓
15. Have you had, or have you been advised to have, any operation. *(If yes, describe and give age at which occurred.)*		✓
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.)*		✓
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.)*	✓	
18. Have you ever been rejected for military service because of physical, mental, or other reasons? *(If yes, give date and reason for rejection.)*		✓
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.)*		✓
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.)*		✓
21. Have you ever been arrested or convicted of a crime, other than minor traffic violations. *(If yes, provide details.)*		✓
22. Have you ever been diagnosed with a learning disability? *(If yes, give type, where, and how diagnosed.)*		✓

12. ✓ Neck hurts when bend or turn head.

17. Neck & shoulder injury

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
	[signature]	

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.)*

Cervical Strain · s/p MVA Accident X-rays mild deg. changes C1-2, 2-3

(L) Shoulder Pain X-rays neg.

(R) Knee Condition

26a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	26b. SIGNATURE	26c. DATE
		11/5/05

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5/24/2004	Servicemember Seen Following his vehicles Collision with a s Tow Truck. Complaints of Severe cervicle pain headaches, left shoulder dysfunction & discomfort, blurry vision and numbness to his left hand. Exam - Cervical motion limited by pain - 30° flexion; 20 degrees (R)(L) Lateral Bend; 5deg extension; 25 degrees Rt Rotation Tenderness c1-2; c2-3 Nodulet left. X-rays negative (Spine/Bilateral Shoulders Eyes - pupils fully dilated - normal. Left shoulder full range of motion but with hesitancy and pain upon insertion of keep at rotator Cuff. Dx- Cervical Strain, Mild radiculopathy (L) Left Shoulder Pain Motrin for pain & discomfort - return 2 x weeks Ice + Rest

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR?S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT?S IDENTIFICATION *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*	REGISTER NO.	WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPPC V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7/2004	Pt. is complaining of pain in (L) shoulder Taking pain medication (Motrin)

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR?S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT?S IDENTIFICATION *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*	REGISTER NO.	WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPPC V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

6/1/2004

Patient States- pain in ® Knee w/ Swelling
Taking Motrin for pain.
Continue Exercises.
Also complaint of pain in the neck.
Taking motrin for pain.

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR?S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT?S IDENTIFICATION *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*	REGISTER NO.	WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPPC V1.00

FOR TRAINING PURPOSES ONLY

Unit: 22nd MEF
Personal Data – Privacy Act of 1974 (PL 63-579)

Division: Logistics/Munitions
Automated Version SF600

Primary Care Clinic	Dr L McCoy Name of physician	11/12/2004 Date	2000 Time

Reason for visit: lumbosacral strain
INSURANCE: Yes/No

BP: 125/75 PULSE: 61 RESP: 25 TEMP: 98.6 HT: 73.5 WT: 190 AGE:

ALLERGIES: N/A

Allergies:

Medications:

Time Screened/Initials:

ADDITIONAL COMMENTS:

Patient seen in emergency room, complaining of neck pain following a motor vehicle accident. Physical examination noted fasciculations along the upper back, as well as warmth. Range of motion was limited to 0 to 30 degrees forward flexion, with normal range of motion for the backward extension and bilateral flexion and rotation. Order input for physical therapy.

Radiologist report revealed degenerative disc disease of the cervical spine.

Diagnosis was degenerative changes of the cervical spine.

20/000-00-000

Last, First MI: Case, Test
DOB 02/14/1977 PHONE: BR549 Spon.: Name
CS: Rank: E-5
UNIT: 22MEF RR: OUTPATIENT RECORDS

SF600

FOR TRAINING PURPOSES ONLY

FOR TRAINING PURPOSES ONLY

Unit: 22nd MEF
Division: Logistics/Munitions
Personal Data -- Privacy Act of 1974 (PL 63-579)
Automated Version SF600

Primary Care Clinic	Dr Sheldon Freudian Name of physician	08/01/2004 Date	0830 Time

Reason for visit: Shoulder pain
INSURANCE: Yes/No

BP: 140/75 PULSE: 68 RESP: 25 TEMP: 98.6 HT: 73.5 WT: 176 AGE

ALLERGIES: N/A

Allergies:

Medications:

Time Screened/Initials:

ADDITIONAL COMMENTS:

Patient seen in clinic for complaints of shoulder pain following an accident that he was involved in when transporting MP's in Iraq. Physical review noted warmth to the Left shoulder. There was slight crackling sound in the left shoulder, none in the right shoulder. No subluxation noted. Range of motion was noted to be 0 to 180 degrees in the right and 0 to 90 degrees in the left with pain. X-ray requested.

Radiologist report was negative.

20/000-00-000
Last, First MI: Case, Test
DOB
PHONE: BR549 Spon.: Name
CS:
Rank: E-5
UNIT: 22MEF
RR: OUTPATIENT RECORDS

SF600

FOR TRAINING PURPOSES ONLY

RADIOLOGIC CONSULTATION REQUEST/REPORT
(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography examinations)

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (SPONSOR)	WARD/CLINIC	REGISTRER NO.
X-ray of right knee		M	000000000		
	FILM NO. 04081989-0000-Veteran				PREGNANT Yes XXX No
	REQUESTED BY (Print) Frank N Stein, MD, DO				TELEPHONE NO. 11223
	SIGNATURE OF REQUESTOR Frank N Stein				DATE REQUESTED 04/08/2005

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)

Patient has had complaints of right knee pain, especially following physical exercise/5 mile humps. Need to r/o arthiritis.

Patient also has complaints of neck pain, after his HumVee hit a 5 ton truck while he was a passenger

DATE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSACTION (Month, day, year)
04/08/2005	04/08/2005	04/08/2005

RADIOLOGIC REPORT

Three views of the right knee were taken. No other abnormalities noted.
Three views of the cervical spine were taken showing degenerative changes of C-4, C-5 and C-6

PATIENT'S IDENTIFICATION (LAST-FIRST-MIDDLE NAME, MEDICAL FACILITY)	LOCATION OF MEDICAL RECORDS
Veteron, Tommy Base Clinic, Fort Campbell	Fort Campbell Medical Clinic
	LOCATION OF RADIOLOGIC FACILITY Fort Campbell Medical Clinic
	SIGNATURE Dr Cureall

RADIOLOGIC CONSULTATION REQUEST/REPORT SF519-B (VA)

FOR TRAINING PURPOSES ONLY

MEDICAL RECORD	REPORT OF MEDICAL EXAMINATION	DATE OF EXAM 11/25/98

1. LAST NAME-FIRST NAME-MIDDLE NAME	2. IDENTIFICATION NUMBER	3. GRADE AND COMPONENT OR POSITION
Case, Test I	000-00-0000	

4. HOME ADDRESS (Number, street, or RFD, city or town, state and ZIP Code)	5. EMERGENCY CONTACT (Name and address of contact)
1 Rural Road Anywhere USA 0000	Robert Case 1 Rural Road Anywhere USA 00000

6. DATE OF BIRTH	7. AGE	8. SEX	9. RELATIONSHIP OF CONTACT
02/14/1977		___ FEMALE XXX MALE	Dad

10. PLACE OF BIRTH	11. RACE					
Hospital @ Anywhere USA	XXX WHITE	___ BLACK	___ AMERICAN INDIAN/ ALAKAN NATIVE	___ HISPANIC WJITE	___ HISPANIC BLACK	___ ASIAN/PACIFIC ISLANDER

12a. AGENCY	12b. ORGANIZATION UNIT	13. TOTAL YEARS GOVERNMENT SERVICE	
		a. MILITARY	B. CIVILIAN
N/A	N/A	N/A	N/A

14. NAME OF EXAMINING FACILITY OR EXAMINER, AND ADDRESS	15. RATING OR SPECIALTY OF EXAMINER
Dr Charles F Xavier 55 Medical Way Anywhere USA 0000	Neurology and Physiology
	16. PURPOSE OF EXAMINATION Entrance to military

17. CLINICAL EVALUATION

NOR-MAL	(Check each item in appropriate column, enter "NE" if not evaluated)	ABNOR-MAL	NOR-MAL	(Check each item in appropriate column, enter "NE" if not evaluated)	ABNOR-MAL
X	A. HEAD, FACE, NECK, AND SCALP		X	O. PROSTATE (Over 40 or clinically indicated)	
X	B. EARS – GENERAL (INTERNAL CANALS) (Auditory acuity under items 39 and 40)		X	P. TESTICULAR	
			X	Q. ANUS AND RECTUM (Hemorrhoids, Fistulae)(Hemocult results)	
X	C. DRUMS (Perforation)		X	R. ENDOCRINE SYSTEM	
X	D. NOSE		X	S. G-U SYSTEM	
X	E. SINUSES		X	T. UPPER EXTREMITIES (Strength, range of motion)	
X	F. MOUTH AND THROAT		X	U. FEET	
X	G. EYES -- GENERAL (Visual acuity and refraction under items 28, 29, and 30)		X	V. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
X	H. OPTHALMOSCOPIC		X	W. SPINE, OTHER MUSCULOSKELETAL	
X	I. PUPILS (Equality and reaction)		X	X. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
X	J. OCULAR MOTILITY (Associated parallel movements nystagmus)		X	Y. SKIN, LYMPHATICS	
X	K. LUNGS AND CHEST		X	Z. NEUROLOGIC (Equilibrium tests under item 41)	
X	L. HEART (Thrust, size, rhythm, sounds)		X	AA. PSYCHIATRIC (Specify any personality deviation)	
X	M. VASCULAR SYSTEM (Varicosities, etc)		X	BB. BREASTS	
x	N. ABDOMEN AND VISCERA (Include hernia)		X	CC. PELVIC	

NOTES: (Describe every abnormality in detail. Enter pertinent number before each comment. Continue in item 42 and use additional sheets if necessary)

No scars of any kind noted.

18. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth)

o 1 2 3 32 31 30 o Restorable Teeth
/ 1 2 3 32 31 30 / Non-Restorable Teeth
X 1 2 3 32 31 30 X Missing Teeth
X X X 1 2 3 32 31 30 X X X Replaced by Dentures
(X) 1 2 3 32 31 30 (X) Fixed Partial Dentures

R		o															L
I	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	E
G	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	F
H												o					T
T																	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

Mr Veteran has two small cavities/fillings.

19. TEST RESULTS (Copies of results are preferred as attachments)

A. URINALYSIS: (1) SPECIFIC GRAVITY - normal
(2) URINE ALBUMIN - normal
(3) URINE SUGAR - normal
(4) MICROSCOPIC - normal

B. CHEST X-RAY OR PPD (Place, date, film number, and result)
Medical Center, 12/28/85/ 00001228B5-0001 Negative for any abnormalities

C. SYPHILIS SEROLOGY (Specify test used and results)

D. EKG
normal

E. BLOOD TYPE AND RH FACTOR
O pos/- Rh

F. OTHER TESTS
N/A

NAME	IDENTIFICATION NUMBER	NO. SHEETS ATTACHED
Test, Case	(xxx-xx-xxxx)	0

MEASUREMENTS AND OTHER FINDINGS

20. HEIGHT	21. WEIGHT	22. COLOR HAIR	23. COLOR EYES	24. BUILD	25. TEMPERATURE
73.5"	165	brown	green	XXX SLENDER ___ MEDIUM ___ HEAVY ___ OBESE	

26. BLOOD PRESSURE (Arm at heart level)

A. SITTING	B. RECUV-BENT	C. STANDING (3 MINS.)
SYS. 122 / DIAS. 65	SYS. 121 / DIAS. 67	SYS. 139 / DIAS. 70

27. PULSE (Arm at heart level)

A. SITTING	B. RECUVBENT	C. STANDING (3 MINS.)	D. AFTER EXERCISE	E. 2 MINS. AFTER
59	57	59	75	66

28. DISTANT VISION	29. REFRACTION	30. NEAR VISION
RIGHT 20/ 20 CORR. TO 20/	BY S. CX	CORR. TO BY
LEFT 20/ 20 CORR. TO 20/	BY S. CX	CORR. TO BY

31. HETEROPHORIA (Specify distance)

ESO EXO R.H. L.H. PRISM DIV. PRISM CONV. CT FC PD

32. ACCOMMODATION	33. COLOR VISION *(Test used and result) normal*	34. DEPTH PERCEPTION *(Test used and result)*	UNCORRECTED
RIGHT LEFT			CORRECTED
35. FIELD OF VISION	**36. NIGHT VISION *(Test used and result) normal***	**37. RED LENS TEST**	**38. INTRAOCULAR TENSION**
RIGHT LEFT			RIGHT LEFT

39. HEARING			40. AUDIOMETER								41. PSYCHOLOGICAL AND PSYCHOMOTOR *(Test used and score)*
RIGHT W/V	/15SV	/15		500	1000	2000	3000	4000	6000	8000	N/A
LEFT W/V	/15SV	/15	RIGHT	5	5	10	10	15	10	10	0
			LEFT	0	0	5	10	5	10	15	0

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

None

(Use additional sheets if necessary)

43. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers)*

None

44. RECOMMENDATIONS – FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)	45A. PHYSICAL PROFILE
N/A	P U L H E S: 1 1 1 1 1 1
46. EXAMINEE (Check) A. XXX IS QUALIFIED FOR B. ___ IS NOT QUALIFIED FOR	45B. PHYSICAL CATEGORY
47. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER	A: 1 B: 1 C: 1 E: 1

48. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
John H Watson, MD	John H Watson
49. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
50. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which)	SIGNATURE
Herbert Wonka, DMD	Herbert Wonka
51. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE
Henry Blake, MD, LtCol	Henry Blake