

CERTIFICATE OF RELEASE OR DISCHARGE FROM ACTIVE DUTY

For Training Purposes Only

1. NAME (Last, First, Middle) Case, Test		2. DEPARTMENT, COMPONENT AND BRANCH Army/RA		3. SOCIAL SECURITY No. 000 00 0000	
4. a. GRADE, RATE OR RANK SGT		4. b. PAY GRADE E05		5. DATE OF BIRTH (YYMMDD) 19770214	
				6. RESERVE OBLIG. TERM. DATE 000 000 000	
7. a. PLACE OF ENTRY INTO ACTIVE DUTY Bedrock, USA			7. b. HOME OF RECORD AT TIME OF ENTRY (City and state, or complete address if known) 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 <input type="checkbox"/> 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)
		a. Date Entered AD This Period		1998	11
		b. Separation Date This Period		2005	11
		c. Net Active Service This Period		07	00
		d. Total Prior Active Service		00	00
		e. Total Prior Inactive Service			
		f. Foreign Service			
		g. Sea Service			
		h. Effective Date of Pay Grade		2003	09
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 TERRORISM 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	
B. HIGH SCHOOL GRADUATE OR EQUIVALENT		X		X	
17. MEMBER HAS PROVIDED COMPLETE DENTAL EXAMINATION AND ALL APPROPRIATE DENTAL SERVICES AND TREATMENT WITHIN 90 DAYS PRIOR TO SEPARATION				Yes	No
DENTAL SERVICES AND TREATMENT WITHIN 90 DAYS PRIOR TO SEPARATION					X
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) 301 Cobblestone Way, Bedrock, USA			19. b. NEAREST RELATIVE (Name and address -- Include Zip Code) 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 End of Service		24. CHARACTER OF SERVICE (include upgrades) HONORABLE	
25. SEPARATION AUTHORITY AR 635-40, PARA 4-24B		26. SEPARATION CODE SFK	27. REENTRY CODE 4R
28. NARRATIVE REASON FOR SEPARATION Disability, Temporary			
29. DATES OF TIME LOST DURING THIS PERIOD None			30. MEMBER REQUESTS FJF Initials

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

For training purposes only

DEPARTMENT OF VETERANS AFFAIRS
123 State 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*.

File Number: 000000000

Test Case

- 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.

File Number: 000000000

Test Case

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.

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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.

File Number: 000000000
Test Case

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

TRAINING PURPOSES ONLY

**VA Department of
Veterans Affairs**

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

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.

Received August 1, 2009

<p>SECTION I</p> <p>Tell us what you are applying for</p> <p>Check the box that says what you are applying for. Be sure to complete the other Parts you need.</p>	<p>1. What are you applying for? If you are unsure please refer to the "General Instructions", page 2</p> <p>Section 1: Preparing your application</p> <p><input checked="" type="checkbox"/> Pension Fill out Part A of VA Form 21-526, and PARTS B and C</p> <p><input type="checkbox"/> Compensation and Pension Fill out Part A of VA Form 21-526, and PARTS C and D</p> <p><input type="checkbox"/> Compensation and Pension Fill out Part A of VA Form 21-526, and PARTS B, C, and D</p>		
	<p>2a. Have you ever filed a claim with VA?</p> <p><input checked="" type="checkbox"/> No <i>(If No, skip item 2b and go to item 3)</i></p> <p><i>(If yes, provide file number below)</i></p> <p><input type="checkbox"/> Yes _____</p>	<p>2b. I filed a claim for:</p> <p><input type="checkbox"/> Compensation <input type="checkbox"/> Pension</p> <p><input type="checkbox"/> Other _____</p>	
<p>SECTION II</p> <p>Tell us about you</p> <p>We need information about you to process your claim faster.</p> <p>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.</p> <p>OWCP used to be called the U.S. Bureau of Employees Compensation</p>	<p>3. What is your name?</p> <p>Test Case</p> <p>_____</p> <p>First Middle Last Suffix (if applicable)</p>		
	<p>4. What is your Social Security Number?</p> <p>111-11-1111</p>	<p>5. What is your sex?</p> <p><input checked="" type="checkbox"/> Male <input type="checkbox"/> Female</p>	
	<p>6a. Did you serve under another name?</p> <p><input type="checkbox"/> Yes <i>(If Yes, go to Item 6b)</i></p> <p><input checked="" type="checkbox"/> No <i>(If No, go to item 7)</i></p>	<p>6b. Please list the other name(s) you served under</p> <p>_____</p> <p>_____</p>	
	<p>7. What is your address?</p> <p>59 Evergreen Terrace</p> <p>Street address, Rural Route, or P.O. Box Apt Number</p> <p>Springfield USA 11111</p> <p>City State ZIP Code Country</p>		
	<p>8. What are your telephone numbers?</p> <p>989-444-0000</p> <p>Daytime _____</p> <p>989-444-0000</p> <p>Evening _____</p>		<p>9. What is your email address?</p> <p>Not setup yet</p> <p>_____</p>
	<p>10. What is your date of birth?</p> <p>02/14/1977</p> <p>_____</p>		<p>11. Where were you born? <i>(City, State, Count.)</i></p> <p>Springfield USA</p> <p>_____</p>
	<p>12a. Are you receiving disability benefits from the Office of Workers' Compensation (OWCP)?</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p><i>(If Yes, answer 12b and 12c also)</i></p>		<p>12b. When was the claim filed?</p> <p>_____</p>
	<p>12c. What disability are you receiving benefits for?</p> <p>_____</p>		<p>12b. When was the claim filed?</p> <p>_____</p>
	<p>13a. What is the name of your nearest relative or other person we could contact if necessary?</p> <p>Bob Case</p>		<p>13b. What is his/her telephone number?</p> <p>989-444-0000</p> <p>Daytime _____</p> <p>989-444-0000</p> <p>Evening _____</p>
	<p>13c. What is the person's address?</p> <p>Same as noted in box 7</p>		<p>13d. How is this person related to you?</p> <p>Father</p>

TRAINING PURPOSES ONLY

<p>SECTION III Tell us about your active duty</p> <p>1. Enter complete information for all periods of service. If more space is needed, use Item 29 "Remarks".</p> <p>2. Attach your original DD214 or a certified copy to this form. (We will return original documents to you.)</p> <p><i>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.</i></p> <p>SECTION IV Tell us about your reserve duty</p>	<p>14a. I entered active service the first time... 11/25/1998</p> <p>mo day yr</p>	<p>14b. Place: NY, NY</p>	<p>14c. My service number was ... 111-11-1111</p>		
	<p>14d. I left active service ... 11/24/2005</p> <p>mo day yr</p>	<p>14e. Place: NY, NY</p>	<p>14f. Branch of Service Army</p>	<p>14g. Grade, rank, or rating... E-5</p>	
	<p>14h. I entered my second period of active service</p> <p>mo day yr</p>	<p>14i. Place:</p>	<p>14j. My service number was</p>		
	<p>14k. I left this active service.....</p> <p>mo day yr</p>	<p>14l. Place:</p>	<p>14m. Branch of Service</p>	<p>14n. Grade, rank, or rating....</p>	
	<p>15a. Did you serve in Vietnam? ___ Yes XXX No (If yes, answer Item 15b also)</p>		<p>15b. When were you in Vietnam? from to mo day yr mo day yr</p>		
	<p>16a. Were you in the Gulf after August 1, 1990? ___X___ Yes ___ No (If Yes, answer 16b also)</p>		<p>16b. Do you want to have medical and other information about you included in the "Gulf War Veterans' Health Registry" ___ Yes XXX No</p>		
	<p>17 a. Have you ever been a Prisoner of War? ___ Yes XXX No (If yes, answer Items 17b, 17c, and 17d also)</p>		<p>17b. What country or government imprisoned you?</p>		
	<p>17c. When were you confined? from to mo day yr mo day yr</p>		<p>17d. What was the name of the camp or sector and what are the names of the city and country near its location?</p>		
	<p>18a. Are you currently assigned to an active reserve unit? ___ Yes XXX No (If Yes, answer 18b also)</p>		<p>18b. What is the name, mailing address, and telephone number of your current unit?</p>		
	<p>18c. Were you previously assigned to an active reserve unit within the last 2 years? ___ Yes XXX No (If Yes, answer 18d also)</p>		<p>18d. What is the name, mailing address, and telephone number of that unit?</p>		

TRAINING PURPOSES ONLY

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

TRAINING PURPOSES ONLY

<p>SECTION VI Tell us about your travel status</p>	<p>20a. were you injured while traveling to or from your military assignment?</p> <p><input type="checkbox"/> Yes <input checked="checked" type="checkbox"/> No <i>(If Yes, answer Items 20b thru 20e and Section I of Part B: Compensation)</i></p>	<p>20b. When did your injury occur?</p> <p>_____ mo day yr</p>	<p>20c. Where did your injury occur? <i>(City, State, Country)</i></p>	<p>20d. Where were you treated? <i>(Provide name and address of physician's office or hospital)</i></p>	<p>20e. What agency did you file an accident report with?</p>														
<p>SECTION VII Tell us about your military benefits</p> <p><small>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.</small></p> <p><small>You must sign 21e if you want to keep getting military retired pay instead of VA compensation.</small></p> <p><small>Please see page 4 of the General Instructions for VA Form 21-526.</small></p> <p><small>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.</small></p>	<p>21a. Are you receiving or will you receive retired or retainer pay that is based on your military service?</p> <p><input type="checkbox"/> Yes <input checked="checked" type="checkbox"/> No <i>(If Yes, answer Items 21b thru 21f. If No, skip to Item 22).</i></p>	<p>21b. What branch of service is paying or will pay your retired or retained pay?</p>		<p>21c. What is the monthly amount? _____</p>															
<p>21d. What is your retirement based on?</p> <p><input checked="checked" type="checkbox"/> Length of service <input type="checkbox"/> Disability <input type="checkbox"/> TDRL (Temporary Disability Retired List)</p> <p>21e. Sign here if you want to receive military retired pay instead of VA compensation</p> <p>_____</p>																			
<p>21f. Have you received or will you receive any of the following military benefits? <i>(Please check the appropriate boxes and tell us the amount)</i></p> <table border="1"> <thead> <tr> <th data-bbox="423 831 1097 867">Benefit</th> <th data-bbox="1097 831 1385 867">Amount</th> </tr> </thead> <tbody> <tr> <td data-bbox="423 867 1097 940">(1) <input type="checkbox"/> Lump Sum Readjustment Pay</td> <td data-bbox="1097 867 1385 940">\$ _____</td> </tr> <tr> <td data-bbox="423 940 1097 1014">(2) <input type="checkbox"/> Separation Pay under 10 USC 1174</td> <td data-bbox="1097 940 1385 1014">\$ _____</td> </tr> <tr> <td data-bbox="423 1014 1097 1087">(3) <input type="checkbox"/> Special Separation Benefit (SSB)</td> <td data-bbox="1097 1014 1385 1087">\$ _____</td> </tr> <tr> <td data-bbox="423 1087 1097 1161">(4) <input type="checkbox"/> Voluntary Separation incentive (VSI)</td> <td data-bbox="1097 1087 1385 1161">\$ _____</td> </tr> <tr> <td data-bbox="423 1161 1097 1234">(5) <input type="checkbox"/> Disability Severance Pay (name of disability _____)</td> <td data-bbox="1097 1161 1385 1234">\$ _____</td> </tr> <tr> <td data-bbox="423 1234 1097 1312">(6) <input type="checkbox"/> Other (tell us the type of benefit _____)</td> <td data-bbox="1097 1234 1385 1312">\$ _____</td> </tr> </tbody> </table>						Benefit	Amount	(1) <input type="checkbox"/> Lump Sum Readjustment Pay	\$ _____	(2) <input type="checkbox"/> Separation Pay under 10 USC 1174	\$ _____	(3) <input type="checkbox"/> Special Separation Benefit (SSB)	\$ _____	(4) <input type="checkbox"/> Voluntary Separation incentive (VSI)	\$ _____	(5) <input type="checkbox"/> Disability Severance Pay (name of disability _____)	\$ _____	(6) <input type="checkbox"/> Other (tell us the type of benefit _____)	\$ _____
Benefit	Amount																		
(1) <input type="checkbox"/> Lump Sum Readjustment Pay	\$ _____																		
(2) <input type="checkbox"/> Separation Pay under 10 USC 1174	\$ _____																		
(3) <input type="checkbox"/> Special Separation Benefit (SSB)	\$ _____																		
(4) <input type="checkbox"/> Voluntary Separation incentive (VSI)	\$ _____																		
(5) <input type="checkbox"/> Disability Severance Pay (name of disability _____)	\$ _____																		
(6) <input type="checkbox"/> Other (tell us the type of benefit _____)	\$ _____																		
<p>SECTION VIII Give us direct deposit information</p> <p><small>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:</small></p> <p>1. Attach a voided check, or</p> <p>2. Answer questions 22-24 to the right.</p>	<p>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</p> <p>22. Account number (Please check the appropriate box and provide that account number, if applicable)</p> <p><input type="checkbox"/> Checking <input type="checkbox"/> I certify that I do not have an account with a financial institution or certified payment agent</p> <p><input checked="checked" type="checkbox"/> Savings Account number: _____</p> <p>23. Name of Financial institution: Bank of Springfield USA</p> <hr/> <p>24. Routing or transit number: 0</p> <hr/>																		

TRAINING PURPOSES ONLY

TRAINING PURPOSES ONLY

<p>SECTION IX</p> <p align="center">Give us your signature</p> <p>1. Read the box that starts, "I certify and authorize the release of information."</p> <p>2. Sign the box that says, "Your signature".</p> <p>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.</p>	<p>I certify and authorize the release of information.</p> <p>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.</p>	
	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
<p>SECTION X</p> <p>Remarks – Use this space for any additional statement that you would like to make concerning your application for Compensation and/or Pension.</p> <p>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.</p>	<p>29. Remarks. <i>(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")</i></p>	

FOR TRAINING PURPOSES ONLY

**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:		
		<ul style="list-style-type: none"> • List all disabilities you believe are related to military service • List all the treatments you received for your disabilities, including <ol style="list-style-type: none"> 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 _____ To _____ mo day yr mo day yr		staff
Right knee condition	_____ mo day yr	From _____ To _____ mo day yr mo day yr		staff
	_____ mo day yr	From _____ To _____ mo day yr mo day yr		
	_____ mo day yr	From _____ To _____ mo day yr mo day yr		
	_____ mo day yr	From _____ To _____ mo day yr mo day yr		
	_____ mo day yr	From _____ To _____ mo day yr mo day yr		
	_____ mo day yr	From _____ To _____ mo day yr mo day yr		
	_____ mo day yr	From _____ To _____ mo day yr mo day yr		
	_____ mo day yr	From _____ To _____ mo day yr mo day yr		

FOR TRAINING PURPOSES ONLY

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 <i>(If Yes, answer Item 6b and 6c also)</i>	6b. What is your disability?			
		7a. Were you exposed to mustard gas? ___ Yes XXX No <i>(If Yes, answer Item 7b and 7c also)</i>	6c. When and how were you exposed?			
		8a. Were you exposed to ionizing radiation? ___ Yes XXX No <i>(If Yes, answer Items 8b, 8c, and 8d also)</i>	7b. What is your disability?			
		9a. Were you exposed to an environmental hazard in the Gulf War? ___ Yes XXX No <i>(If Yes, answer Items 9b and 9c)</i>	7c. When and how were you exposed?			
		10a. Did you have a separation or retirement physical examination? XXX Yes ___ No <i>(If Yes, answer Items 10b and 10c also)</i>	8b. What is your disability?	8c. When was your last exposure? _____ mo day yr		
		11. Explanation	9b. What is your disability?	9c. What was the hazard?		
		11. Explanation	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.			
		Your Name: Test Case		Your Social Security Number		

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.

MEDICAL RECORD		REPORT OF MEDICAL HISTORY		DATE OF EXAM <i>11/5/05</i>
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) <i>CASE TEST 1</i>		2. IDENTIFICATION NUMBER	3. GRADE <i>E-5</i>	
4a. HOME STREET ADDRESS (Street or RFD; City or Town; State; and ZIP Code) <i>Any Street</i>		5. EXAMINING FACILITY		
4b. CITY <i>Any Street City</i>	4c. STATE <i>WA</i>	4d. ZIP CODE		
6. PURPOSE OF EXAMINATION <i>Discharge</i>				

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

a. PRESENT HEALTH <i>600+</i>	b. CURRENT MEDICATION	REGULAR OR INTERM.
	<i>Motrin - hand/wrist/neck by interm as needed</i>	
c. ALLERGIES (Include insect bites/stings and common foods)		
d. HEIGHT		e. WEIGHT
8. PATIENT'S OCCUPATION		9. ARE YOU (Check one)
		<input checked="" type="checkbox"/> RIGHT HANDED <input type="checkbox"/> LEFT HANDED

10. PAST/CURRENT MEDICAL HISTORY

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

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.		<input checked="" type="checkbox"/>
b. Inability to perform certain motions.	<input checked="" type="checkbox"/>	
c. Inability to assume certain positions.		<input checked="" type="checkbox"/>
d. Other medical reasons (If yes, give reasons.)		<input checked="" type="checkbox"/>
13. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details.)		<input checked="" type="checkbox"/>
14. Have you ever been denied life insurance? (If yes, state reason and give details.)		<input checked="" type="checkbox"/>
15. Have you had, or have you been advised to have, any operation. (If yes, describe and give age at which occurred.)		<input checked="" type="checkbox"/>
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.)		<input checked="" type="checkbox"/>
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.)	<input checked="" type="checkbox"/>	
18. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection.)		<input checked="" type="checkbox"/>
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.)		<input checked="" type="checkbox"/>
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.)		<input checked="" type="checkbox"/>
21. Have you ever been arrested or convicted of a crime, other than minor traffic violations. (If yes, provide details.)		<input checked="" type="checkbox"/>
22. Have you ever been diagnosed with a learning disability? (If yes, give type, where, and how diagnosed.)		<input checked="" type="checkbox"/>

neck hurts when bend or turn head.

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 <i>[Signature]</i>	24c. DATE
--	--------------------------------------	-----------

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 - sp. neck Accident X-rays mild deg. changes C1-2; 2-3
 (D) Shoulder Pain X-rays neg.
 (R) knee condition

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

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
5/24/2007	<p>Service member SEBND Following his VEHICLES Collision with a 5 TON TRUCK. Complaints of Severe Cervical pain headaches, left shoulder dysfunction & discomfort, blurry vision and numbness to his left hand.</p>
	<p>Exam - Cervical motion limited by pain - 20° Flexion; 20 degrees (R) (L) Lateral Bending; slight extension; 25 degrees Rot Rotation Tenderness C1-2; C2-3 no defect felt. 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 hoop at rotator cuff.</p>
	<p>DX Cervical Strain, mild radiculopathy (L) Left Shoulder Pain</p>
	<p>Modicum for pain & discomfort - return 2 x weeks Ice + Rest</p>

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.

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 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

FOR TRAINING PURPOSES ONLY

RADIOLOGIC CONSULTATION REQUEST/REPORT <i>(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography examinations)</i>					
EXAMINATION(S) REQUESTED X-ray of right knee	AGE	SEX	SSN (SPONSOR)	WARD/CLINIC	REGISTRER NO.
		M	090000920		
	FILM NO.	REQUESTED BY (Print)			PREGNANT
	04081989-0000-Veteran	Frank N Stein, MD, DO			Yes XXX No
	SIGNATURE OF REQUESTOR			TELEPHONE NO.	DATE REQUESTED
	Frank N Stein			11223	04/08/2005
SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)					
<p><i>Patient has had complaints of right knee pain, especially following physical exercise/5 mile humps. Need to r/o arthiritis.</i></p> <p><i>Patient also has complaints of neck pain, after his HumVee hit a 5 ton truck while he was a passenger</i></p>					
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					
<p>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</p>					
PATIENT'S IDENTIFICATION (LAST-FIRST-MIDDLE NAME, MEDICAL FACILITY)			LOCATION OF MEDICAL RECORDS		
Veteran, Tommy			Fort Campbell Medical Clinic		
Base Clinic, Fort Campbell			LOCATION OF RADIOLOGIC FACILITY		
			Fort Campbell Medical Clinic		
			SIGNATURE		
			<i>Dr Cureall</i>		
RADIOLOGIC CONSULTATION REQUEST/REPORT				5F519-B (VA)	

FOR TRAINING PURPOSES ONLY

FOR TRAINING PURPOSES ONLY

NAME Test Case		IDENTIFICATION NUMBER 000-00-0000			NO. SHEETS ATTACHED 0					
MEASUREMENTS AND OTHER FINDINGS										
20. HEIGHT 73.5"	21. WEIGHT 165	22. COLOR HAIR brown	23. COLOR EYES green	24. BUILD XXX SLENDER MEDIUM HEAVY OBESE		25. TEMPERATURE				
26. BLOOD PRESSURE (Arm at heart level)				27. PULSE (Arm at heart level)						
A. SITTING	SYS. 122 DIAS. 65	B. RECUMBENT	SYS. 123 DIAS. 67	C. STANDING (3 min.)	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	EKO	R.H.	L.H.	PRISM DIV.	PRISM CONV. CT	PC PD				
32. ACCOMMODATION		33. COLOR VISION (Test used and result) normal			34. DEPTH PERCEPTION (Test used and result) normal					
RIGHT	LEFT				UNCORRECTED					
35. FIELD OF VISION		36. NIGHT VISION (Test used and result) normal			37. RED LENS TEST					
RIGHT	LEFT				38. INTRAOCULAR TENSION					
					RIGHT LEFT					
39. HEARING			40. AUDIOMETER				41. PSYCHOLOGICAL AND PSYCHOMOTOR (Test used and score)			
RIGHT WW	115SV	115	124 114	118 114	122 114	126 114	N/A			
LEFT WW	115SV	115	RIGHT	5	5	10		10		
			LEFT	0	0	5		10		
42. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY										
None										
<i>(Use additional sheets if necessary)</i>										
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)					45B. PHYSICAL CATEGORY					
A. XXX IS QUALIFIED FOR										
B. ___ IS NOT QUALIFIED FOR										
47. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER					A	B	C	E		
					1	1	1	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						