OMB Control No. 2900-0075
Respondent Burden: 15 minutes
Expiration Date: 12/31/2020

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

STATEMENT IN SUPPORT OF CLAIM

INSTRUCTIONS: Read the Privacy Act and Respondent Burden on Page 2 before completing the form. Complete as much of Section I as possible. The information requested will help process your claim for benefits. If you need any additional room, use the second page.

SECTION I: VETERAN/BENEFICIARY'S IDENTIFICATION INFORMATION

NOTE: You will *either* complete the form online or by hand. Please print the information request in ink, neatly, and legibly to help process the form.

1. VETERAN/BENEFICIARY'S NAME *(First, Middle Initial, Last)*

2. VETERAN'S SOCIAL SECURITY NUMBER	3. VA FILE NUMBER *(If applicable)*	4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)* Month Day Year
– –		– –

5. VETERAN'S SERVICE NUMBER *(If applicable)*	6. TELEPHONE NUMBER *(Include Area Code)*	7. E-MAIL ADDRESS *(Optional)*

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

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

SECTION II: REMARKS

(The following statement is made in connection with a claim for benefits in the case of the above-named veteran/beneficiary.)

VETERAN'S SOCIAL SECURITY NO. – –

SECTION II: REMARKS ***(Continued)***
(The following statement is made in connection with a claim for benefits in the case of the above-named veteran/beneficiary.)

SECTION III: DECLARATION OF INTENT

I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.

9. SIGNATURE *(Sign in ink)*	10. DATE SIGNED *(MM/DD/YYYY)*

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false.

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

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

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1. VETERAN/BENEFICIARY'S NAME *(First, Middle Initial, Last)*

JOE J SCHMOE

2. VETERAN'S SOCIAL SECURITY NUMBER: 999-99-9999

3. VA FILE NUMBER *(If applicable)*: E34321443

4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)*: Month 05 – Day 21 – Year 1981

5. VETERAN'S SERVICE NUMBER *(If applicable)*:

6. TELEPHONE NUMBER *(Include Area Code)*: 999-999-9999

7. E-MAIL ADDRESS *(Optional)*: jollyjoe85@giggle.com

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

No. & Street: 1313 MOCKINGBIRD LANE

Apt./Unit Number:

City: NEW YORK

State/Province: NY

Country: US

ZIP Code/Postal Code: 21102-3231

SECTION II: REMARKS

(The following statement is made in connection with a claim for benefits in the case of the above-named veteran/beneficiary.)

I am an Air Force (rank) with 7 years active duty. Over this time, I have developed numerous medical conditions, some of which have made me unfit to continue on active duty. I am currently in the process of being honorably discharged because of my medical conditions.

I would like to submit the following conditions for VA disability:

- Intervertebral Disc Syndrome: I first began having (list symptoms) in (month and year) after a strenuous weight lifting session. I first saw a physician for this condition on (date of exam). I was diagnosed with (official diagnosis). I began (treatment details). After 2 months, I saw little improvement. A (test) was performed on (date) and showed (results). I underwent (treatments). I recently had another exam on (date), which shows my current conditions as (note the severity, like range of motion measurements, etc.). This condition is being considered by the MEB as service-related.
-Hearing Loss: I first noticed a decrease in my hearing after being in close range to numerous explosions while deployed. I saw an audiologist for this condition on (date). My test results showed a significant decrease in hearing. The test results were as follows: (test results). I was recently re-tested on (date) with the following results (list results). The MEB is considering this condition as service-related.

I have included the following supporting evidence with my application:
- All medical records concerning the conditions I am submitting for VA Disability
- (Any form or evidence you have that notes your future retirement date)
- Commander's Statement (if you have one. A signed letter from your commander that notes how your conditions effect your ability to perform your job can be helpful to your case.)

Thank you for reviewing my case.

VETERAN'S SOCIAL SECURITY NO. 9 9 9 – 9 9 – 9 9 9 9

SECTION II: REMARKS ***(Continued)***
(The following statement is made in connection with a claim for benefits in the case of the above-named veteran/beneficiary.)

(Use this page if your statement doesn't fit in the box on the previous page.)

SECTION III: DECLARATION OF INTENT

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