OMB Control No. 2900-0324
Respondent Burden: 45 Mins.

Department of Veterans Affairs

SUPPLEMENTAL PHYSICAL EXAMINATION REPORT

PRIVACY ACT INFORMATION: This report is authorized by law (38 CFR 8.8, 8.9, and 8.22). The information is required to help us make a decision on the veteran's claim for the insurance benefits under consideration. Responses may be disclosed outside VA only if the disclosure is authorized by the Privacy Act, including the routine uses identified in the VA system of records, 36VA00, Veterans and Armed Forces Personnel U.S. Government Life Insurance Records - VA, published in the Federal Register.

RESPONDENT BURDEN: VA may not conduct or sponsor, and respondent is not required to respond to this collection of information unless it displays a valid OMB Control Number. Public reporting burden for this collection of information is estimated to average 45 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have comments regarding this burden estimate or any other aspect of this collection of information, call 1-800-827-1000 for mailing information on where to send your comments.

1. NAME OF APPLICANT *(Type or print)*	2. INSURANCE FILE NUMBER

NOTICE TO APPLICANT

Any examinations required in connection with V, RS, W, RH or K insurance or in connection with reinstatement or change of plan of "J" insurance may be made by medical officers in active service or physicians of the U.S. Public Health Service, for those entitled, or may be made free of charge by a physician of the VA Regional Office or Medical Center. The examination may also be made at the applicant's own expense by a physician duly licensed for practice of medicine by a State, Territory or Possession of the United States, or District of Columbia, who is not related to the applicant, by blood or marriage, associated with his/her business, or financially interested in the granting of this insurance. Any medical examination required in connection with the issuance of the Total Disability Income Provision to "J" insurance must be made at the applicant's own expense.

NOTICE TO PHYSICIAN

Please furnish all pertinent information. If more space is needed, you may use the reverse of this form. The completed form should be sent to the office checked below. Please do not return it to the applicant. Thank you.

RETURN TO:

Department of Veterans Affairs
Regional Office and Insurance Center
P.O. Box 7208
Philadelphia, PA 19101

3. LIST ALL BLOOD PRESSURE READINGS BEFORE TREATMENT

A. DATE	B. SYSTOLIC	C. DIASTOLIC

4A. HAS APPLICANT EVER BEEN TREATED FOR HYPERTENSION? *(If "Yes," complete Items 4B, 4C, and 4D)* ☐ YES ☐ NO	4B. DATE TREATMENT BEGAN	4C. DATE ALL TREATMENT ENDED	4D. NAME OF DRUGS USED, DOSAGE AND FREQUENCY

5. LIST ALL BLOOD PRESSURE READINGS AFTER TREATMENT

A. DATE	B. SYSTOLIC	C. DIASTOLIC

6. DIAGNOSIS

7. IS ANY CARDIAC DISEASE PRESENT? *(Explain)*

8. REMARKS *(Include cause if known)*

9. NAME OF EXAMINING PHYSICIAN *(Type or print)*	10. DATE EXAMINED	11. STATE IN WHICH LICENSED TO PRACTICE

12. SIGNATURE OF PHYSICIAN *(Do not print)*	13. ADDRESS OF PHYSICIAN *(City, county, State and ZIP Code)*

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.