



SHOULDER AND ARM CONDITIONS DISABILITY BENEFITS QUESTIONNAIRE

IMPORTANT - THE DEPARTMENT OF VETERANS AFFAIRS (VA) *WILL NOT PAY* OR *REIMBURSE* ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER
-------------------------	--

NOTE TO PHYSICIAN - Your patient is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the veteran's claim.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE/SHE EVER HAD A SHOULDER AND/OR ARM CONDITION?

YES NO IF YES, PROVIDE ONLY DIAGNOSES THAT PERTAIN TO SHOULDER AND/OR ARM CONDITIONS:

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO SHOULDER AND/OR ARM CONDITIONS

DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS:	SIDE AFFECTED: <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> BOTH
DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS:	SIDE AFFECTED: <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> BOTH
DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS:	SIDE AFFECTED: <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> BOTH

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO SHOULDER AND/OR ARM CONDITIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (*including onset and course*) OF THE VETERAN'S SHOULDER AND/OR ARM CONDITION (*brief summary*)

2B. DOMINANT HAND:

RIGHT LEFT AMBIDEXTROUS

SECTION III - FLARE-UPS

3. DOES THE VETERAN REPORT THAT FLARE-UPS IMPACT THE FUNCTION OF THE SHOULDER AND/OR ARM?

YES NO

IF YES, DOCUMENT THE VETERAN'S DESCRIPTION OF THE IMPACT OF FLARE-UPS IN HIS OR HER OWN WORDS:

SECTION IV - INITIAL RANGE OF MOTION (ROM) MEASUREMENTS

4. MEASURE ROM WITH A GONIOMETER, ROUNDING EACH MEASUREMENT TO THE NEAREST 5 DEGREES. DURING THE MEASUREMENTS, DOCUMENT THE POINT AT WHICH PAINFUL MOTION BEGINS, EVIDENCED BY VISIBLE BEHAVIOR SUCH AS FACIAL EXPRESSION, WINCING, ETC. REPORT INITIAL MEASUREMENTS BELOW.

FOLLOWING THE INITIAL ASSESSMENT OF ROM, PERFORM REPETITIVE USE TESTING. FOR VA PURPOSES, REPETITIVE USE TESTING MUST BE INCLUDED IN ALL JOINT EXAMS. THE VA HAS DETERMINED THAT 3 REPETITIONS OF ROM (*at a minimum*) CAN SERVE AS A REPRESENTATIVE TEST OF THE EFFECT OF REPETITIVE USE. AFTER THE INITIAL MEASUREMENT, REASSESS ROM AFTER 3 REPETITIONS. REPORT POST-TEST MEASUREMENTS IN SECTION 5.

A. RIGHT SHOULDER FLEXION

Select where flexion ends (*normal endpoint is 180 degrees*):

0 5 10 15 20 25 30 35 40 45 50 55 60 65
 70 75 80 85 90 95 100 105 110 115 120 125 130 135
 140 145 150 155 160 165 170 175 180

Select where objective evidence of painful motion begins:

No objective evidence of painful motion
 0 5 10 15 20 25 30 35 40 45 50 55 60 65
 70 75 80 85 90 95 100 105 110 115 120 125 130 135
 140 145 150 155 160 165 170 175 180

SECTION IV - INITIAL RANGE OF MOTION (ROM) MEASUREMENTS (Continued)

B. RIGHT SHOULDER ABDUCTION

Select where abduction ends (*normal endpoint is 180 degrees*):

- 0 5 10 15 20 25 30 35 40 45 50 55 60 65
 70 75 80 85 90 95 100 105 110 115 120 125 130 135
 140 145 150 155 160 165 170 175 180

Select where objective evidence of painful motion begins:

- No objective evidence of painful motion
 0 5 10 15 20 25 30 35 40 45 50 55 60 65
 70 75 80 85 90 95 100 105 110 115 120 125 130 135
 140 145 150 155 160 165 170 175 180

C LEFT SHOULDER FLEXION

Select where flexion ends (*normal endpoint is 180 degrees*):

- 0 5 10 15 20 25 30 35 40 45 50 55 60 65
 70 75 80 85 90 95 100 105 110 115 120 125 130 135
 140 145 150 155 160 165 170 175 180

Select where objective evidence of painful motion begins:

- No objective evidence of painful motion
 0 5 10 15 20 25 30 35 40 45 50 55 60 65
 70 75 80 85 90 95 100 105 110 115 120 125 130 135
 140 145 150 155 160 165 170 175 180

D. LEFT SHOULDER ABDUCTION

Select where abduction ends (*normal endpoint is 180 degrees*):

- 0 5 10 15 20 25 30 35 40 45 50 55 60 65
 70 75 80 85 90 95 100 105 110 115 120 125 130 135
 140 145 150 155 160 165 170 175 180

Select where objective evidence of painful motion begins:

- No objective evidence of painful motion
 0 5 10 15 20 25 30 35 40 45 50 55 60 65
 70 75 80 85 90 95 100 105 110 115 120 125 130 135
 140 145 150 155 160 165 170 175 180

E. IF ROM DOES NOT CONFORM TO THE NORMAL RANGE OF MOTION IDENTIFIED ABOVE BUT IS NORMAL FOR THIS VETERAN (*for reasons other than a shoulder or arm condition, such as age, body habitus, neurologic disease*), EXPLAIN:

SECTION V - ROM MEASUREMENTS AFTER REPETITIVE USE TESTING

5A. IS THE VETERAN ABLE TO PERFORM REPETITIVE-USE TESTING WITH 3 REPETITIONS?

- YES NO

IF UNABLE, PROVIDE REASON:

IF VETERAN IS UNABLE TO PERFORM REPETITIVE-USE TESTING, SKIP TO SECTION 6.

IF VETERAN IS ABLE TO PERFORM REPETITIVE-USE TESTING, MEASURE AND REPORT ROM AFTER A MINIMUM OF 3 REPETITIONS.

5B. RIGHT SHOULDER POST-TEST ROM

Select where flexion ends:

- 0 5 10 15 20 25 30 35 40 45 50 55 60 65
 70 75 80 85 90 95 100 105 110 115 120 125 130 135
 140 145 150 155 160 165 170 175 180

Select where abduction ends:

- 0 5 10 15 20 25 30 35 40 45 50 55 60 65
 70 75 80 85 90 95 100 105 110 115 120 125 130 135
 140 145 150 155 160 165 170 175 180

SECTION V - ROM MEASUREMENTS AFTER REPETITIVE USE TESTING (Continued)

5C. LEFT SHOULDER POST-TEST ROM

Select where flexion ends:

- 0 5 10 15 20 25 30 35 40 45 50 55 60 65
 70 75 80 85 90 95 100 105 110 115 120 125 130 135
 140 145 150 155 160 165 170 175 180

Select where abduction ends:

- 0 5 10 15 20 25 30 35 40 45 50 55 60 65
 70 75 80 85 90 95 100 105 110 115 120 125 130 135
 140 145 150 155 160 165 170 175 180

SECTION VI - FUNCTIONAL LOSS AND ADDITIONAL LIMITATION IN ROM

6. THE FOLLOWING SECTION ADDRESSES REASONS FOR FUNCTIONAL LOSS, IF PRESENT, AND ADDITIONAL LOSS OF ROM AFTER REPETITIVE-USE TESTING, IF PRESENT. THE VA DEFINES FUNCTIONAL LOSS AS THE INABILITY TO PERFORM NORMAL WORKING MOVEMENTS OF THE BODY WITH NORMAL EXCURSION, STRENGTH, SPEED, COORDINATION AND/OR ENDURANCE.

6A. DOES THE VETERAN HAVE ADDITIONAL LIMITATION IN ROM OF THE SHOULDER AND ARM FOLLOWING REPETITIVE-USE TESTING?

- YES NO

6B. DOES THE VETERAN HAVE ANY FUNCTIONAL LOSS AND/OR FUNCTIONAL IMPAIRMENT OF THE SHOULDER AND ARM?

- YES NO

6C. IF THE VETERAN HAS FUNCTIONAL LOSS, FUNCTIONAL IMPAIRMENT AND/OR ADDITIONAL LIMITATION OF ROM OF THE SHOULDER AND ARM AFTER REPETITIVE USE, INDICATE THE CONTRIBUTING FACTORS OF DISABILITY BELOW (check all that apply and indicate side affected):

- NO FUNCTIONAL LOSS FOR RIGHT UPPER EXTREMITY
 NO FUNCTIONAL LOSS FOR LEFT UPPER EXTREMITY
 LESS MOVEMENT THAN NORMAL Right Left Both
 MORE MOVEMENT THAN NORMAL Right Left Both
 WEAKENED MOVEMENT Right Left Both
 EXCESS FATIGABILITY Right Left Both
 INCOORDINATION, IMPAIRED ABILITY TO EXECUTE SKILLED MOVEMENTS SMOOTHLY Right Left Both
 PAIN ON MOVEMENT Right Left Both
 SWELLING Right Left Both
 DEFORMITY Right Left Both
 ATROPHY OF DISUSE Right Left Both

SECTION VII - PAIN (pain on palpation)

7A. DOES THE VETERAN HAVE LOCALIZED TENDERNESS OR PAIN ON PALPATION OF JOINTS/SOFT TISSUE/BICEPS TENDON OF EITHER SHOULDER?

- YES NO IF YES, SHOULDER AFFECTED: Right Left Both

7B. DOES THE VETERAN HAVE GUARDING OF EITHER SHOULDER?

- YES NO IF YES, SHOULDER AFFECTED: Right Left Both

SECTION VIII - MUSCLE STRENGTH TESTING

8. RATE STRENGTH ACCORDING TO THE FOLLOWING SCALE:

- 0/5 NO MUSCLE MOVEMENT
1/5 PALPABLE OR VISIBLE MUSCLE CONTRACTION, BUT NO JOINT MOVEMENT
2/5 ACTIVE MOVEMENT WITH GRAVITY ELIMINATED
3/5 ACTIVE MOVEMENT AGAINST GRAVITY
4/5 ACTIVE MOVEMENT AGAINST SOME RESISTANCE
5/5 NORMAL STRENGTH

- SHOULDER ABDUCTION Right 5/5 4/5 3/5 2/5 1/5 0/5
Left 5/5 4/5 3/5 2/5 1/5 0/5
SHOULDER FORWARD FLEXION: Right 5/5 4/5 3/5 2/5 1/5 0/5
Left 5/5 4/5 3/5 2/5 1/5 0/5

SECTION IX - ANKYLOSIS

9. DOES THE VETERAN HAVE ANKYLOSIS OF THE GLENOHUMERAL ARTICULATION (SHOULDER JOINT)?

- YES NO

IF YES, INDICATE SEVERITY AND SIDE AFFECTED:

- ABDUCTION TO 60 DEGREES; CAN REACH MOUTH AND HEAD Right Left Both
 ABDUCTION LIMITED TO BETWEEN 60 AND 25 DEGREES Right Left Both
 ABDUCTION LIMITED TO 25 DEGREES FROM THE SIDE Right Left Both

SECTION X - SPECIFIC TESTS FOR ROTATOR CUFF CONDITIONS

10A. HAWKINS' IMPINGEMENT TEST *(Forward flex the arm to 90 degrees with the elbow bent to 90 degrees. Internally rotate arm. Pain on internal rotation indicates a positive test; may signify rotator cuff tendinopathy or tear)*

POSITIVE NEGATIVE UNABLE TO PERFORM N/A
 IF POSITIVE, SIDE AFFECTED: Right Left Both

10B. EMPTY-CAN TEST *(Abduct arm to 90 degrees and forward flex 30 degrees. Patient turns thumbs down and resists downward force applied by the examiner. Weakness indicates a positive test; may indicate rotator cuff pathology, including supraspinatus tendinopathy or tear)*

POSITIVE NEGATIVE UNABLE TO PERFORM N/A
 IF POSITIVE, SIDE AFFECTED: Right Left Both

10C. EXTERNAL ROTATION/INFRASPINATUS STRENGTH TEST *(Patient holds arms at side with elbow flexed 90 degrees. Patient externally rotates against resistance.. Weakness indicates a positive test; may be associated with infraspinatus tendinopathy or tear)*

POSITIVE NEGATIVE UNABLE TO PERFORM N/A
 IF POSITIVE, SIDE AFFECTED: Right Left Both

10D. LIFT-OFF SUBSCAPULARIS TEST *(Patient internally rotates arm behind lower back, pushes against examiner's hand. Weakness indicates a positive test; may indicate subscapularis tendinopathy or tear)*

POSITIVE NEGATIVE UNABLE TO PERFORM N/A
 IF POSITIVE, SIDE AFFECTED: Right Left Both

SECTION XI - HISTORY AND SPECIFIC TESTS FOR INSTABILITY/DISLOCATION/LABRAL PATHOLOGY

11A. IS THERE A HISTORY OF MECHANICAL SYMPTOMS *(clicking, catching, etc.)?*

YES NO IF YES, SIDE AFFECTED: Right Left Both

11B. IS THERE A HISTORY OF RECURRENT DISLOCATION (subluxation) OF THE GLENOHUMERAL (scapulohumeral) JOINT?

YES NO IF YES, INDICATE FREQUENCY, SEVERITY AND SIDE AFFECTED *(check all that apply):*

<input type="checkbox"/> INFREQUENT EPISODES	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> FREQUENT EPISODES	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> GUARDING OF MOVEMENT ONLY AT SHOULDER LEVEL	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> GUARDING OF ALL ARM MOVEMENTS	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both

11C. CRANK APPREHENSION AND RELOCATION TEST *(With patient supine, abduct patient's arm to 90 degrees and flex elbow 90 degrees. Pain and sense of instability with further external rotation may indicate shoulder instability)*

POSITIVE NEGATIVE UNABLE TO PERFORM N/A
 IF POSITIVE, SIDE AFFECTED: Right Left Both

SECTION XII - HISTORY AND SPECIFIC TESTS FOR CLAVICLE, SCAPULA, ACROMIOCLAVICULAR (AC) JOINT AND STERNOCLAVICULAR JOINT CONDITIONS

12A. DOES THE VETERAN HAVE AN AC JOINT CONDITION OR ANY OTHER IMPAIRMENT OF THE CLAVICLE OR SCAPULA?

YES NO

IF YES, INDICATE SEVERITY AND SIDE AFFECTED

<input type="checkbox"/> MALUNION OF CLAVICLE OR SCAPULA	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> NONUNION OF CLAVICLE OR SCAPULA WITHOUT LOOSE MOVEMENT	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> NONUNION OF CLAVICLE OR SCAPULA WITH LOOSE MOVEMENT	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> DISLOCATION (ACROMIOCLAVICULAR SEPARATION OR STERNOCLAVICULAR DISLOCATION)	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> OTHER <i>(Describe)</i> _____	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both

12B. IS THERE TENDERNESS ON PALPATION OF THE AC JOINT?

YES NO IF YES, INDICATE SIDE: Right Left Both

12C. CROSS-BODY ADDUCTION TEST *(Passively adduct arm across the patient's body toward the contralateral shoulder. Pain may indicate acromioclavicular joint pathology)*

POSITIVE NEGATIVE UNABLE TO PERFORM N/A
 IF POSITIVE, SIDE AFFECTED: Right Left Both

SECTION XIII - JOINT REPLACEMENT AND/OR OTHER SURGICAL PROCEDURES

13A. HAS THE VETERAN HAD A TOTAL SHOULDER JOINT REPLACEMENT?

YES NO

IF YES, INDICATE SIDE AND SEVERITY OF RESIDUALS

RIGHT SHOULDER

DATE OF SURGERY: _____

RESIDUALS:

NONE

INTERMEDIATE DEGREES OF RESIDUAL WEAKNESS, PAIN AND/OR LIMITATION OF MOTION

CHRONIC RESIDUALS CONSISTING OF SEVERE PAINFUL MOTION AND/OR WEAKNESS

OTHER *(Describe)* _____

LEFT SHOULDER

DATE OF SURGERY: _____

RESIDUALS:

NONE

INTERMEDIATE DEGREES OF RESIDUAL WEAKNESS, PAIN AND/OR LIMITATION OF MOTION

CHRONIC RESIDUALS CONSISTING OF SEVERE PAINFUL MOTION AND/OR WEAKNESS

OTHER *(Describe)* _____

13B. HAS THE VETERAN HAD ARTHROSCOPIC OR OTHER SHOULDER SURGERY?

YES NO IF YES, INDICATE SIDE AFFECTED: Right Left Both

DATE AND TYPE OF SURGERY: _____

13C. DOES THE VETERAN HAVE ANY RESIDUAL SIGNS AND/OR SYMPTOMS DUE TO ARTHROSCOPIC OR OTHER SHOULDER SURGERY?

YES NO IF YES, INDICATE SIDE AFFECTED: Right Left Both

IF YES, DESCRIBE RESIDUALS: _____

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

14A. DOES THE VETERAN HAVE ANY SCARS *(surgical or otherwise)* RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN DIAGNOSIS SECTION 1?

YES NO

IF YES, ARE ANY OF THE SCARS PAINFUL/OR UNSTABLE, OR IS THE TOTAL AREA OF ALL RELATED SCARS GREATER THAN 39 SQUARE cm *(6 square inches)*?

YES NO

IF YES, ALSO COMPLETE VA FORM 21-0960F-1, SCARS/DISFIGUREMENT DISABILITY BENEFITS QUESTIONNAIRE.

14B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN DIAGNOSIS SECTION 1?

YES NO IF YES, DESCRIBE *(Brief summary)*: _____

SECTION XV - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

15. DUE TO THE VETERAN'S SHOULDER AND/OR ARM CONDITIONS, IS THERE FUNCTIONAL IMPAIRMENT OF AN EXTREMITY SUCH THAT NO EFFECTIVE FUNCTION REMAINS OTHER THAN THAT WHICH WOULD BE EQUALLY WELL SERVED BY AN AMPUTATION WITH PROSTHESIS? *(Functions of the upper extremity include grasping, manipulation, etc)*

YES, FUNCTIONING IS SO DIMINISHED THAT AMPUTATION WITH PROSTHESIS WOULD EQUALLY SERVE THE VETERAN.

NO

IF YES, INDICATE EXTREMITY(IES) *(check all extremities for which this applies)*:

Right upper Left upper

FOR EACH CHECKED EXTREMITY, DESCRIBE LOSS OF EFFECTIVE FUNCTION, IDENTIFY THE CONDITION CAUSING LOSS OF FUNCTION, AND PROVIDE SPECIFIC EXAMPLES *(brief summary)*: _____

SECTION XVI - DIAGNOSTIC TESTING

NOTE: The diagnosis of degenerative arthritis (osteoarthritis) or traumatic arthritis must be confirmed by imaging studies. Once such arthritis has been documented, no further imaging studies are required by VA, even if arthritis has worsened.

16A. HAVE IMAGING STUDIES OF THE SHOULDER BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

YES NO

IF YES, IS DEGENERATIVE OR TRAUMATIC ARTHRITIS DOCUMENTED?

YES NO

IF YES, INDICATE SHOULDER:

Right Left Both

16B. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

YES NO

IF YES, PROVIDE TYPE OF TEST OR PROCEDURE, DATE AND RESULTS (*Brief summary*):

SECTION XVII - FUNCTIONAL IMPACT AND REMARKS

17. DOES THE VETERAN'S SHOULDER CONDITION IMPACT HIS OR HER ABILITY TO WORK?

YES NO

IF YES, DESCRIBE THE IMPACT OF EACH OF THE VETERAN'S SHOULDER CONDITIONS PROVIDING ONE OR MORE EXAMPLES:

SECTION XVIII - FUNCTIONAL IMPACT AND REMARKS

18. REMARKS (*If any*)

SECTION XIX - PHYSICIAN'S CERTIFICATION AND SIGNATURE

CERTIFICATION - To the best of my knowledge, the information contained herein is accurate, complete and current.

19A. PHYSICIAN'S SIGNATURE

19B. PHYSICIAN'S PRINTED NAME

19C. DATE SIGNED

19D. PHYSICIAN'S PHONE AND FAX NUMBER

19E. PHYSICIAN'S MEDICAL LICENSE NUMBER

19F. PHYSICIAN'S ADDRESS

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

IMPORTANT - Physician please fax the completed form to _____

(VA Regional Office FAX No.)

NOTE - A list of VA Regional Office FAX Numbers can be found at www.vba.va.gov/disabilityexams or obtained by calling 1-800-827-1000.

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

RESPONDENT BURDEN: We need this information to determine entitlement to benefits (38 U.S.C. 501). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information, and complete the form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.