



Camp Lejeune Family Member Program Treating Physician Report

Please note: This form must be completed and signed by your physician

Attention: After reviewing the following information, complete the form in its entirety (print or type only), and return with the required documentation to the Department of Veterans Affairs, Financial Services Center, PO Box 149200, Austin TX, 78714-9200.

Record of Examination

Patient's Name (Last, First, Middle)	Date of Birth (MMDDYYYY)	Social Security Number
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Is there any history of the following conditions/illnesses? Yes No

Check conditions below that apply to your patient.

(If more than one, a separate form must be completed for each illness.)

‡Must provide additional information to support conclusion. *Please indicate the dates of Miscarriage and Female Infertility. These must have occurred concurrent with exposure, prior to 1988.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Bladder cancer | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Scleroderma | <input type="checkbox"/> Female infertility* Dates _____ |
| <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Multiple myeloma | <input type="checkbox"/> Hepatic steatosis‡ | <input type="checkbox"/> Miscarriage* Dates _____ |
| <input type="checkbox"/> Esophageal cancer | <input type="checkbox"/> Myelodysplastic syndrome | <input type="checkbox"/> Renal toxicity‡ | |
| <input type="checkbox"/> Kidney cancer | <input type="checkbox"/> Non-Hodgkin's lymphoma | <input type="checkbox"/> Neurobehavioral effects‡ | |
| <input type="checkbox"/> Lung cancer | | | |

What is your specific diagnosis?

ICD-9/10 code(s)

Date of diagnosis	Date of most recent visit for this condition
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Indicate the status of the condition Active Remission Other

What treatment has been provided?

- | | | |
|---------------------------------------|------------------|--------------------------------------|
| <input type="checkbox"/> Radiation | Start Date _____ | Anticipated Treatment End Date _____ |
| <input type="checkbox"/> Chemotherapy | Start Date _____ | Anticipated Treatment End Date _____ |
| <input type="checkbox"/> Surgery | Start Date _____ | Anticipated Treatment End Date _____ |

Other treatment

Ongoing/future treatment

Narrative: List any co-morbidities, risk factors, or other exposures that may have also contributed to this illness.

Medical records regarding the claimed condition are required in order to determine clinical eligibility.

‡ For these three conditions (Hepatic steatosis, Renal toxicity, Neurobehavioral effects) list symptoms, diagnostic tests, etc.

Signature

I certify the above statement to be true to the best of my abilities and acknowledge that providing false statements may subject me to felony criminal prosecution. I affirm that I have reviewed the Release of Information signed by the patient.

Signature of Physician			Date	
Name of Physician (Please print)				
Street Address			Tax ID Number	
City		State	Zip Code	National Provider Identifier (NPI)
Email Address		Phone Number		Indicate speciality, if any

For more information go to: <https://www.cfamilymembers.fsc.va.gov/>

NOTE TO PHYSICIAN: Your patient is applying to the Department of Veterans Affairs (VA). VA will consider the information you provide on this questionnaire as part of their eligibility determination for this program. This program's eligibility criteria will be determined through the VA. **Submission of this application does not guarantee acceptance into this program.**

The Paperwork Reduction Act: This information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. Public reporting burden for this collection of information is estimated to average 30 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. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. The purpose of this data collection is to determine eligibility for benefits.

Privacy Act Information: The authority for collection of the requested information on this form is 38 USC 1787. The purpose of collecting this information is to determine your eligibility for reimbursement of health care related to conditions determined to result from contaminated water while you resided at Camp Lejeune, North Carolina, for a period of at least 30 days. The information you provide may be verified by computer matching programs with authoritative sources such as Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPV), Department of Defense (DoD), Defense Enrollment Eligibility Reporting System (DEERS), Centers for Medicare & Medicaid Services (CMS) or any other applicable authoritative source at any time. You are requested to provide your social security number as your VA record is filed and retrieved by this number. You do not have to provide the requested information on this form but if any or all of the requested information is not provided, it may delay or result in denial of your request for Camp Lejeune Family Member Program benefits. Failure to furnish the requested information will have no adverse impact on any other VA benefit to which you may be entitled. The responses you submit are considered confidential and may be disclosed outside VA only if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records number 23VA16. For example, information including your social security number may be disclosed to the Department of Defense, contractors, trading partners, health care providers and other suppliers of health care services to determine your eligibility for medical benefits and payment for services.