OMB Control No. 2900-0822
Estimated Burden: 15 Minutes
Expiration Date: XX/XX/20XX

Department of Veterans Affairs

CAMP LEJEUNE FAMILY MEMBER PROGRAM TREATING PHYSICIAN REPORT

RECORD OF EXAMINATION

Patient's Name *(Last, First, Middle)*	Date of Birth *(MM/DD/YYYY)*	Social Security Number *(999-99-9999)*

Is there any history of the following conditions/illnesses? ☐ Yes ☐ No

These conditions/illnesses may be related to the patient's exposure to contaminated water at Camp Lejeune while living there for at least thirty days between August 1, 1953 and December 31, 1987.

If Yes: check condition/illness below that applies. (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.

☐ Bladder cancer	☐ Leukemia	☐ Hepatic steatosis‡	
☐ Breast cancer	☐ Multiple myeloma	☐ Renal toxicity‡	
☐ Esophageal cancer	☐ Myelodysplastic syndrome	☐ Neurobehavioral effects‡	
☐ Kidney cancer	☐ Non-Hodgkin's lymphoma	☐ Female infertility*	Date *(MM/DD/YYYY)* _____
☐ Lung cancer	☐ Scleroderma	☐ Miscarriage*	Date *(MM/DD/YYYY)* _____

What is your specific diagnosis?

ICD-9/10 code(s):

Date of Diagnosis *(MM/DD/YYYY)*	Date of most recent visit for this condition *(MM/DD/YYYY)*

Indicate the status of the condition: ☐ Active ☐ Remission ☐ Other:

Please indicate current treatment for active cancers *(to be active an individual must be receiving chemo, radiation, surgery or has elected hospice after)*:

☐ Radiation	Start Date *(MM/DD/YYYY)* _____		Anticipated Treatment End Date *(MM/DD/YYYY)* _____	
☐ Chemotherapy	Start Date *(MM/DD/YYYY)* _____		Anticipated Treatment End Date *(MM/DD/YYYY)* _____	
☐ Surgery	Start Date *(MM/DD/YYYY)* _____		Anticipated Treatment End Date *(MM/DD/YYYY)* _____	
☐ Hospice	Start Date *(MM/DD/YYYY)* _____			

Other treatment:

Ongoing/future treatment:

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

Historical and current 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 *(MM/DD/YYYY)*
Name of Physician *(Please print)*			
Street Address			Tax ID Number
City	State	Zip Code	National Provider Identifier (NPI)
Email Address	Phone Number *((999) 999-9999)*		Indicate specialty, if any

For more information go to: https://www.clfamilymembers.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.**

PRIVACY ACT INFORMATION: Authority for this information collection is found in 38 USC 1787. The purpose of collecting this information is to determine your eligibility for reimbursement for health care related to conditions resulting from contaminated water while you resided at Camp Lejeune, NC, for a period of at least 30 days. The information you provide may be verified by computer matching programs with authoritative sources, such as CHAMPVA, DoD, DEERS, CMS, or any other applicable authoritative source at any time. You are requested to provide your SSN because your VA record is filed and retrieved by this number. If any or all of the requested information is not provided it may delay or result in denial of your requested benefit. 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, such as payment for services.

VA BURDEN STATEMENT: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-0822, and it expires XX/XX/20XX. Public reporting burden for this collection of information is estimated to average 10 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to VA Reports Clearance Officer at vapra@va.gov. Please refer to OMB Control No. 2900-0822 in any correspondence. Do not send your completed VA Form 10-10068b to this email address.