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CHECKLIST FOR CLAIMS INVOLVING SERVICE IN GULF WAR AND SOUTHWEST ASIA

Veteran's Name: _____ SS No.: _____

- Pertinent References:
- 38 CFR 3.317, 38 CFR 3.309
 - M21-1 MR, Part IV, Subpart ii, Chapter 2, Section D
 - Training Letter 10-01

Yes
 No

Does the veteran have service in Southwest Asia between August 2, 1990 until present?

Yes
 No

Does the veteran have signs or symptoms that involve any of the following areas? **If yes, have the veteran fully describe the specific nature of the disability.**

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Neuropsychological |
| <input type="checkbox"/> Skin | <input type="checkbox"/> Respiratory System |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Sleep Disturbance |
| <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Gastrointestinal, or Abnormal Weight Loss |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Cardiovascular |
| <input type="checkbox"/> Neurological | <input type="checkbox"/> Menstrual Disorders |

Yes
 No

Does the veteran have one of the presumptive service connected illnesses identified in 38 CFR 3.309? **If so, have the veteran fully describe the specific nature of the illness (Symptoms and actual treatment should be indicated).** _____

What was the source of exposure? _____

- | | |
|---|--|
| <input type="checkbox"/> Acute/Sub-acute Peripheral Neuropathy | <input type="checkbox"/> Epithelioid Malignant Leiomyosarcoma |
| <input type="checkbox"/> Adult Onset Type II Diabetes Mellitus | <input type="checkbox"/> Epithelioid Malignant Schwannoma |
| <input type="checkbox"/> AL Amyloidosis | <input type="checkbox"/> Epithelioid Sarcoma |
| <input type="checkbox"/> Chloracne | <input type="checkbox"/> Extraskelatal Ewing's Sarcoma |
| <input type="checkbox"/> Hodgkins Disease | <input type="checkbox"/> All Chronic B-Cell Leukemias |
| <input type="checkbox"/> Ischemic Heart Disease (IHD) | <input type="checkbox"/> Hemangiosarcoma |
| <input type="checkbox"/> Non-Hodgkins Lymphoma | <input type="checkbox"/> Infantile Fibrosarcoma |
| <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Leiomyosarcoma |
| <input type="checkbox"/> Peripheral Neuropathy | <input type="checkbox"/> Liposarcoma |
| <input type="checkbox"/> Porphyria Cutanea Tarda | <input type="checkbox"/> Lymphangiosarcoma |
| <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Cancer of the Bronchus | <input type="checkbox"/> Malignant Fibrous Histiocytoma |
| <input type="checkbox"/> Cancer of the Larynx | <input type="checkbox"/> Malignant Giant Cell Tumor of the Tendon Sheath |
| <input type="checkbox"/> Cancer of the Lung | <input type="checkbox"/> Malignant Glandular Schwannoma |
| <input type="checkbox"/> Cancer of the Prostate | <input type="checkbox"/> Malignant Glomus Tumor |
| <input type="checkbox"/> Cancer of the Trachea | <input type="checkbox"/> Malignant Hemangiopericytoma |
| <input type="checkbox"/> Adult Fibrosarcoma | <input type="checkbox"/> Malignant Mesenchymoma |
| <input type="checkbox"/> Alveolar Soft Part Sarcoma | <input type="checkbox"/> Malignant Shwannoma with Rhabdomyoblastic |
| <input type="checkbox"/> Angiosarcoma | <input type="checkbox"/> Multiple Myeloma |
| <input type="checkbox"/> Chronic Lymphocytic Leukemia (Hairy-Cell Leukemia) | <input type="checkbox"/> Proliferating Angiodeliomatosis |
| <input type="checkbox"/> Clear Cell Sarcoma of Tendons | <input type="checkbox"/> Rhabdomyosarcoma |
| <input type="checkbox"/> Congenital Fibrosarcoma | <input type="checkbox"/> Sarcoma |
| <input type="checkbox"/> Dermatofibrosarcoma | <input type="checkbox"/> Soft Tissue Sarcoma |
| <input type="checkbox"/> Ectomesenchymoma | <input type="checkbox"/> Synovial Sarcoma |



CHECKLIST FOR CLAIMS INVOLVING SERVICE IN GULF WAR AND SOUTHWEST ASIA (Continued)

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the veteran have one of these diagnosed multi-system illnesses identified in 38 CFR 3.317? <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Chronic Fatigue Syndrome
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the veteran have any other medically diagnosed illness without pathology or ideology? If so, have the veteran fully describe the specific nature of the disability and body systems involved (This should require medical evidence rather than just credible symptoms). _____ _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the veteran had a Gulf War Registry Exam? If so, document when and where. _____ _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the veteran sought treatment for the disability(ies) at issue? If so, complete a VA Form 21-4142 for each private physician involved. If at a government facility, document the specific dates and places of treatment.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are there friends, employers, or co-workers who can provide relevant observations concerning the disability(ies) as to changes in the veteran's habits, time lost from work, etc.? If so, get a signed and certified statement from each of them to include with the claim (Should include how long they have known the veteran and how long over time period have they observed the disability).

**After you have assembled the evidence that you can submit with the claim, request a VA examination in accordance with 38 CFR 3.159(c)(4), itemizing how the veteran meets the criteria for each element so that there is no doubt that an examination is warranted to fairly resolve the issue.