# APPLICATION FOR MEDICAL CARE

Reset Form

**PRIVACY ACT STATEMENT**

**AUTHORITY:** Title 10, U.S.C. Chapter 55.

**PRINCIPAL PURPOSE:** To obtain information on an applicant's participation as a research subject in a U.S. Army chemical or biological substance testing program from 1942 to 1975 and medical data on any injury or disease believed to be proximately caused by participation in such programs.

**ROUTINE USE:** This information will be used to determine applicant's eligibility for medical care for an injury or disease believed to be proximately caused by participation as a research subject in a U.S. Army chemical and biological substance testing program.

**DISCLOSURE:** Voluntary. Failure to provide certain information necessary to determine eligibility may result in denial of services.

**GENERAL INSTRUCTIONS**

*(Complete this form carefully and accurately.)*

## Please Read Before You Start . . . What is this application used for?

1. This application is used by Veterans to apply for medical care for any diseases or conditions believed to be proximately caused by the Veteran's participation, as a research subject, in a U.S. Army chemical or biological substance testing program from 1942 to 1975. The information provided in this application will be used by the Department of the Army to determine your eligibility for medical care for proximately caused diseases or conditions.
2. If you require assistance in completing the application form or have general questions, please contact the Army Medical Command Hotline: 1-800-984-8523.

## COMPLETING YOUR APPLICATION:

1. Complete applications include:
   a. MEDCOM Form 840, Application for Medical Care, to include, a medical diagnosis (in Section V, Item 16) for diseases or conditions believed to be caused by your participation in a U.S. Army chemical or biological substance testing program. If you cannot afford to pay for a medical examination for the purpose of obtaining a diagnosis to support your application, annotate this in Section V, Item 16, and the Army will arrange an examination for you at the nearest military medical treatment facility.
   b. Copies of records demonstrating participation in such research programs (i.e., DD214s, War Department (WD) forms, award or decoration citations for research participation, Enlisted/Officer Record Brief, etc.).
   c. Any Veterans Administration service connection decisions.
2. You or an individual to whom you have granted Power of Attorney must sign and date the application form. If the application is not signed and dated, it will be returned to you to complete. Unsigned application forms will not be processed. **Do not send original documents, as they will not be returned.**

## SUBMITTING YOUR APPLICATION:

Mail your application and supporting documentation to:

U.S. Army Public Health Center (USAPHC)
ATTN: Benefits Application Panel
8252 BLACKHAWK ROAD
APG, MD 21010-5403

## APPLICATION FOR MEDICAL CARE

Control Number (Official Use Only):

### SECTION I – GENERAL INFORMATION

| | |
|---|---|
| **1. NAME:** (Last, First, Middle Initial) | **6. MAILING ADDRESS:** |
| | **a. HOME ADDRESS:** *(Street, Apartment No., City, State, and Zip Code)* |
| **2. LAST 4 OF SOCIAL SECURITY OR SERVICE NUMBER:** / **3. DATE OF BIRTH:** *(YYYYMMDD)* | |
| **4. Sex:** ☐ **MALE** ☐ **FEMALE** | |
| **5. E-MAIL ADDRESS:** | **b. HOME PHONE:** *(Incl. area code)* / **c. CELL PHONE:** *(Incl. area code)* |

### SECTION II – PRELIMINARY REQUIREMENTS

| **8. MARK AN (X) NEXT TO THE APPROPRIATE ANSWER FOR EACH STATEMENT.** | **Yes** | **No** |
|---|---|---|
| a. I have a DD Form 214 or War Department (WD) discharge/separation form(s) or functional equivalent. | ☐ | ☐ |
| b. I participated in a U.S. Army chemical or biological substance testing program from 1942 to 1975. | ☐ | ☐ |
| c. I have an injury or disease that is believed to be proximately caused by participation in a U.S. Army chemical or biological substance testing program from 1942 to 1975. | ☐ | ☐ |

**NOTE: If you answered NO to any question above, contact the Army Medical Command Hotline for assistance at 1-800-984-8523.**

### SECTION III – MILITARY SERVICE INFORMATION

*(You must provide copies of evidence needed to verify this information (e.g., DD214's, WDs, awards, evaluations, etc.)*

| | | |
|---|---|---|
| **9. BRANCH OF SERVICE:** | **10. LAST GRADE/RANK HELD:** | **11. GRADE/RANK HELD WHILE PARTICIPATING IN A CHEMICAL OR BIOLOGICAL TESTING PROGRAM:** |
| **12. SERVICE ENTRY DATE:** | **13. DISCHARGE DATE:** | **14. DISCHARGE LOCATION:** *(Installation, City and State)* |

### SECTION IV - REQUEST FOR MEDICAL CARE DETERMINATION

**15. MEDICAL INJURY OR DISEASE DESCRIPTION**

| | |
|---|---|
| **a. TYPE OF INJURY OR DISEASE:** | **b. BODY PART(S) AFFECTED:** *(e.g., right knee)* |
| **c. UNIT OF ASSIGNMENT WHEN PARTICIPATED IN CHEM-BIO TESTING:** | **d. LOCATION/AREA OF ASSIGNMENT WHEN PARTICIPATION OCCURRED:** |

**e. IN YOUR OWN WORDS, DESCRIBE THE EVENTS SURROUNDING THE PARTICIPATION:** *(Include why you believe your injury or disease resulted from your participation or exposure during testing. If known, provide dates, name of agent or substance you were exposed to, dosages, routes (injection, oral, intravenous, inhalation), antidotes provided, and whether or not you received a diagnosis and medical care at the time):*

| | | | | |
|---|---|---|---|---|
| **f. ARE YOU CURRENTLY RECEIVING MEDICAL CARE THROUGH A DOD MEDICAL TREATMENT FACILITY FOR THE INJURY OR DISEASE DESCRIBED ABOVE?** (If so, please provide copies of relevant medical treatment information) | ☐ | **YES** | ☐ | **NO** |
| **g ARE YOU CURRENTLY RECEIVING MEDICAL CARE THROUGH THE VA FOR THE INJURY OR DISEASE DESCRIBED ABOVE?** *(If so, please provide copies of relevant medical treatment information)* | ☐ | **YES** | ☐ | **NO** |
| **h. ARE YOU CURRENTLY RECEIVING MEDICAL CARE THROUGH A PRIVATE PHYSICIAN FOR THE INJURY OR DISEASE DESCRIBED ABOVE?** *(If so, please provide copies of relevant medical treatment information)* | ☐ | **YES** | ☐ | **NO** |

## APPLICATION FOR MEDICAL CARE

| NAME: *(Last, First, Middle Initial)* | LAST 4 OF SOCIAL SECURITY OR SERVICE NUMBER: |
|---|---|
| | |

### SECTION V – ATTENDING PHYSICIAN STATEMENT

**16. ATTENDING PHYSICIAN STATEMENT:** *(Diagnosis of injury or disease the Veteran believes to be proximately caused by their participation in a U.S. Army chemical or biological substance testing program. In addition, please list other existing health conditions. Attach supporting documentation, as necessary.*

| 17. PHYSICIAN NAME: | 18. PHYSICIAN SIGNATURE: | 19. PHONE NUMBER: | 20. DATE: |
|---|---|---|---|
| | | | |

### SECTION VI - REQUIRED DOCUMENTATION

**21. PLEASE SUBMIT THE FOLLOWING DOCUMENTATION WITH YOUR APPLICATION. (DO NOT SEND ORIGINAL DOCUMENTS - COPIES ONLY!)**

**a.** All DD214s or WD forms.

**b.** Any VA ratings, decisions, letters, and code sheets (current and prior).

**c.** Medical records or notes verifying the injury or disease believed to have been proximately caused by participation in a U.S. Army chemical or biological substance testing program.

**d**. Any evidence which can be used to verify the events or circumstances (e.g., award or decoration citations for research participation, Enlisted/Officer Record Brief, etc.).

### SECTION VII - CERTIFICATION

**22. SIGNATURE OF APPLICANT OR INDIVIDUAL TO WHOM THE APPLICANT HAS DELEGATED POWER OF ATTORNEY.**
I certify under penalty of perjury that the foregoing is true and correct, and understand that the above information, if misrepresented or incomplete, may subject me to civil and/or criminal penalties.

| a. SIGNATURE OF APPLICANT: | b. DATE SIGNED: |
|---|---|
| | |



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