

(12) TRAINEE HANDOUTS

TRAINING FOR VSO LESSON TWELVE ISSUE SPECIFIC CLAIMS DEVELOPMENT

PREREQUISITE TRAINING	Prior to this training you must have completed the following lesson plans: <i>SHARE, MAP-D, PIES, Reference Materials, Tour of the C&P Website, Establishing Veteran Status, and Claims Recognition.</i>
PURPOSE OF LESSON	<p>The purpose of this lesson is to teach you the evidentiary requirements for establishing a special issue claim.</p> <p>Provided with the appropriate manual and regulatory references and handouts, access to academy mode MAP-D and SHARE, and case scenarios, you will be able to:</p> <ul style="list-style-type: none">▪ Identify issue specific claims▪ Identify 5 types of specific claims that need little or no additional development▪ Recognize an HIV—AIDS claim and identify special development▪ Relate the history of mustard gas lewisite claims and identify the presumptive conditions associated with mustard gas exposure.
TIME REQUIRED	2.75 hours lecture; 1.25 review exercise.
INSTRUCTIONAL METHOD	Lecture, participatory discussion, practical exercise
MATERIALS/ TRAINING AIDS	<ul style="list-style-type: none">▪ <i>Issue Special Claims Development Trainee Handouts</i>▪ <i>Issue Specific Claims Development PowerPoint presentation.</i>

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REFERENCES

- 38 U.S.C. §1151:** 38 U.S.C. §1151; 38 CFR §§3.361, 3.362, & 3.363; M21-1MR, Part IV, Subpart ii, 1.A.3; M21-1MR, Part III, Subpart ii, 2.B.6.e; M21-1MR, Part IV, Subpart ii, 2.G; and *Brown v. Gardner*, U.S. Supreme Court, No. 93-1128, dated 12-12-1994.
- Cold Exposure:** 38 U.S.C. 1154(a); 38 CFR 3.303(a) & 3.304(d); M21-1MR, Part III, Subpart iv, 4.E.21; C&P Service Fast Letters 5-72, 97-33, 97-81; C&P Service Training Letter 93-1, dated 01-26-1993 with attached VHA (Information Letter) IL 11-92-0006, dated 11-02-1992; Unit Assignment Roster for Chosin Reservoir (if available); and *Long-term Sequelae of Cold Injury: Diagnosis and Management*, VHA, 06-12-1997 [with a video on same issued May 1998]
- Conditions Secondary To Drug and Alcohol Use:** 38 U.S.C. 105(a); 38 CFR 3.310; USB Letter 20-98-14, dated May 22, 1998; M21-1MR, Part IV, Subpart ii, 2.K.67 & 68; VAOPGCPREC 2-98, dated 2/10/1998; and Adjudication Officers' Conference Call, 2/19/1998
- Homeless:** 38 CFR 1.170; VBA Circular 20-91-9, dated 06-06-1991 and VBA Circular 20-95-3, dated 02-14-1995
- Toxic Chemical Exposure:** GAO Study Regarding Military Testing of Chemical Agents (Cranston Study)

HIV-AIDS REFERENCES

- M21-1MR
Part III, Subpart ii, 4.A.5
Part III, Subpart iv, 4.I.34.d
Part IV, Subpart ii, 1.H.30
Part IV, Subpart ii, 2.K.68
- Merck Manual, 16th Edition

MUSTARD GAS EXPOSURE REFERENCES

- 38 CFR §3.316
- M21-1MR, Part IV, Subpart ii, 1.F
- Training Letter (TL) 05-01

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DEVELOPING ISSUE SPECIFIC CLAIMS — TRACKING HANDOUT

- EP Code Tracking—*M21-4, Appendix C*

1	[incremented end product code]
2	Radiation
3	POW Status
4	Post Traumatic Stress Disorder
5	Agent Orange Exposure
6 & 7	Foreign Case
8	Personal Trauma
9	Gulf War

Note: The Gulf War modifier (9) is used with all end product codes. The Gulf War modifier of 9 has priority over all other third digit modifiers and is used regardless of what other modifier might also be applicable.

The foreign case modifiers (6) & (7) are only to be used by VARO Houston, Washington Regional Office, and VAMROC White River Junction. This modifier is applicable to EP 120 in addition to EPs 010, 110, 020, and 140.

- *Proposed Tracking List of Issue Specific Claims*

- Agent Orange (AO) (Herbicide Exposure)
- Prisoner of War (POW)
- Radiation
- Asbestos
- PTSD
- AIDS
- Mustard Gas
- Gulf War
- Tobacco
- Sexual Trauma
- 38 U.S.C. 1151
- Prostate cancer
- Peripheral Neuropathy (presumptive basis)
- Hepatitis C
- Character of Discharge
- Sarcodosis
- DRO Ratings
- Biological Agents (Anthrax inoculation)
- Pre-separation cases

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ISSUE SPECIFIC REVIEW EXERCISES HANDOUT

A review is a tool used to judge the level of knowledge the group has acquired as a result of the training. It is not used for an individual evaluation.

Please complete the following review. You will be allowed 15 minutes to complete this task.

1. Identify the five major *Issue Specific Claims*.

- a.
- b.
- c.
- d.
- e.

2. Name two reasons why these issues are special.

- a.
- b.

3. List four types of *Issue Specific Claim* development procedures.

- a.
- b.
- c.
- d.

4. Please read the scenario for Henry McLaughlin and answer the questions that follow.

Henry McLaughlin honorably served with the U.S. Army for four years. During his hitch with the Army, Henry was subjected to exposure to lysergic acid diethylamide (LSD) because he was part of secret experiments. Henry is claiming residual effects to LSD exposure.

- a. Which *Issue Specific Claim* is this?
- b. What development action do you need to take?

(12) TRAINEE HANDOUTS HIV-AIDS HANDOUT

Acquired

Immune

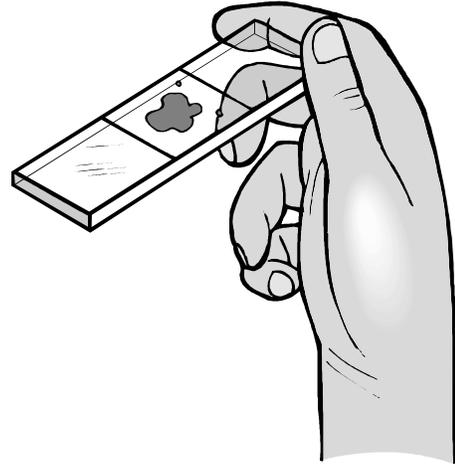
Deficiency

Syndrome

Human

Immunodeficiency

Virus



AIDS or Acquired Immune Deficiency Syndrome

Defined by the *Centers for Disease Control* as a disease at least moderately predictive of a defect in cell-mediated immunity occurring in a person with no known cause for diminished resistance to that disease. AIDS is a syndrome and therefore may be identified by any number of associated diseases. AIDS is caused by HIV.

HIV or Human Immunodeficiency Virus

An infection caused by one of several retroviruses that become incorporated into host cell DNA and result in a wide range of clinical presentations varying from asymptomatic carrier states to severely debilitating and fatal disorders.

Epidemiology

HIV is **not** transmitted by casual contact or even the close non-sexual contact that normally occurs at work, home or in school. HIV is transmitted through bodily fluid contact (i.e. breast milk, blood, semen).

Testing

The most commonly used laboratory test for AIDS is the HIV antibody test. Two antibody tests are available, namely the screening ELISA test and the confirmatory Western Blot.

Reference: Merck Manual, 16th Edition

**(12) TRAINEE HANDOUTS
VA FORM 21-526**

Department of Veterans Affairs	VETERAN'S APPLICATION FOR COMPENSATION OR PENSION
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IMPORTANT - Read instructions carefully before completing this form. Answer all items fully. Detach and retain only the instruction sheets. If more space is required, attach additional sheets and identify each answer by item number. Write clearly or print the answers.

1A. FIRST, MIDDLE, LAST NAME OF VETERAN Michael Garrett Gallagher Sr	1B. TELEPHONE NO. (Include Area Code) DAY: unlisted EVENING: unlisted	(DO NOT WRITE IN THIS SPACE) VA DATE STAMP
1C. IF YOU SERVED UNDER ANOTHER NAME, GIVE NAME AND PERIOD DURING WHICH YOU SERVED AND SERVICE NUMBER.	3A. VETERAN'S SOCIAL SECURITY NO. 123-XX-9876	
2. MAILING ADDRESS OF VETERAN (No. and street or rural route, City or P.O., State and ZIP Code) 1198 Seashore Blvd NW Sarasota, FL 12345	3B. SPOUSE'S SOCIAL SECURITY NO.	
4. DATE OF BIRTH 5/30/1976	5. PLACE OF BIRTH Wilmington, DE	6. SEX M
7. RAILROAD RETIREMENT NO.		

8. HAVE YOU EVER FILED A CLAIM FOR COMPENSATION FROM THE OFFICE OF WORKERS' COMPENSATION PROGRAMS? (Formerly the US Bureau of Employees Compensation) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	9A. VA FILE NO. C- 123-XX-9876
9B. HAVE YOU EVER FILED A CLAIM FOR COMPENSATION FROM THE OFFICE OF WORKERS' COMPENSATION PROGRAMS? (Formerly the US Bureau of Employees Compensation) <input checked="" type="checkbox"/> NONE <input type="checkbox"/> HOSPITALIZATION OR MEDICAL CARE <input type="checkbox"/> DISABILITY PENSION OR COMPENSATION <input type="checkbox"/> VOCATIONAL REHABILITATION <input type="checkbox"/> VETERANS EDUCATIONAL ASSISTANCE <input type="checkbox"/> DEPENDENTS EDUCATIONAL ASSISTANCE <input type="checkbox"/> DENTAL OR OUTPATIENT TREATMENT <input type="checkbox"/> WAIVER OF NSLI PREMIUMS <input type="checkbox"/> OTHER (Specify)	9C. VA OFFICE HAVING YOUR RECORDS (If known)

PART I - SERVICE INFORMATION (See Instructions, Paragraph H)

NOTE: Enter complete information for each period of active duty. Attach DD Form 214 or other separation papers for all periods of active duty to expedite processing of your claim. If you do not have your DD Form 214 or other separation papers check () here

10A. ENTERED ACTIVE SERVICE		10B. SERVICE NO.	10C. SEPARATED FROM ACTIVE SERVICE		10D. GRADE, RANK OR RATING, ORGANIZATION AND BRANCH OF SERVICE
DATE	PLACE		DATE	PLACE	
9/2/1996	Sarasota, FL		5/2/1998	Camp Lejeune	U.S.M.C. E-2

RESERVE AND NATIONAL GUARD SERVICE

11A. ENTERED ACTIVE SERVICE		11B. SERVICE NO.	11C. SEPARATED FROM ACTIVE SERVICE		11D. GRADE, RANK OR RATING, ORGANIZATION AND BRANCH OF SERVICE
DATE	PLACE		DATE	PLACE	

10E. HAVE YOU EVER BEEN A PRISONER OF WAR? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If Yes, complete Items 10F and 10G)	10F. NAME OF COUNTRY	10G. DATES OF CONFINEMENT
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12. IF DISABILITY OCCURRED DURING ACTIVE OR INACTIVE DUTY FOR TRAINING, GIVE BRANCH OF SERVICE AND DATE OF OCCURRENCE

13A. IF YOU ARE NOW A MEMBER OF THE RESERVE FORCES OR NATIONAL GUARD GIVE THE BRANCH OF SERVICE	13B. RESERVE STATUS <input type="checkbox"/> ACTIVE <input type="checkbox"/> RESERVE OBLIGATION <input type="checkbox"/> INACTIVE	13C. RESERVE OR NATIONAL GUARD UNIT ADDRESS
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14A. ARE YOU NOW OR WILL YOU RECEIVE RETIREMENT OR RETAINER PAY FROM THE ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If Yes, complete Items 14B, 14C & 14D)	14B. BRANCH OF SERVICE	14C. MONTHLY AMOUNT \$	14D. RETIRED STATUS <input type="checkbox"/> PERMANENT <input type="checkbox"/> TEMPORARY DISABILITY RETIRED LIST
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15A. HAVE YOU EVER APPLIED FOR OR RECEIVED DISABILITY SEVERANCE PAY FROM THE ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO (If Yes, complete Item 15B)	15B. AMOUNT \$	16A. HAVE YOU RECEIVED LUMP SUM READJUSTMENT OR SEPARATION PAY FROM THE ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If Yes, complete Item 15B)	16B. AMOUNT \$
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NATURE AND HISTORY OF DISABILITIES

17. NATURE OF SICKNESS, DISEASE OR INJURIES FOR WHICH THIS CLAIM IS MADE AND DATE EACH BEGAN
discharged via Physical Evaluation Board(PEB)
pneumonia, decreased T cell count, hairy cell leukoplakia

18A. ARE YOU NOW OR HAVE YOU BEEN HOSPITALIZED OR FURNISHED DOMICILARY CARE WITHIN THE PAST 3 MONTHS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If Yes, complete Items 18B & 18C)	18B. DATES OF HOSPITALIZATION OR DOMICILARY CARE	18C. NAME AND ADDRESS OF INSTITUTION
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YOU MUST SIGN AND DATE THIS FORM AT THE BOTTOM OF PAGE 10.

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SKIP ITEMS 19, 20 AND 21 IF YOU ARE NOT CLAIMING COMPENSATION FOR A SERVICE-CONNECTED DISABILITY				
IF YOU RECEIVED ANY TREATMENT WHILE IN SERVICE, COMPLETE THE FOLLOWING INFORMATION (ATTACH TO THIS APPLICATION COPIES OF ANY SERVICE MEDICAL RECORDS YOU HAVE)				
19A. NATURE OF SICKNESS, DISEASE, OR INJURY	19B. TREATMENT DATES		19C. NAME, NUMBER OR LOCATION OF HOSPITAL, FIRST-AID STATION, DRESSING STATION, OR INFIRMARY	19D. ORGANIZATION/UNIT AT TIME SICKNESS, DISEASE, OR INJURY WAS INCURRED
	BEGINNING DATE	ENDING DATE		
pneumonia	4/15/1998	7/2/1998	Camp Lejeune, N.C.	
20. LIST CIVILIAN PHYSICIANS AND HOSPITALS WHERE YOU WERE TREATED FOR ANY SICKNESS, INJURY, OR DISEASE FOR WHICH YOU ARE CLAIMING SERVICE CONNECTION BEFORE, DURING, OR SINCE YOUR SERVICE, AND ANY MILITARY HOSPITALS SINCE YOUR LAST DISCHARGE.				
A. NAME	B. PRESENT ADDRESS	C. DISABILITY	D. DATE	
21. LIST PERSONS OTHER THAN PHYSICIANS WHO KNOW ANY FACTS ABOUT SICKNESS, INJURY, OR DISEASE SHOWN IN ITEM 19A, WHICH YOU HAD BEFORE, DURING, OR SINCE YOUR SERVICE				
A. NAME	B. PRESENT ADDRESS	C. DISABILITY	D. DATE	
IF YOU CLAIM TO BE TOTALLY DISABLED (Complete Items 22A through 25E)				
22A. ARE YOU NOW EMPLOYED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		22B. IF YOU WERE SELF-EMPLOYED BEFORE BECOMING TOTALLY DISABLED, WHAT PART OF THE WORK DID YOU DO?		
22C. DATE YOU LAST WORKED 7/2/1998		22D. IF YOU ARE STILL SELF-EMPLOYED WHAT PART OF THE WORK DO YOU DO NOW?		
23A. EDUCATION (Circle highest year completed) 1 2 3 4 5 6 7 8 1 2 3 4 1 2 3 4 (GRADE SCHOOL) (HIGH SCHOOL) (COLLEGE)			23B. NATURE OF AND TIME SPENT IN OTHER EDUCATION AND TRAINING	
LIST ALL YOUR EMPLOYMENT, INCLUDING SELF-EMPLOYMENT, FOR ONE YEAR BEFORE YOU BECAME TOTALLY DISABLED				
24A. NAME AND ADDRESS OF EMPLOYER	24B. KIND OF WORK	24C. MONTHS WORKED	24D. TIME LOST FROM ILLNESS	24E. TOTAL EARNINGS
LIST ALL YOUR EMPLOYMENT, INCLUDING SELF-EMPLOYMENT, SINCE YOU BECAME TOTALLY DISABLED				
25A. NAME AND ADDRESS OF EMPLOYER	25B. KIND OF WORK	25C. MONTHS WORKED	25D. TIME LOST FROM ILLNESS	25E. TOTAL EARNINGS
MARITAL AND DEPENDENCY INFORMATION				
26A. MARITAL STATUS (If widowed or divorced, complete Items 26B, 26F, and 29A through 29D only) <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> NEVER MARRIED (If so, do not complete Items 26B through 30D)			26B. SPOUSE'S BIRTH DATE	
26C. NUMBER OF TIMES YOU HAVE BEEN MARRIED	26D. NUMBER OF TIMES YOUR PRESENT SPOUSE HAS BEEN MARRIED	26E. IS YOUR SPOUSE ALSO A VETERAN? (If yes, complete Items 26F, if known) <input type="checkbox"/> YES <input type="checkbox"/> NO		26F. SPOUSE'S VA FILE NO. (If any) C-
27A. DO YOU LIVE TOGETHER? <input type="checkbox"/> YES <input type="checkbox"/> NO (If No, complete Items 27B through 27D)		27B. REASON FOR SEPARATION (For example, marital problems, job requirements, health, etc.)		27C. PRESENT ADDRESS OF SPOUSE
27D. AMOUNT YOU CONTRIBUTE TO YOUR SPOUSE'S SUPPORT MONTHLY \$				
28. CHECK () WHETHER YOUR CURRENT MARRIAGE WAS PERFORMED BY: <input type="checkbox"/> CLERGYMAN OR AUTHORIZED <input type="checkbox"/> PUBLIC OFFICIAL <input type="checkbox"/> OTHER (Explain)				

YOU MUST SIGN AND DATE THIS FORM AT THE BOTTOM OF PAGE 10.

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NOTE: Furnish the following information about each of your marriages. A certified copy of the public or church record of your CURRENT marriage is required.									
29A. DATE AND PLACE OF MARRIAGE	29B. TO WHOM MARRIED	29C. TERMINATED <i>(Death, divorce)</i>	29D. DATE AND PLACE TERMINATED						
FURNISH THE FOLLOWING INFORMATION ABOUT EACH PREVIOUS MARRIAGE OF YOUR PRESENT SPOUSE									
30A. DATE AND PLACE OF MARRIAGE	30B. TO WHOM MARRIED	30C. TERMINATED <i>(Death, divorce)</i>	30D. DATE AND PLACE TERMINATED						
IDENTIFICATION OF CHILDREN AND INFORMATION RELATIVE TO CUSTODY									
NOTE: Furnish the following information for each of your unmarried children. A certified copy of the public or church record of birth or court record of adoption is required.									
31A. NAME OF CHILD <i>(First, middle, initial, last)</i>	31B. DATE OF BIRTH <i>(Month, day, year)</i>	31C. SOCIAL SECURITY NUMBER OF CHILD	31D. CHECK EACH APPLICABLE CATEGORY						
			MARRIED PREVIOUSLY	STEPCHILD OR ADOPTED	ILLEGITIMATE	OVER 18 ATTENDING SCHOOL	SERIOUSLY DISABLED		
Michael Garrett Gallagher Jr.	6/1/1998	123-XX-7890			X				
31E. NAME(S) OF ANY CHILD(REN) NOT IN YOUR CUSTODY Michael		31F. NAME AND ADDRESS OF PERSON HAVING CUSTODY Boonsom Saukseugen, with me in FL		31G. MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT \$					
32A. IS YOUR FATHER DEPENDENT UPON YOU FOR SUPPORT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>(If Yes, complete Item 32 B)</i>		32B. NAME AND ADDRESS OF DEPENDENT FATHER		32C. IS YOUR MOTHER DEPENDENT UPON YOU FOR SUPPORT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>(If Yes, complete Item 32D)</i>					
32D. NAME AND ADDRESS OF DEPENDENT MOTHER		32E. NAME AND ADDRESS OF NEAREST RELATIVE Michael Thomas Gallagher 3 Thorndike Rd, Wilmington, DE 12345			32F. RELATIONSHIP TO NEAREST RELATIVE				
NET WORTH OF VETERANS AND DEPENDENTS									
NOTE: Items 33A through 33D should be completed ONLY if you are applying for nonservice-connected pension.									
ITEM NO.	SOURCE	AMOUNTS			NAME OF CHILDREN				
		VETERAN	SPOUSE						
33A	STOCKS, BONDS, BANK DEPOSITS								
33B	REAL ESTATE <i>(Do not include residence)</i>								
33C	OTHER PROPERTY								
33D	TOTAL NET WORTH								
INCOME RECEIVED AND EXPECTED FROM ALL SOURCES									
NOTE: Items 34A through 34D should be completed ONLY if you are applying for nonservice-connected pension.									
34A. HAVE YOU OR YOUR SPOUSE APPLIED FOR OR ARE YOU RECEIVING OR ENTITLED TO RECEIVE ANY BENEFITS FROM THE SOCIAL SECURITY ADMINISTRATION (OTHER THAN SSI) OR RAILROAD RETIREMENT BOARD? <i>(If yes, complete Items 34B through 34F as applicable)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO		34B. MONTHLY AMOUNT <i>(Include Medicare Deduction)</i>		34C. BEGINNING DATE		34D. DATE YOU EXPECT BENEFITS TO BEGIN			
		VETERAN							
		SPOUSE							
		34E. WILL YOU OR YOUR SPOUSE APPLY FOR EITHER BENEFIT DURING THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO		34F. DATE OF INTENTION TO APPLY					
		VETERAN		SPOUSE					
35A. HAVE YOU OR YOUR SPOUSE APPLIED FOR OR ARE YOU RECEIVING OR ENTITLED TO RECEIVE ANNUITY OR RETIREMENT BENEFITS OR ENDOWMENT INSURANCE FROM ANY SOURCE? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If yes, complete Items 35B through 35F)</i>									
YOU MUST SIGN AND DATE THIS FORM AT THE BOTTOM OF PAGE 10.									

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35B. MONTHLY AMOUNT	35C. BEGINNING DATE	35D. DATE OF INTENTION TO APPLY	35E. SOURCE OF BENEFITS		
VETERAN					
SPOUSE					
VETERAN'S AND DEPENDENTS' MONTHLY INCOME					
NOTE: For each source report gross monthly amount, including deductions, for each family member					
ITEM NO.	SOURCE OF MONTHLY INCOME	AMOUNTS (If none, write NONE or "0")			
		VETERAN	SPOUSE	NAME OF CHILDREN	
36A	SOCIAL SECURITY				
36B	U.S. CIVIL SERVICE				
36C	U.S. RAILROAD RET.				
36D	MILITARY RETIREMENT				
36E	BLACK LUNG BENEFIT				
36F	SSI/PUBLIC ASSISTANCE				
36G	ALL OTHER MONTHLY				
VETERAN'S AND DEPENDENTS' OTHER INCOME					
NOTE: Please provide the amount of annual income or one-time nonrecurring income (specify source) for the 12 month period preceding the date the claim is filed with the Department of Veterans Affairs.					
37A	TOTAL WAGES				
37B	TOTAL INTEREST/DIVIDENDS				
37C	ALL OTHER INCOME				
NOTE: Please provide the amount of expected annual income or one-time nonrecurring income (specify source) for the 12 month period following the date the claim is filed with the Department of Veterans Affairs.					
38A	TOTAL WAGES				
38B	TOTAL INTEREST/DIVIDENDS				
38C	ALL OTHER INCOME				
39A. GROSS AMOUNT OF FINAL PAY	40. REMARKS (Identify your statements by their applicable item number. If additional space is required, attach separate sheet and identify your statements by their item numbers.)				
39B. DATE FINAL PAY RECEIVED					
NOTE: Items 41A through 41G should be completed only if you are applying for nonservice-connected pension					
INFORMATION CONCERNING MEDICAL, LEGAL, OR OTHER EXPENSES					
NOTE: Family medical expenses actually paid by you may be deductible from your income. Show the amount of unreimbursed medical expenses you paid for yourself or relatives you are under an obligation to support. Also, show medical, legal or other expenses you paid because of a disability for which civilian disability benefits have been awarded. When determining your income, we may be able to deduct them from the disability benefits for the year in which the expenses are paid. Do not include any expenses for which you were reimbursed. Show the Medicare deduction in line 1.					
41A. AMOUNT PAID BY YOU	41B. DATE PAID	41C. PURPOSE (Doctor's fees, hospital charges, etc.)	41D. PAID TO (Name of doctor, pharmacy, Attorney, etc.)	41E. DISABILITY OR RELATIONSHIP OF PERSON FOR WHOM EXPENSES PAID	
		Medicare (Part B)	SOCIAL SECURITY ADMINISTRATION		
41F. ARE YOU NOW A PATIENT IN A NURSING HOME? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If Yes, complete Item 41G)		41G. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If yes, give the name and address of the nursing home in Item 40. Remarks)			
NOTE: Filing of this application constitutes a waiver of military retired pay in the amount of any VA compensation to which you may be entitled. See instructions for Items 14A through 14D inclusive, Retired Pay.					
CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION - I CERTIFY THAT the foregoing statements are true and complete to the best of my knowledge and belief. I CONSENT THAT any physician, surgeon, dentist, or hospital that has treated or examined me for any purpose, or that I have consulted professionally, may furnish to the Department of Veterans Affairs any information about myself, and I waive any privilege which renders such information confidential. DO YOU WANT TO HAVE MEDICAL AND OTHER INFORMATION ABOUT YOU INCLUDED IN THE "GULF WAR VETERANS HEALTH REGISTRY?" (See "GENERAL INSTRUCTIONS", paragraph K.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
42. SIGNATURE OF CLAIMANT				43. DATE SIGNED	
SIGN HERE ► <i>Michael Garrett Gallagher Sr</i>				5/3/1998	
WITNESS TO SIGNATURE OF CLAIMANT IF MADE BY "X" MARK					
NOTE: A signature by mark must be witnessed by two persons to whom the person making the statement is personally known. The witnesses must sign their names in Items 44A and 45A and type or print their names and address in Items 44B and 45B.					
44A. SIGNATURE OF WITNESS			45A. SIGNATURE OF WITNESS		
44B. NAME AND ADDRESS OF WITNESS (Type or print)			45B. NAME AND ADDRESS OF WITNESS (Type or print)		
PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.					

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EXPOSURE TO MUSTARD GAS (LEWISITE) HANDOUT
38 CFR §3.316

American Service Personnel Were Exposed to Mustard Gas

- During warfare in WWI and WWII
- During experiments on protective clothing and equipment during WWII (*either full body or localized*)
- While manufacturing and handling vesicant agents in service

Effects of Exposure

Direct contact produces local damage and the effects are delayed with symptoms occurring hours or days later.

How to Identify the Characteristics of a Claim for Disabilities Resulting from Exposure to Mustard Gas

Development for evidence of full-body exposure to mustard gas or lewisite is necessary only:

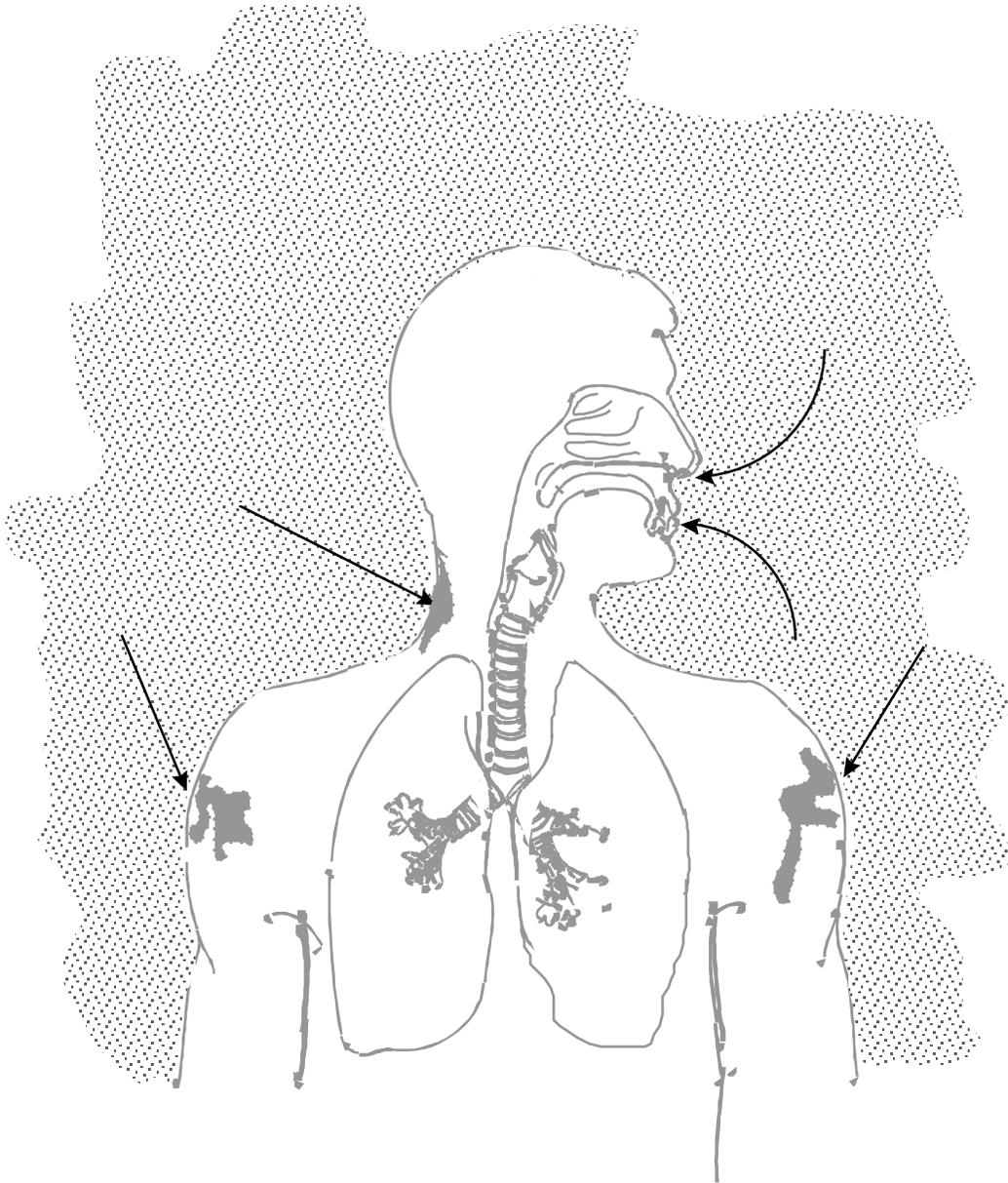
- If the veteran claims exposure, or
- If the veteran claims a mustard gas condition, or
- If the veteran's name is included in the list of test participants.

Presumptive Conditions for Mustard Gas Exposure

Keratitis	Chronic Bronchitis
Chronic Emphysema	Chronic Conjunctivitis
Scar Formation	Corneal Opacities
Laryngeal Cancer	Chronic Laryngitis
Nasopharyngeal Cancer	Chronic Asthma
Lung Cancer (<i>except Mesothelioma</i>)	
Acute Nonlymphocytic Leukemia	
Squamous Cell Carcinoma of Skin	
Chronic Obstructive Pulmonary Disease	

(12) TRAINEE HANDOUTS
GRAPHIC REPRESENTATION OF MUSTARD GAS EXPOSURE

Exposure to Mustard Gas



Mustard Gas affects the areas it touches--
skin, respiratory systems

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HIV-AIDS REVIEW

A review is a tool used to judge the level of knowledge the group has acquired as a result of the training. It is not used for an individual evaluation.

Please complete the following review. You will be allowed 15 minutes to complete this task.

1. Please indicate what type of test is utilized for the detection of HIV and name the two most commonly used tests.

2. Please review the attached VA Form 21-526 for Michael G. Gallagher, Sr., and answer the following questions. Note: all service medical records and service personnel records are attached with the form.

A: Is this a claim for HIV/AIDS?

B: What, if any information, is necessary to properly process this claim? Explain what information is required and how you would request it, or explain why no development action is necessary.

3. How is HIV transmitted?

4. What does AIDS stand for? Define the disease AIDS.

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MUSTARD GAS REVIEW EXERCISE

A review is a tool used to judge the level of knowledge the group has acquired as a result of the training. It is not used for an individual evaluation.

Please complete the following review. You will be allowed 15 minutes to complete this task.

1. Under what circumstances were Americans exposed to mustard gas?
2. What 38 CFR governs mustard gas? What was the effective date?
3. What are the effects of exposure?
4. When is development for exposure to mustard gas required?
5. Name 5 of the presumptive conditions associated with mustard gas.