OMB Approved No. 2900-0324
Respondent Burden: 45 Minutes

Department of Veterans Affairs

ATTENDING PHYSICIAN'S STATEMENT

Important Notice About Information Collection: We need this information to determine, establish or verify your eligibility for VA Insurance benefits (38 U.S.C. 5902) Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 45 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet page at www.whitehouse.gov/library/omb/OMBINVC.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

Privacy Act Notice: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 5, Code of Federal Regulations 1.526 for routine uses identified in the VA system of records, 36VA00, Veterans and Armed Forces Personnel U.S. Government Life Insurance Records-VA, published in the Federal Register. Your obligation to respond is voluntary, but your failure to provide us the information could impede processing. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The responses you submit are considered confidential (38 U.S.C. 5701).

1. NAME OF APPLICANT ***(Type or print)***	2. INSURANCE FILE NUMBER

NOTICE TO APPLICANT	NOTICE TO PHYSICIAN
Any examination required in connection with V, RS, W, or RH insurance or in connection with reinstatement or change of plan of "J" insurance may be made by medical officers in active service or physicians of the U.S. Public Health Service, for those entitled, or may be made free of charge by a physician of the VA Regional Office or Medical Center. The examination may also be made at the applicant's own expense by a physician duly licensed for practice of medicine by a State, Territory or Possession of the United States, or District of Columbia, who is not related to the applicant, by blood or marriage, associated with his/her business, or financially interested in the granting of this insurance. Any medical examination required in connection with the insurance of the Total Disability Income Provision to "J" insurance must be made at the applicant's own expense.	Please furnish all pertinent information. If more space is needed, you may use the reverse of this form. The completed form should be sent to: Department of Veterans Affairs Regional Office and Insurance Center P.O. Box 7208 Philadelphia, PA 19101

SECTION I - TO BE COMPLETED BY APPLICANT (Complete applicable items)

3. DATE FIRST SEEN BY PHYSICIAN	4. TIME LOST FROM WORK	5. DATE RETURNED TO WORK
6. DATE OF ILLNESS, DISEASE OR INJURY - SYMPTOMS AND NATURE OF IMPAIRMENT		
7. SIGNATURE OF APPLICANT ***(Do not print)***		8. DATE

SECTION II - TO BE COMPLETED BY PHYSICIAN (Complete applicable items)

9. DETAILED HISTORY OF SYMPTOMS AND TREATMENT ***(Medical, surgical - including any complications)***		
10. NAMES AND ADDRESSES OF HOSPITALS WHERE TREATED - DATES OF HOSPITALIZATION		
11. NAMES AND ADDRESSES OF ATTENDING PHYSICIANS - DATES OF TREATMENT		
12. PHYSICAL EXAMINATION - GIVE SPECIFIC ATTENTION TO AREAS INVOLVED		
13. X-RAY REPORT ***(Do not send film)***		14. LABORATORY REPORT
15. DIAGNOSIS	16. IS CONDITION: ☐ STATIONARY ☐ PROGRESSIVE ☐ RECURRENT	17. PROGNOSIS
18. NAME OF PHYSICIAN ***(Type or print)***	19. DATE EXAMINED	20. STATE IN WHICH LICENSED TO PRACTICE
21. SIGNATURE OF PHYSICIAN ***(Do not print)***		22. ADDRESS OF PHYSICIAN ***(City, county, State and ZIP Code)***