Post Examination Assessment Form

VA File Number: _____

Please Type or Print

Full Name of Veteran: _____ Date of Birth (mm/dd/yyyy): _____

Veteran Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Email: _____

Type of Exam: ☐ Comp & Pen Exam ☐ VA Medical Exam ☐ Civilian Medical Exam

☐ Cardiovascular	☐ General Surgery	☐ Neurological
☐ Dental & Oral	☐ Genitourinary	☐ Ophthalmological
☐ Dermatological	☐ Gynecological	☐ Psychological
☐ Ear, Nose & Throat	☐ Hematologic & Lymphatic	☐ Respiratory
☐ Endocrinological	☐ Infectious Disease	☐ Rheumatological
☐ Gastrointestinal	☐ Musculoskeletal	

Examine Performed By: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

Email: _____

Date of Exam (mm/dd/yyyy): _____ Start Time for Exam: _____

Exam Findings Witnessed by Veteran: _____

_____

_____

_____

Travel Check Received: ☐ Yes ☐ No

If "No," why not? _____

_____

Veteran Signature: _____ Date: _____

☐ **By signing above I confirm all information on this form is completed to the best of my abilities.**

NOTICE: This form may be used by the veteran to record their examination results as perceived by the veteran. Your personal information and all relevant health information you provide on this form will be viewed and/or exchanged with other healthcare professionals, veterans service officers, and Department of Veterans Affairs (VA) staff members, for the purpose of assessing your current health condition. The information you provide may or may not be used for future healthcare considerations and/or ratings. All information you provide and send to any healthcare organization via fax, email, hand-deliver or U.S. Postal Service using this form is done of your on volition. U.S. Veteran Compensation Programs (USVCP) is not responsible for content, errors or inaccuracies on this form.

Instructions

1. Use the Post Examination Assessment Form (USVCP Form 200) to record results of your medical examinations. It may be best to record information on form immediately after your examination.
2. If sending form to your Department of Veterans Affairs Regional Office (VARO), Veterans Service Officer (VSO), attorney, or veterans organization representative assisting you with your claim, the information on form may be helpful documentation for staff member(s) to use as supportive evidence for your claim.

Where To Send Documentation

If you live in any of the following locations:

United States

Alabama, Connecticut, Delaware, District of Columbia, Florida, Georgia, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, Mississippi, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Puerto Rico

Other Locations

Europe, Asia, Australia, Africa, Canada, Palau, Marshall Islands, The U.S. Virgins Islands, Federated States of Micronesia

Send your evidence/correspondence to:

Mail
Department of Veterans Affairs
Evidence Intake Center
P.O. Box 4444
Newman, GA 30271-0020

Fax
1-844-531-7818

DID
1-248-524-4260

If you live in any of the following locations:

United States

Alaska, Arizona, Arkansas, California, Colorado, Louisiana, Hawaii, Idaho, Illinois, Iowa, Kansas, Oklahoma, Oregon, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, South Dakota, Texas, Utah, Washington, Wisconsin, Wyoming

Other Locations

Mexico, Central America, South America, Caribbean, Philippines, American Samoa, Guam, Northern Mariana Islands

Send your evidence/correspondence to:

Mail
Department of Veterans Affairs
Evidence Intake Center
P.O. Box 4444
Janesville, WI 53547-4444

Fax

1-844-822-5246

DID

1-608-373-6690

Note: If you are being represented by an attorney, VSO, or veterans organization staff member(s), it may be helpful for you to send form to them as supportive evidence for your claim.