



Department of Veterans Affairs

NOTICE OF DISAGREEMENT

A CLAIMANT OR HIS OR HER DULY APPOINTED REPRESENTATIVE MAY FILE NOTICE EXPRESSING THEIR DISSATISFACTION OR DISAGREEMENT WITH AN ADJUDICATIVE DETERMINATION BY THE AGENCY OF ORIGINAL JURISDICTION. A DESIRE TO CONTEST THE RESULT WILL CONSTITUTE A NOTICE OF DISAGREEMENT (NOD.) WHILE SPECIAL WORDING IS NOT REQUIRED, THE NOD MUST BE IN TERMS WHICH CAN BE REASONABLY CONSTRUED AS DISAGREEMENT WITH THAT DETERMINATION AND A DESIRE FOR APPELLATE REVIEW. (AUTHORITY: 38 U.S.C. 7105)

TO FILE A VALID NOD, THERE IS A TIME LIMIT OF ONE YEAR FROM THE DATE VA MAILED THE NOTIFICATION OF THE DECISION TO THE CLAIMANT. FOR CONTESTED CLAIMS INCLUDING CLAIMS OF APPORTIONMENT, THIS TIME LIMIT IS 60 DAYS FROM THE DATE VA MAILED THE NOTIFICATION OF THE DECISION TO THE CLAIMANT.

**(DO NOT WRITE IN THIS SPACE)
(VA DATE STAMP)**

PART I - PERSONAL INFORMATION

1A. VETERAN'S FIRST NAME Gulf	1B. MIDDLE NAME War	1C. LAST NAME Veteran
2. VA FILE NUMBER C/CSS - 11111111		3. VETERAN'S SOCIAL SECURITY NUMBER

CLAIMANT'S PERSONAL INFORMATION

4A. CLAIMANT'S FIRST NAME	4B. MIDDLE NAME	4C. LAST NAME
5. STREET ADDRESS	6. APT. NO.	7. CITY
	8. STATE	9. ZIP CODE
10. DAYTIME TELEPHONE NUMBER	11. EVENING TELEPHONE NUMBER	12. EMAIL ADDRESS

PART II - TELEPHONE CONTACT

13. WOULD YOU LIKE TO RECEIVE A TELEPHONE CALL OR EMAIL FROM A REPRESENTATIVE AT YOUR LOCAL REGIONAL OFFICE REGARDING YOUR NOD?

YES NO *(If you answered "Yes," VA will make up to two attempts to call you between 8:00 a.m. and 4:30 p.m. local time at the telephone number and time period you select below. Please select up to two time periods you are available to receive a phone call.)*

8:00 a.m. - 10:00 a.m. 10:00 a.m. - 12:30 p.m. 12:30 p.m. - 2:00 p.m. 2:00 p.m. - 4:30 p.m.

Phone number I can be reached at the above checked time: (222) 333-4444

PART III - SPECIFIC ISSUES OF DISAGREEMENT

14. NOTIFICATION/DECISION LETTER DATE

11/20/2014

15. PLEASE LIST EACH SPECIFIC ISSUE OF DISAGREEMENT AND NOTE THE AREA OF DISAGREEMENT. IF YOU DISAGREE ON THE EVALUATION OF A DISABILITY, SPECIFY PERCENTAGE EVALUATION SOUGHT, IF KNOWN. PLEASE LIST ONLY ONE DISABILITY IN EACH BOX. YOU MAY ATTACH ADDITIONAL SHEETS IF NECESSARY.

A. Specific Issue of Disagreement	B. Area of Disagreement	C. Percentage (%) Evaluation Sought <i>(If known)</i>
Undiagnosed symptom joint pains due to my service in the gulf war	<input checked="" type="checkbox"/> Service Connection <input type="checkbox"/> Effective Date of Award <input type="checkbox"/> Evaluation of Disability <input type="checkbox"/> Other <i>(Please specify)</i>	
Undiagnosed symptom of muscle pains due to my service in the gulf war	<input checked="" type="checkbox"/> Service Connection <input type="checkbox"/> Effective Date of Award <input type="checkbox"/> Evaluation of Disability <input type="checkbox"/> Other <i>(Please specify)</i>	
Undiagnosed symptom of diarrhea due to my service in the gulf war	<input checked="" type="checkbox"/> Service Connection <input type="checkbox"/> Effective Date of Award <input type="checkbox"/> Evaluation of Disability <input type="checkbox"/> Other <i>(Please specify)</i>	30

PART III - SPECIFIC ISSUES OF DISAGREEMENT (Continued)

A. Specific Issue of Disagreement	B. Area of Disagreement	C. Percentage (%) Evaluation Sought (If known)
	<input type="checkbox"/> Service Connection <input type="checkbox"/> Effective Date of Award <input type="checkbox"/> Evaluation of Disability <input type="checkbox"/> Other (Please specify)	
	<input type="checkbox"/> Service Connection <input type="checkbox"/> Effective Date of Award <input type="checkbox"/> Evaluation of Disability <input type="checkbox"/> Other (Please specify)	

16A. IN THE SPACE BELOW, OR ON A SEPARATE PAGE, PLEASE EXPLAIN WHY YOU FEEL WE INCORRECTLY DECIDED YOUR CLAIM, AND LIST ANY DISAGREEMENT(S) NOT COVERED ABOVE:

The rater is in error for denying my claim on these 3 issues by not applying "undiagnosed illnesses" regulations as found in CFR 38§ 3.317 (a) (1) (ii), CFR 38§ 3.317 (a) (2), CFR 38§ 3.317 (a) (3) and as found in the VA TL 10-01.

My symptoms did not show up in medical test as per CFR 38§ 3.317 (a) (3).

I feel that the rater did not follow M21-1MR, Part IV.ii.2.D (rating GW claims) right as my claim was denied on the grounds that my illness could not be diagnosed. That would mean I met the requirement of 3.317 for the granting of the claim as an undiagnosed illness, as long as the rest of the regulation is there.

The rater erred by not listing what rating code was used to rate my claims with to say why I did not meet a 10% rating as is required by the regulations. Also see (Stankevich v. Nicholson)

(Veteran needs to add here how they see PCP, meds, how long ECT)

16B. DID YOU ATTACH ADDITIONAL PAGES TO THIS NOD?

YES NO (If so, how many?)

PART IV - CERTIFICATION AND SIGNATURE

I CERTIFY THAT THE STATEMENTS ON THIS FORM ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

17A. SIGNATURE

17B. DATE SIGNED

PENALTY: THE LAW PROVIDES SEVERE PENALTIES WHICH INCLUDE A FINE, IMPRISONMENT, OR BOTH, FOR THE WILLFUL SUBMISSION OF ANY STATEMENT OR EVIDENCE OF A MATERIAL FACT, KNOWING IT TO BE FALSE.