ARMY BOARD FOR CORRECTION OF MILITARY RECORDS

RECORD OF PROCEEDINGS

IN THE CASE OF: [redacted]

BOARD DATE: 4 October 2024

DOCKET NUMBER: AR20230014419

APPLICANT REQUESTS:

- reconsideration of his prior request for a physical disability separation or retirement
- a personal appearance before the Board

APPLICANT'S SUPPORTING DOCUMENT(S) CONSIDERED BY THE BOARD:

- DD Form 293 (Application for the Review of Discharge from the Armed Forces of the United States)
- numerous pages of Chart Notes from Ireland Clinic of Chiropractic, LLC, from 28 June 2018 – 16 October 2018
- Magnetic Resonance Imaging (MRI), Cervical Spine, 14 September 2018
- Radiology Administrative Note, 24 March 2020
- Compensation and Pension (C&P) Examination Note, PTSD, Initial Evaluation, 17 April 2020
- Record of Proceedings for Army Board for Correction of Military Records (ABCMR) case in Docket Number AR20220011505, 21 June 2023

FACTS:

1. Incorporated herein by reference are military records which were summarized in the previous consideration of the applicant's case by the ABCMR in Docket Number AR20220011505 on 21 June 2023.

2. The applicant states:

a. He was cheated out of a Medical Evaluation Board (MEB)/Physical Evaluation Board (PEB) for his service-connected post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), sleep apnea, spinal injuries, planter fasciitis, vertigo, and moderate to severe cervical strain. He would like to submit medical information explaining how his chain of command refused to acknowledge these issues at the time.

b. He read the Board's denial of his prior application and would like to point out several discrepancies and inaccuracies in that decision letter. He strongly disagrees with the Board's decision and will explain why this military injustice makes absolutely no sense. He wants to speak directly to the Board about his case and wants to know what he needs to do to make that happen. He would also like to remove his prior Counsel from his case effective immediately.

c. The first thing he would like to question is why the Brigade Surgeon started an MEB/PEB for him in 2016, but then was told to abruptly stop and close the file. The Brigade Surgeon had reported a mild to moderate vitamin D deficiency in his medical records but ignored every other injury up to that point. This incident is ear marked in his Army medical records and has been pointed out to him by several civilian doctors.

d. When he filed his medical issues with the Department of Veterans Affairs (VA) Claims and Pensions in Anchorage, AK, he was given a physical exam by the VA. They knowingly left out his Combat Infantryman Badge (CIB), combat orders for 27 months of service in Afghanistan, written statements pertaining to combat operations, and instead pushed for a diagnosis of attention deficit hyperactivity disorder (ADHD) instead of PTSD and TBI, when the Army's own medical records clearly states otherwise. He has on record a bad fall through a roof in Afghanistan, two bad parachute jumps, and a military vehicle accident in Vicenza, Italy, in 2007. He was ignored for months by the VA and was forced to hire an attorney out of pocket to get the claims corrected. PTSD and TBI were eventually recognized by the VA as combat-related.

e. The civilian neurologists and chiropractors always have this puzzled look on their faces when they see his medical records showing he has a moderate to severe cervical strain with radiculopathy, several TBIs (in-service), a pelvic floor injury and brain fog related to parachute jumps, several spinal injuries, sleep disorder (a sleep apnea test was done in service) vitamin D deficiency, melanoma removed from his cheek while in service, several lower back cortisol injections done while in service as pain management treatment, Brostrom reconstructive surgery on the left ankle resulting from fallen arches, pronating ankle, plantar fasciitis with neuropathy, balance issues, vertigo, and two vascular surgeries on both legs for burst varicose veins.

f. He was in no shape to take an Army Physical Fitness Test (APFT) in 2017, so he is not sure who "hand-jammed" an APFT card for him, but he has a rather good idea about who it may have "hand-jammed" his APFT card. He also had a mental health visit that the Record of Proceedings does not talk about. If you look a little further past the APFT card date, you will see his unit commander (his Rater) and the first sergeant (1SG) who signed that APFT card and his Noncommissioned Officer Evaluation Report (NCOER), were relieved for cause in Afghanistan just a few months later, due to a sexual assault case involving his unit commander and two subordinate male Soldiers, if his memory serves him right. This type of false, and inaccurate reporting has always

plagued that unit. This flimsy piece of paper called an APFT card, written by questionable leadership, was not a strong indicator of his physical and mental health at the time. He wonders why the Board would you use one piece of information against him and then ignore the other insurmountable pile of concrete evidence provided and recorded by the Army.

g. These service-connected injuries compounded and place a huge burden on his family. He is unable to work full-time and he can not push past this pain he feels every day when he wakes up. He had some real medical issue, which severely impacted his performance as a senior NCO in and airborne brigade durign his last few years in the Army. He does not understand the cold and heartless response for his honorable service to this country. He gave the Army everything he had and then some, only to be discarded like a piece of trash that reached its shelf life.

h. He provided a reference showing why he could no longer wear an Advanced Combat Helmet (ACH); it was due to the moderate to severe cervical strain on his neck with radiculopathy. He was also unable to wear body armor or drive in military vehicles for longer than 30 minutes without feeling intense pressure in his pelvic floor because of several spinal injuries. Please help him understand why this information was completely ignored and disregarded. His service-connected disabilities listed above do not meet retention standards in accordance with Army Regulation 40-501 (Standards of Medical Fitness). Thank you for taking the time to read his rebuttal.

3. The applicant enlisted in the Regular Army on 12 November 2003, and was awarded the Military Occupational Specialty (MOS) 11B (Infantryman).

4. A Standard Form 600 (Chronological Record of Medical Care), shows on 14 March 2005, the applicant was seen for evaluation of his neck pain, with stiffness and little mobility after a motor vehicle accident. He had neck and back pain after standing for prolonged periods and moving around made it worse. He as assessed with muscular skeletal strain and prescribed Percocet and Flexeril.

5. Multiple documents titled Medical Record, all of which have been provided in full to the Board for review, and in pertinent part show:

a. On 20 December 2005, he reported numbness (hypesthesia), date of onset unknown.

b. On 6 February 2006, he was involved in a motor vehicle traffic accident wherein he fractured his vertebral column.

6. He served in Afghanistan from 12 May 2007 to 19 July 2008.

7. Multiple documents titled Medial Record show:

a. On 26 July 2008, the applicant reported varicose veins of the lower extremities, date of onset unknown.

b. On 18 November 2010, the applicant reported and was seen for adjustment disorder, date of onset unknown.

8. He served in Afghanistan from 1 December 2009 to 1 December 2010.

9. A DD Form 2900 (Post-Deployment Health Re-Assessment (PDHRA)), shows the applicant completed the form on 3 March 2011, indicating:

- he redeployed from Afghanistan on 8 November 2010
- overall, he would rate his health in the past month as excellent
- compared to before his most recent deployment he would rate his health in general about the same as before he deployed
- a deployment-related condition of his was vascular issues
- he experienced a blast or explosion
- he had symptoms of irritability
- the health care provider indicated there was no evidence of TBI and remarked the applicant was seeking care for his chronic vascular issues with his right leg

10. A Medical Record shows the applicant was seen for acquired deformity of ankle on 13 June 2013.

11. A DA Form 1059 (Service School Academic Evaluation Report), dated 21 July 2015, shows:

a. This is a referred report.

b. The applicant failed to achieve course standards while attending Maneuver Senior Leader Course at Fort Benning, GA, from 7 July 2015 through 21 July 2015, and was released from the course due to academic deficiency, after failing to achieve a passing score on an examination on the initial exam and the reexamination.

c. He passed his APFT on 8 July 2015.

12. A DA Form 2166-9-2 (NCOER (Staff Sergeant (SSG) – First Sergeant (1SG)/Master Sergeant (MSG), covering the rating period from 2 September 2015 through 2 May 2016, shows:

a. The applicant was rated in his principal duty title as Platoon Sergeant.

b. Part IV (Performance Evaluation, Professionalism, Attributes, and Competencies) shows:

- he was rated by his Rater as either “Met Standard” or “Exceeded Standard” in all sections
- he passed his APFT on 1 December 2015

13. A second DA Form 1059, dated 11 July 2016, shows:

a. This is a referred report.

b. The applicant failed to achieve course standards while attending Maneuver Senior Leader Course at Fort Benning, GA, from 11 July 2016 through 25 July 2016, and was released from the course due to academic deficiency after failing to achieve a passing score on an examination on the initial exam and the reexamination.

c. He passed his APFT on 12 July 2016.

14. A Medical Record, dated 28 October 2016, shows the applicant underwent an MRI of the brain without contrast. The reason for the order was a history of previous mild concussion.

15. A U.S. Army Human Resources Command (AHRC) memorandum, dated 3 April 2017, shows:

a. The applicant was notified he was denied continued active duty service under the Qualitative Management Program (QMP).

b. A QMP Selection Board conducted a comprehensive review of his record for potential denial of continued service under the QMP and recommended he be denied continued active duty service.

c. The Director of Military Personnel Management approved the Board’s recommendation and he was advised he would be involuntarily discharged from the Army no later than 1 November 2017.

d. He was advised he had the option to request an earlier separation date or appeal the decision and request retention on active duty based on newly discovered evidence, removal of documents from his Army Military Human Resource Record (AMHRR), or material error.

16. Multiple additional documents titled Medical Record show:

a. A Left Ankle Series Report dated, 5 May 2017, shows radiologic imaging reflects no evidence fracture or dislocation; mild tibiotalar joint space narrowing and marginal osteophyte formation. The impression shows no acute findings; mild tibiotalar arthrosis.

b. A Right Forearm Series Report ,dated 8 May 2017, shows radiologic imaging reflects early osteoarthrosis of the radiocarpal joint; nonunion of the ulna styloid; no acute fracture or dislocation identified; soft tissues are unremarkable.

c. A Left Ankle Series Report, dated 30 May 2017, shows radiologic imaging reflects no fracture or significant degenerative changes; mild pes planus; small ankle joint effusion; mild lateral soft tissue swelling. The impression shows no acute osseous abnormality; mild pes planus.

d. A Left Foot Weight Bearing Series Report, dated 30 May 2017, shows radiologic imaging reflects no fracture or significant degenerative changes; mild pes planus; small ankle joint effusion; mild lateral soft tissue swelling. The impression shows no acute osseous abnormality; mild pes planus

e. The applicant was seen for other spondylosis with radiculopathy, lumbosacral region on 19 June 2017.

f. An MRI L-Spine Without Contrast Report, dated 29 June 2017, shows an impression of degenerative disc disease at L4-L5 and L5-S1 and sub-centimeter T2 hyperintense left renal lesion is incompletely characterized, but likely a simple cyst.

17. Installation Management Command Orders 194-0175, dated 13 July 2017, honorably discharged the applicant under the provisions of Army Regulation 635-200 (Active duty Enlisted Administrative Separations) effective 1 November 2017, with entitlement to 5 percent separation pay.

18. A second NCOER, covering the rating period from 3 May 2016 through 2 August 2017, shows:

a. The applicant was rated in his principal duty title as Brigade Marksmanship NCO in charge (NCOIC).

b. Part IV shows:

- he was rated by his Rater as either “Met Standard” or “Exceeded Standard” in all sections
- he passed his APFT on 7 December 2016

19. A physical profile is used to classify a Soldier's physical disabilities in terms of six factors or body systems, as follows: "P" (Physical capacity or stamina), "U" (Upper extremities), "L" (Lower extremities), "H" (Hearing), "E" (Eyes), and "S" (Psychiatric) and is abbreviated as PULHES. Each factor has a numerical designation: 1 indicates a high level of fitness, 2 indicates some activity limitations are warranted, 3 reflects significant limitations, and 4 reflects one or more medical conditions of such a severity that performance of military duties must be drastically limited. Physical profile ratings can be either permanent (P) or temporary (T).

20. The applicant previously provided a partial DD Form 2808 (Report of Medical Examination), dated 21 August 2017, which consists of page one, showing he underwent medical examination on the date of the form for the purpose of separation. The portion of the form reflecting his PULHES and the medical provider's assessment of his qualification for separation or retention is not included. The only items listed as "abnormal" are identifying body marks in the form of tattoos on the left deltoid upper back.

21. A DD Form 2807-1 (Report of Medical History) shows the applicant provided his medical history in 2017 for the purpose of separation.

a. He indicated he had:

- painful shoulder, elbow, or wrist
- foot trouble
- impaired use of arms, legs, hands, or feet
- swollen or painful, knee trouble
- knee or foot surgery
- broken bones
- frequent indigestion or heartburn
- dizziness or fainting spells
- headache
- head injury
- concussion
- pain or pressure in the chest
- high or low blood pressure
- nervous trouble, including memory loss and frequent trouble sleeping

b. The medical examiners comments, dated 22 August 2017, include reference to two concussions, occasional hemorrhoids, right epicondylitis (tennis elbow).

22. A Medical Record, Active Problems, dated 5 October 2017 shows the applicant's conditions of calculus of kidney and radiculopathy, lumbar region, reported on the date of the form.

23. The applicant's available service records do not contain a DA Form 3349 (Physical Profile) nor do they show:

- he was issued a permanent physical profile rating
- he suffered from a medical condition, physical or mental, that affected his ability to perform the duties required by his MOS and/or grade or rendered him unfit for military service
- he was diagnosed with a medical condition that warranted his entry into the Army Physical Disability Evaluation System (PDES)
- he was diagnosed with a condition that failed retention standards and/or was unfitting

24. The applicant's DD Form 214 (Certificate of Release or Discharge from Active Duty) shows:

a. He was honorably discharged on 1 November 2017, under the provisions of Army Regulation 635-200, chapter 4, due to non-retention on active duty, with corresponding separation code JGH.

b. He was credited with 13 years, 11 months, and 20 days of net active service and received separation pay in the amount of $34,140.65.

c. Among his decorations, medals, and badges awarded or authorized are the Afghanistan Campaign Medal with two campaign stars, Combat Infantryman Badge, Expert Infantryman Badge, Ranger Tab, and Parachutist Badge.

25. The applicant's Enlisted Record Brief (ERB), dated 2 November 2017, shows:

- his PULHES was 112111, with a physical profile rating of "2" in factor L for lower extremities
- his medical readiness classification code (MRC) was "1" (fully medically ready; deployable)
- he passed his last APFT in October 2016, with a score of 280 out of 300
- his last physical exam was 9 May 2017

26. A VA Rating Decision, dated 6 April 2018, shows the applicant was granted service-connection for the following conditions effective 2 November 2017:

- obstructive sleep apnea (OSA), 50 percent
- bilateral pes planus, 30 percent
- healed fracture, right wrist (dominant), 10 percent
- intervertebral disc syndrome (IVDS) lumbosacral spine L4-L5, L5-S1 with spondylolisthesis, 10 percent
- radiculopathy, left lower extremity secondary to service-connected IVDS lumbosacral spine L4-L5, L5-S1 with spondylolisthesis, 20 percent
- left ankle, collateral ligament sprain with tendonitis, status post Bostrom reconstructive surgery, 10 percent
- right distal radius fracture residuals (dominant), 10 percent
- tinnitus, 10 percent
- nephrolithiasis (kidney stones) with right renal cortical syst, 0 percent
- scarring, status post endovenous laser ablation (right leg surgery varicose veins removal), right lower extremity, 0 percent
- left ankle surgical scar secondary to service-connected left ankle, collateral ligament sprain with tendonitis, status post Bostrom reconstructive surgery, 0 percent
- left arm (non-dominant) hairline fracture was denied

27. The applicant provided multiple pages of Ireland Clinic of Chiropractic, LLC, Chart Notes, dated between June 2018 – September 2018, which have been provided in full to the Board for review and in pertinent part show:

a. He was seen for assessment and treatment on 28 June 2018, 9 July 2018, 30 August 2018, and 13 September 2018 for complaints of acute upper right back pain since 4 March 2009, after a fall through a roof and acute left lower back pain after a car accident in 2006.

b. He was diagnosed with:

- segmental and somatic dysfunction of thoracic region
- pain in thoracic spine
- segmental and somatic dysfunction of cervical region
- radiculopathy, cervical region
- segmental and somatic dysfunction of lumbar region
- lumbago with sciatica, left side

c. Treatment included chiropractic manipulative therapy to the cervical dorsal spinal region and lumbosacral spinal region.

28. A Cervical Spine MRI, dated 14 September 2018, findings show the cervical curvature is reversed in the mid and upper cervical region. No fracture or malalignment.

The disc spaces are normal except at C3-C5-6 suggesting early disc space narrowing. Cervical cord is normal in signal and caliber.

29. Ireland Clinic of Chiropractic, LLC, Chart Notes, dated 16 October 2018, shows the applicant underwent manual therapy, myofascial release on the date of the notes for the above listed diagnoses.

30. A VA Rating Decision, dated 13 May 2019, shows the applicant was granted the following service-connected ratings:

- radiculopathy of sciatic nerve, left lower extremity, which was currently 20 percent disabling was decreased to 10 percent effective 15 April 2019
- radiculopathy of upper and middle radicular nerve, left upper extremity, 20 percent effective 19 February 2019
- radiculopathy of upper and middle radicular nerves, right upper extremity, 20 percent effective 19 February 2019
- IVDS lumbosacral spine L4-L5, L5-S1 with spondylolisthesis, continued at 10 percent
- cervical neck strain, 10 percent effective 19 February 2019
- radiculopathy of sciatic nerve, right lower extremity, 10 percent effective 19 February 2019
- decision on entitlement to compensation for atypical melanocytic proliferation, left cheek, was deferred

31. A Radiology Admin Note, dated 24 March 2020, shows the applicant was scheduled to have an MRI examination, however he did not wisht to have the exam at that time due to COVID-19 concerns and he would reschedule for a later date.

32. A C&P Examination Note, PTSD Initial Evaluation, dated 27 April 2020, shows in pertinent part that the applicant received a diagnosis of PTSD on 31 December 2019 and on 18 February 2020, he received a diagnosis of TBI, with the symptoms attributable to each condition explained and differentiated in the report.

33. A VA Rating Decision, dated 30 April 2020, shows the applicant was granted service-connection for the following conditions effective 4 September 2019:

- PTSD, 50 percent
- TBI, 40 percent

34. The applicant previously applied to the ABCMR, requesting referral to the DES for eventual physical disability retirement in lieu of honorable administrative discharge due to non-retention on active duty subsequent to a QMP board.

a. In the adjudication of this case, a medical opinion was provided by the Army Review Boards Agency (ARBA) medical advisor, who opined there is no probative evidence the applicant had any medical condition which would have failed the medical retention standards of Army Regulation 40-501, or prevented him from reasonably performing the duties of his office or grade; thus, there is no cause for referral to the DES.

b. On 21 June 2023, the Board denied the applicant's request, determining the evidence presented does not demonstrate the existence of a probable error or injustice and the merits of his case are insufficient as a basis for correcting his records.

35. The Army rates only conditions determined to be physically unfitting at the time of discharge, which disqualify the Soldier from further military service. The Army disability rating is to compensate the individual for the loss of a military career. The VA does not have authority or responsibility for determining physical fitness for military service. The VA may compensate the individual for loss of civilian employability.

36. MEDICAL REVIEW:

a. The Army Review Boards Agency (ARBA) Medical Advisor reviewed the supporting documents, the Record of Proceedings (ROP), and the applicant's available records in the Interactive Personnel Electronic Records Management System (iPERMS), the Health Artifacts Image Management Solutions (HAIMS) and the VA's Joint Legacy Viewer (JLV). The applicant requests medical discharge processing for his VA service-connected disabilities. He specifically mentioned the following: PTSD, TBI, Sleep Apnea, Spinal Injuries, Plantar Fasciitis, Vertigo, Cervical Strain, Left Cheek Melanoma, Varicose Veins, and Vitamin D deficiency. This is a request for reconsideration of a previous denial.

b. The ABCMR ROP summarized the applicant's record and circumstances surrounding the case. The applicant entered the Regular Army 12Nov2003. His MOS was 11B Infantryman. He had two combat deployments to Afghanistan 20091201 to 20101201 and 20070512 to 20080719. He was discharged 01Nov2017 in accordance with AR 635-200, chapter 4 for non-retention on active duty under the Qualitative Management Program (QMP). His service was characterized as honorable. He received severance pay (non-disability) in the amount of $34,140.

c. In his ABCMR application, the applicant indicated he was not selected per QMP due to failure to pass a course. He had failed the Maneuver Senior Leader Course, Class 005-16, given 20160711 thru 20160725. He also stated in his application "My last few years in the Army, I was having some real medical issues that severely impacted my performance as a Senor Non-Commissioned Officer in an airborne brigade". A summary of medical and related pertinent records is below.

d. PTSD condition. The VA service-connected PTSD 50% effective 04Sep2019.

(1) 18Nov2010 while in Italy, he was referred for individual therapy due to positive BH screening for nightmares and sleep problems (VCZ Psychology). He was given a 30-day prescription of Trazodone. Diagnosis: Adjustment Disorder.

(2) 03Mar2011 Post-deployment Health Re-Assessment. The applicant reported blast or explosion exposure during deployment and subsequent 'onset or worsening irritability'. He also endorsed that during the prior 4 weeks his emotional problems made it 'somewhat difficult to do his work, take care of things at home or get along with other people'.

(3) There were no BH issues during the 09Jan2012 PHA. No BH issues during the 05Sep2014 Multi-D BH out-processing record review. No BH or deployment related issues during the out-processing visit 17Oct2014 Social Work Clinic, Ft Richardson. No BH or deployment related issues during PHA, PDHA or Deployment BH Screening during the 17Nov2015 SRP Primary Care and SRP BH visits except he reported that tinnitus was bothering him.

(4) 17Oct2016 BH Richardson THC. The applicant was seen by BH reporting difficulty concentrating and memory issues. He stated that he failed the test for SLC due to his memory and was concerned he may be "getting QMP". He reported 3 concussions in the past. His BH scores were consistent with subclinical to low level of general distress. The 28Oct2016 brain MRI was unremarkable. Diagnosis: Adjustment Disorder, Unspecified.

(5) 21Aug2017 Report of Medical History (DD Form 2807-1) for separation. He endorsed nervous trouble, frequent trouble sleeping, but denied depression or excessive worry and suicide attempt.

(6) 19Sep2019 Psychology Assessment VAMC. He underwent psychological testing on 11Mar2019 but did not show for follow up therefore interpretation was limited. Testing took place to clarify ADHD and/or other BH diagnosis. Based on test results, there was moderate anxiety, minimal depression, and mild insomnia. PTSD (PCL-5 score 6) and ADHD diagnoses were less likely.

(7) 31Dec2019 Initial PTSD DBQ. BH treatment included Trazadone briefly in November 2010. And after discharge from service, he underwent individual counseling at the Vet Center in early 2018; individual counseling at the Anchorage VAMC from April to June 2018 and from January to July 2019; he took methylphenidate from May 2018 to December 2019; and he took Sertraline intermittently in 2019. He shared that he drank "like a fish" the last year of service. After service, he cut down to one drink on the weekend and started occasional marijuana use. Stressors: He described "a pretty

nasty fight" during which he fired about forty-eight 60mm rounds in about forty minutes, one of his guys was shot and about 17 Taliban were killed. He described a most gruesome scene after artillery fire involving a man and his son that were sheep herders. He also saw a fellow serviceman immediately after he was killed by their interpreter. DSM-5 Diagnosis: PTSD. The VA examiner opined the PTSD condition caused occupational and social impairment due to mild or transient symptoms resulting in decreased work efficiency and ability to perform occupational tasks only during periods of significant stress, or; symptoms controlled by medication (10% disability level). After review of the Initial TBI DBQ when the applicant was diagnosed with TBI, a 17Apr2020 PTSD DBQ was completed and differentiated PTSD symptoms from his TBI symptoms.

(8) TBI condition. The VA rated the TBI condition at 40% for objective evidence on testing of mild cognitive impairment, effective 04Sep2019.

(9) 18Oct2016 THC Richardson. The applicant presented with no significant past medical history concerning his cognition. He first noticed problems only two years prior, while at the Senior Leader's Course (SLC). He was having trouble concentrating during an exam in the course: He was tense, his heart rate was fast, he had anxiety and sweating, and difficulty remembering items resulting in incorrect answers. He returned to SLC one year later and had the same result. He had experienced similar physiological reactions at times, apparently at random. He reported a head injury when he fell through a roof (approximately nine feet) in 2009. He saw 'stars' for that incident. In 2010, in Croatia, he was in a car accident, and saw stars as well. A similar accident with head hitting the dash occurred in 2005 in Washington DC. He had never had an injury that resulted in a loss of consciousness. He scored a 27/30 (normal) on a MoCA exam with points lost for word recall after five minutes.

(10) 28Oct2016 Brain MRI was Unremarkable.

(11) 21Aug2017 Report of Medical History (DD Form 2807-1) for separation. He endorsed 'a period of unconsciousness or concussion'; a 'head injury, memory loss or amnesia'; and 'frequent or severe headaches'.

(12) 24Apr2018 BH Consult VAMC. He was currently attending school at UAA to get a bachelor's in business with a specialty in property management.

(13) 19Sep2019 Psychology Assessment VAMC. Premilitary, he described himself as a generally average student and earned mainly B's and C's. He reported brain fog in ranger school (in 2009). He was currently enrolled in a bachelor's program studying business administration and stated he was typically earning A's and B's. He had earned a total of 63 credits with 28 credits from a traditional in-person class. He was also currently home schooling his son 6 hours per day.

(14) 25Sep2019 Initial History and Physical Bay Pines, FL VAMC. Visit to establish care. “Psychiatric: Denies anxiety, depression, problems with sleep. Memory issues. Denies any unmet mental health needs at this time or suicidal thoughts.” Stressors: Moving and death in family.

(15) 25Sep2019 TBI Consult was canceled by the TBI Clinic. The reason given was the applicant had a completely normal neurologic exam on 18Oct2016, and MoCA score was 27-30 (normal), brain MRI was negative. The neurologist felt the reported anxiety may have contributed to memory issues.

(16) 04Oct2019 Neuropsychology Consult Outpatient VAMC. This consult was discontinued: “Please administer the MoCA or SLUMS and resubmit referral if scores are not within normal limits”.

(17) 12Nov2019 Psychiatry Note VAMC. The applicant was previously treated for ADHD. He was upset because he felt his TBI was not being evaluated properly—the TBI Clinic referral was recently cancelled. Despite the applicant being described as “agitated”, the MoCA was administered during the visit. Score on MoCA was 24/30 (consistent with mild cognitive impairment). He scored 3/5 on delayed memory and 1/2 on digits backward. He was unable to draw a 3-dimensional cube. DSM-5 Diagnosis: Major Depressive Disorder, Rule Out Mild Neurocognitive Disorder.

(18) 31Dec2019 Initial PTSD DBQ. Premilitary, he dropped out of high school, earned a GED in 2001 and worked full time as a landscaper. Post military, he was pursuing a bachelor's degree in business administration and had completed 78 of the 120 required credit hours.

(19) 18Feb2020 Initial TBI DBQ. TBI incidents were listed as follows: A windshield head injury in a car accident in Washington DC in 2005; falling through the roof in Afghanistan in 2010; combat explosion in 2010; bad parachute jumps in 2004 and 2014; and grenade handling training in 2015. Symptoms attributable to TBI: Mild impairment of memory, attention, concentration, or executive functions resulting in mild functional impairment; a failed leadership exam in 2017; and a decline in MoCA score to 24/30 on 13Nov2019 (from prior score 27/30). It should be noted the change in score was 4 years after the most recent potential TBI event. The examiner listed the following MoCA scores/dates: 13Nov2019 24/30 and 12Dec2017 27/30. The examiner did not list the 18Oct2016 27/30 result, nor did they administer a MoCA during the examination.

e. Sleep condition. The VA service-connected Obstructive Sleep Apnea (OSA) 50% effective 02Nov2017.

(1) 12May2017 THC Richardson primary care visit: The applicant requested a sleep study for subjective sleep apnea.

(2) 10Jul2017 Polysomnography Report (Joint DoD/VA Sleep Disorders Center). Diagnosis: Mild Sleep Disorder. He underwent CPAP titration in December 2017 (one month after discharge from service). Diagnosis: Mild OSA.

(3) 21Aug2017 Report of Medical History (DD Form 2807-1) for separation. He endorsed 'frequent trouble sleeping'/

(4) 17Nov2017 Sleep Disorders Center, JBER AK. He was seen for CPAP titration.

(5) 29Mar2018 Sleep Apnea DBQ. He reported persistent daytime somnolence. The condition was managed by CPAP (continuous positive airway pressure).

f. Foot condition, bilateral. The VA service-connected Bilateral Pes Planus 50% effective 02Nov2017, reduced to 30% in 2018.

(1) 28Dec2016 Physical Therapy Richardson THC. He reported fallen arches, both feet, left > right. He was noted to be wearing very soft and flexible shoe inserts.

(2) 12Jan2017 Physical Therapy Richardson THC. This was a follow up visit: He reported the new inserts had eliminated his foot pain.

(3) 30May2017 foot film revealed mild pes planus.

(4) 30May2017 Podiatry ELMNDRF-Richardson Clinic (under 05Jun2017 visit in JLV). Left ankle series showed mild pes planus. He reported gradual onset of pain status post surgery. He denied new trauma. He had received physical therapy after surgery and was currently in physical therapy (2 months). Treatment options included stretching, strengthening, injection therapy, shoe inserts, physical therapy, and surgical correction of deformity. Low impact activities were recommended at the present time including swimming, stationary bike, and the elliptical machine. Further surgery was not recommended at the time.

(5) 21Aug2017 Report of Medical History (DD Form 2807-1) for separation. He endorsed foot trouble and fallen arches in both feet.

(6) 29Mar2018 Foot Conditions DBQ. Diagnosis: Bilateral Pes Planus. Left side worse than right. He had pain with use of his feet and pain with weightbearing. At the time, he endorsed that custom orthotics provided minimal relief.

(7) 24Oct2019 Podiatry Consult. The applicant was requesting custom orthotics since they had provided some relief. The weightbearing exam was normal, and no limp was noted on ambulation. The plan included ordering custom orthotics.

g. Back condition. The VA service-connected Intervertebral Disc Syndrome, Lumbosacral Spine L4-L5, L5-S1 with Spondylolisthesis 10% and Radiculopathy Left Lower Extremity 20% effective 02Nov2017. The VA later service-connected Radiculopathy Right Lower Extremity 10% effective 19Feb2019.

(1) 07Mar2005 Chronological Record of Medical Care. He was seen for back and neck pain after a motor vehicle accident on 05Mar2005. He was restrained in the passenger seat when they were hit from behind.

(2) 14Mar2005 Chronological Record of Medical Care. The back showed full ROM.

(3) 22Apr2005 lumbar MRI. There was bilateral L5 spondylolysis with degenerative
disc disease at L4-L5 and L5-S1 with mild disc bulges present.

(4) 27Jun2005 08Jul2005, 08Aug2005 Chiropractic Clinic visits, Walter Reed AMC.

(5) 20Jan2006 WRNNMC. He was pain free. He just needed a summary of care.

(6) 28Jan2010 Sayed Abad Aid Station Clinic. He had an exacerbation of back pain after a mission 4 days prior.

(7) 07 and 28Dec2016 Physical Therapy Richardson THC. He reported 4/10 backpain of 10 years since the car accident in 2005 at Fort Myer. He had a recent flare of back pain after a C-130 jump. He had been managing the pain on his own (yoga). He reported occasional radiation of pain and numbness down the left leg when sitting. Back pain was aggravated by sitting for a prolonged period of time, sit-ups, flutter kicks, and running long distances. He also reported hip pain. The exam showed pain-free back flexion to his toes, and he had 50% pain-free extension. Plan: Physical therapy and home exercise program, and Motrin 800mg. He was not given a profile.

(8) 12Jan2017 Physical Therapy Richardson Clinic THC. This was a follow up visit. His back pain was decreased to 1-2/10. His current exercise typically included cross fit, weightlifting (not overhead), running, swimming, rucking, and running. He stated the exercises were helping as well as switching from a sitting job to a standing job. He had experienced one episode of radiating pain. He returned for therapy for several in-person physical therapy visits from 05May2017 through 20Jul2017. He endorsed performing HEP (home exercise program).

(9) 21Aug2017 Report of Medical History (DD Form 2807-1) for separation. The

applicant endorsed recurrent back pain (“bulged L-5 disk 2006”) and ‘numbness or tingling’.

(10) 29Mar2018 Back Conditions DBQ. Diagnoses: Intervertebral Disc Syndrome and Spondylolisthesis. X-rays from the car accident in 2005 showed spondylolisthesis as well as herniated disks. Recent treatment included the following: Chiropractic (Aug and Sep2017, 3 visits total); acupuncture (Nov2017, 1 visit); physical therapy (May thru July 2017); and pain management with epidural steroid injections (29Nov2017 and 26Jan2018). During this exam, the applicant endorsed minimal effect on his symptoms of low back pain and left lower extremity radiculopathy. Back ROM: Forward flexion 0 to 90 degrees (normal); and extension 0 to 20 degrees (normal 30 degrees). There was evidence of pain with weightbearing without guarding or muscle spasm. Lower extremity strength was normal. Left straight leg testing was positive. There was mild constant left lower extremity (LLE) pain, paresthesias and numbness and moderate intermittent LLE pain. Diagnosis: Moderate LLE Radiculopathy with involvement of L4/L5/S1/S2/S3 nerve roots (sciatic nerve).

(11) 11Sep2018 follow up chiropractic visit. He had non radiating symptoms. He had slight improvement since last visit.

(12) 15Apr2019 Back Conditions DBQ. Forward flexion was from 0 to 90 degrees (normal); and extension was to 30 degrees (normal). Of note, this provider diagnosed Mild Bilateral Lower Extremity Radiculopathy.

(13) 20Dec2019 Hiler Chiropractic, Naples, FL. He had begun treatment with this
practice in October 2019. “He is feeling better and currently objectively progressing satisfactorily”.

h. Neck condition. The VA service-connected Cervical Neck Strain 10%; Radiculopathy Right Upper Extremity 20%; and Left Upper Extremity 20% effective 19Feb2019.

(1) 14Mar2005 Chronological Record of Medical Care. The neck showed full ROM.

(2) 21Aug2017 Report of Medical History (DD Form 2807-1) for separation was silent for neck concerns.

(3) 11Sep2018, 13Sep2018, 16Oct2018, 24Oct2018 Ireland Chiropractic Clinic, Anchorage AK. These were outside chiropractic and/or physical therapy follow up visits. Treatment for the neck condition took place after discharge from service.

(4) 14Sep2018 University AI Imaging Center cervical spine MRI. There were early degenerative changes with bilateral foraminal narrowing at C3-4 (mild) and C5-6 (moderate to severe).

(5) 15Apr2019 Neck Conditions DBQ. The applicant reported constant dull neck ache with radiating pain to his shoulders and arms. Neck ROM: There was forward flexion 0 to 45 degrees (normal); extension 0 to 45 degrees (normal). There was objective evidence of localized tenderness. Upper extremity strength and reflexes were normal. Diagnosis: Mild Upper Extremity Radiculopathy, Bilateral.

i. Right Wrist condition. The VA service-connected Right (dominant) Wrist Fracture, Healed 10% and Right Distal Radius Fracture, Residuals 10% effective 02Nov2017.

(1) 17Jul2005 fell on outstretched hands and sustained a displaced right distal radial fracture (17Jul2005 WRNMMC film).

(2) 08May2017 right forearm film showed early osteoarthrosis of the radiocarpal joint, and nonunion of the ulna styloid. There was no acute fracture.

(3) 12May2017 THC Richardson primary care visit for results: He stated the pain began approximately 6 weeks prior on a helicopter jump when he sprained his wrist on the exit. Plan: Splint 4 weeks as needed, over-the-counter non-steroidal anti-inflammatories. He declined a profile, stating he could self-limit use. If there was no improvement in 1 month, he would be referred for occupational health. There were no immediate follow up visits.

(4) 21Aug2017 Report of Medical History (DD Form 2807-1) for separation, he reported a 2005 wrist fracture.

(5) 29Mar2018 Wrist Conditions DBQ. He reported painful ROM and decreased ROM of the right wrist. There was evidence of pain with weight bearing and tenderness to palpation over the distal radius. ROM exam: There was palmar flexion 0 to 30 degrees (normal 80 degrees); and dorsiflexion 0 to 30 degrees (normal 70 degrees).

(6) Treatment visits specifically for the right wrist condition were not found within the 12 months following discharge from service.

j. Left Ankle condition. The VA service-connected Left Ankle, Collateral Ligament Sprain with Tendonitis, Status Post Bostrom Reconstructive Surgery 10% effective 02Nov2017.

(1) 09Jan2009 Theater Note. The applicant rolled his left ankle during land navigation exercise. He had rolled his ankle before.

(2) 13Jun2013 Troop MC. He was seen for 10-year history of left ankle laxity.

(3) 24Jan2014 Longstreet Orthopedic and Sports Medicine Clinic, Gainesville, GA. The applicant underwent left ankle surgery. He had a 30-day convalescent leave from 24Jan2014 to 24Feb2014.

(4) 28Dec2016 Physical Therapy THC Richardson. He reported having completed physical therapy outside (civilian) for occasional left ankle pain.

(5) 01May2017 Primary Care Visit. He requested referral to podiatry for left ankle pain for the prior 2 years. He declined a profile.

(6) 05May2017 left ankle film showed mild tibiotalar arthrosis, no acute findings. 09May2017 Physical Therapy. He reported having an off-post podiatry referral.

(7) 30May2017 Podiatry JB ELMNDRF Richardson. There was gradual onset and chronic duration of ankle pain. There was no new trauma. He stated that he was having issue balancing on his left leg. Exam: Muscle strength was 5/5, bilateral. Achilles deep tendon reflex was 2+ (normal), bilateral. Diagnosis: Primary Osteoarthritis, Left Ankle and Foot.

(8) 30May2017 ankle film showed small ankle joint effusion and mild lateral soft tissue swelling.

(9) 21Aug2017 Report of Medical Examination (DD Form 2807-1) for separation. The applicant reported the prior Left Ankle Bostrom Reconstruction surgery.

(10) 29Mar2018 Ankle Conditions DBQ. He reported that he injured his left ankle in 2003 during a road March where he rolled the left ankle. He heard a popping sound. Left ankle ROM: There was dorsiflexion 0 to 10 degrees (normal 20 degrees); and plantar flexion 0 to 10 degrees (normal 45 degrees). There was evidence of pain with weight bearing. Strength was 5/5 (normal). There was evidence of left ankle instability. The applicant regularly used sturdy lace up boots.

(11) Treatment visits specifically for the left ankle condition were not found within the 12 months following discharge from service.

k. A VA rating was not found for Vertigo. The applicant did not endorse dizziness or fainting spells during the separation exam. A VA rating for Vitamin D Deficiency was not found. The Varicose Vein condition was rated at 0% for scarring, status post surgery. The VA deferred rating the Atypical Melanocyte Proliferation, Left Cheek.

l. Summary/Opinion

(1) The applicant was in a significant MVA in March 2005. He passed a pre-deployment physical in February 2007. During the 26Jul2008 PHA (periodic health assessment), he had recently returned from Afghanistan, and no issues were noted except a complaint of painful varicose veins. He passed the flight physical in September 2009. There were no significant issues reported in the 29Jan2012 PHA. The 13Feb2012 "Sniper" exam (Report of Medical Examination) showed Mild Left Foot Pes Planus, Symptomatic. The physical profile showed PULHES 111111, and he was deemed fully qualified for Sniper Training. During the 27Feb2013 Special Forces exam, past or ongoing issues were denied— physical profile showed PULHES 111111. He underwent left ankle surgery in January 2014. He passed the October 2016 APFT with score 280 and the 09May2017 PHA yielded a physical profile PULHES 112111 (02Nov2017 Enlisted Record Brief). It was notable that for the August 2017 separation exam, portions of the physical examination were incomplete: For the spine, upper extremity, and lower extremity examinations, 'NE' (not examined) was selected. However, the NCO Evaluation Report covering the period from 20160503 to 20170802 showed he had also passed the 07Dec2016 APFT. His principal duty title was Brigade Marksmanship NCOIC with his overall performance deemed as 'met standard'. Of note, he exceeded standards in the leadership, development, and achievement categories.

(2) Concerning the TBI and PTSD conditions, review of records showed the most recent combat explosion exposure was in 2010. He subsequently passed the Advanced Leader Course demonstrating 'superior' skills in written and oral communication 12May2011. He also passed the Advanced Leader Common Core 06Oct2012. The most recent potential TBI related exposure endorsed by the VA DBQ examiner, was in 2015 due to grenade handling training. The applicant passed the Maneuver Senior Leader Course, Class 005-15 on 21Jul2015. In addition, in the NCO Evaluation Report from 20160503 to 20170802 while performing in his MOS as Brigade Marksmanship NCOIC he 'met standard' for rater overall performance and senior rater overall potential 'qualified'. He received the Army Commendation Medal for exceptionally meritorious service while serving as the Marksmanship NCOIC from 20Oct2014 to 01Nov2017. The applicant reported that prior to the military, he earned mainly B's and C's. And post military, he was a business administration major in college reportedly earning A's and B's. The applicant did not participate in regular BH services until after discharge from service. There was no history of substance abuse treatment or psychiatric hospitalization. There was no history of psychosis, mania, suicide ideation or attempt.

(3) Based on records available for review, there was insufficient evidence to support the applicant had medical or mental health conditions which failed medical retention standards of AR 40-501 chapter 3 at the time of discharge from service in November 2017. Referral for medical discharge processing is not warranted.

BOARD DISCUSSION:

1. After reviewing the application, all supporting documents, and the evidence found within the military record, the Board found that relief was not warranted. The Board carefully considered the applicant's record of service, documents submitted in support of the petition, and executed a comprehensive review based on law, policy, and regulation. Upon review of the applicant's petition, available military records, and the medical review, the Board concurred with the advising official finding insufficient evidence to support the applicant had a medical or mental health condition which failed medical retention standards in accordance with regulatory guidance at the time of discharge from service on 1 November 2017. Based on this, the Board determined referral of his case to the Disability Evaluation System (DES) is not warranted.

2. The applicant's request for a personal appearance hearing was carefully considered. In this case, the evidence of record was sufficient to render a fair and equitable decision. As a result, a personal appearance hearing is not necessary to serve the interest of equity and justice in this case.

BOARD VOTE:

Mbr 1	Mbr 2	Mbr 3	
:	:	:	GRANT FULL RELIEF
:	:	:	GRANT PARTIAL RELIEF
:	:	:	GRANT FORMAL HEARING
[redacted]	[redacted]	[redacted]	DENY APPLICATION

BOARD DETERMINATION/RECOMMENDATION:

The evidence presented does not demonstrate the existence of a probable error or injustice. Therefore, the Board determined the overall merits of this case are insufficient as a basis for correction of the records of the individual concerned.

[redacted]

I certify that herein is recorded the true and complete record of the proceedings of the Army Board for Correction of Military Records in this case.

REFERENCES:

1. On 25 August 2017, the Office of the Undersecretary of Defense for Personnel and Readiness issued clarifying guidance for the Secretary of Defense Directive to Discharge Review Boards (DRBs) and Boards for Correction of Military/Naval Records (BCM/NRs) when considering requests by veterans for modification of their discharges due in whole or in part to: mental health conditions, including post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), sexual assault, or sexual harassment. Boards are to give liberal consideration to veterans petitioning for discharge relief when the application for relief is based, in whole or in part, on those conditions or experiences.

2. Title 10, U.S. Code, chapter 61, provides the Secretaries of the Military Departments with authority to retire or discharge a member if they find the member unfit to perform military duties because of physical disability. The U.S. Army Physical Disability Agency is responsible for administering the Army physical disability evaluation system (DES) and executes Secretary of the Army decision-making authority as directed by Congress in chapter 61 and in accordance with DOD Directive 1332.18 (Discharge Review Board (DRB) Procedures and Standards) and Army Regulation 635-40 (Physical Evaluation for Retention, Retirement, or Separation).

a. Soldiers are referred to the disability system when they no longer meet medical retention standards in accordance with Army Regulation 40-501 (Standards of Medical Fitness), chapter 3, as evidenced in a Medical Evaluation Board (MEB); when they receive a permanent medical profile rating of 3 or 4 in any factor and are referred by an Military Occupational Specialty (MOS) Medical Retention Board (MMRB); and/or they are command-referred for a fitness-for-duty medical examination.

b. The disability evaluation assessment process involves two distinct stages: the MEB and Physical Evaluation Board (PEB). The purpose of the MEB is to determine whether the service member's injury or illness is severe enough to compromise their ability to return to full duty based on the job specialty designation of the branch of service. A PEB is an administrative body possessing the authority to determine whether or not a service member is fit for duty. A designation of "unfit for duty" is required before an individual can be separated from the military because of an injury or medical condition. Service members who are determined to be unfit for duty due to disability either are separated from the military or are permanently retired, depending on the severity of the disability and length of military service. Individuals who are "separated" receive a one-time severance payment, while veterans who retire based upon disability receive monthly military retired pay and have access to all other benefits afforded to military retirees.

c. The mere presence of a medical impairment does not in and of itself justify a finding of unfitness. In each case, it is necessary to compare the nature and degree of physical disability present with the requirements of the duties the Soldier may reasonably be expected to perform because of their office, grade, rank, or rating. Reasonable performance of the preponderance of duties will invariably result in a finding of fitness for continued duty. A Soldier is physically unfit when a medical impairment prevents reasonable performance of the duties required of the Soldier's office, grade, rank, or rating.

3. Army Regulation 635-40 establishes the Army Disability Evaluation System and sets forth policies, responsibilities, and procedures that apply in determining whether a Soldier is unfit because of physical disability to reasonably perform the duties of his office, grade, rank, or rating. Only the unfitting conditions or defects and those which contribute to unfitness will be considered in arriving at the rated degree of incapacity warranting retirement or separation for disability.

a. Disability compensation is not an entitlement acquired by reason of service-incurred illness or injury; rather, it is provided to Soldiers whose service is interrupted and who can no longer continue to reasonably perform because of a physical disability incurred or aggravated in military service.

b. Soldiers who sustain or aggravate physically-unfitting disabilities must meet the following line-of-duty criteria to be eligible to receive retirement and severance pay benefits:

(1) The disability must have been incurred or aggravated while the Soldier was entitled to basic pay or as the proximate cause of performing active duty or inactive duty training.

(2) The disability must not have resulted from the Soldier's intentional misconduct or willful neglect and must not have been incurred during a period of unauthorized absence.

c. The percentage assigned to a medical defect or condition is the disability rating. A rating is not assigned until the PEB determines the Soldier is physically unfit for duty. Ratings are assigned from the Department of Veterans Affairs (VA) Schedule for Rating Disabilities (VASRD). The fact that a Soldier has a condition listed in the VASRD does not equate to a finding of physical unfitness. An unfitting, or ratable condition, is one which renders the Soldier unable to perform the duties of their office, grade, rank, or rating in such a way as to reasonably fulfill the purpose of their employment on active duty. There is no legal requirement in arriving at the rated degree of incapacity to rate a physical condition which is not in itself considered disqualifying for military service when a Soldier is found unfit because of another condition that is disqualifying. Only the

unfitting conditions or defects and those which contribute to unfitness will be considered in arriving at the rated degree of incapacity warranting retirement or separation for disability.

4. Title 10, U.S. Code, section 1201, provides for the physical disability retirement of a member who has at least 20 years of service or a disability rating of at least 30 percent. Title 10, U.S. Code, section 1203, provides for the physical disability separation of a member who has less than 20 years of service and a disability rating of less than 30 percent.

5. Title 38, U.S. Code, section 1110 (General – Basic Entitlement) states for disability resulting from personal injury suffered or disease contracted in line of duty, or for aggravation of a preexisting injury suffered or disease contracted in line of duty, in the active military, naval, or air service, during a period of war, the United States will pay to any veteran thus disabled and who was discharged or released under conditions other than dishonorable from the period of service in which said injury or disease was incurred, or preexisting injury or disease was aggravated, compensation as provided in this subchapter, but no compensation shall be paid if the disability is a result of the veteran's own willful misconduct or abuse of alcohol or drugs.

6. Title 38, U.S. Code, section 1131 (Peacetime Disability Compensation – Basic Entitlement) states for disability resulting from personal injury suffered or disease contracted in line of duty, or for aggravation of a preexisting injury suffered or disease contracted in line of duty, in the active military, naval, or air service, during other than a period of war, the United States will pay to any veteran thus disabled and who was discharged or released under conditions other than dishonorable from the period of service in which said injury or disease was incurred, or preexisting injury or disease was aggravated, compensation as provided in this subchapter, but no compensation shall be paid if the disability is a result of the veteran's own willful misconduct or abuse of alcohol or drugs.

7. Title 10, U.S. Code, section 1556 requires the Secretary of the Army to ensure that an applicant seeking corrective action by the Army Review Boards Agency (ARBA) be provided with a copy of any correspondence and communications (including summaries of verbal communications) to or from the Agency with anyone outside the Agency that directly pertains to or has material effect on the applicant's case, except as authorized by statute. ARBA medical advisory opinions and reviews are authored by ARBA civilian and military medical and behavioral health professionals and are therefore internal agency work product. Accordingly, ARBA does not routinely provide copies of ARBA Medical Office recommendations, opinions (including advisory opinions), and reviews to Army Board for Correction of Military Records applicants (and/or their counsel) prior to adjudication.

8. Army Regulation 15-185 (Army Board for Correction of Military Records (ABCMR)) prescribes the policies and procedures for correction of military records by the Secretary of the Army acting through the ABCMR. Paragraph 2-11 states applicants do not have a right to a formal hearing before the ABCMR. The Director or the ABCMR may grant a formal hearing whenever justice requires.

//NOTHING FOLLOWS//