ARMY BOARD FOR CORRECTION OF MILITARY RECORDS

RECORD OF PROCEEDINGS

IN THE CASE OF: [redacted]

BOARD DATE: 26 February 2025

DOCKET NUMBER: AR20240005335

APPLICANT REQUESTS:

- retirement for physical disability
- personal appearance before the Board

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

- DD Form 149 (Application for Correction of Military Record)
- DA Form 2173 (Statement of Medical Examination and Duty Status), 18 June 2016
- U.S. Army Reserve (USAR) discharge orders
- Department of Veterans Affairs (VA) summary of benefits letter
- 16 pages of medical records

FACTS:

1. The applicant did not file within the 3-year time frame provided in Title 10, U.S. Code, section 1552(b); however, the Army Board for Correction of Military Records (ABCMR) conducted a substantive review of this case and determined it is in the interest of justice to excuse the applicant's failure to timely file.

2. The applicant states he incurred a traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD) while serving on active duty, but his time and service ran out before he could be sent to a medical board. His mental disorder has had a significant effect on his life and has caused him to experience significant distress and impairment to his daily functioning. He requests that his discharge be changed to a disability retirement in light of the mental disorder he suffered while in the military. A disability retirement will provide him with the financial stability he needs to focus on recovery and make it easier for him to access the appropriate medical care and other services to help with his PTSD and TBI.

3. The applicant enlisted in the USAR, Alternate Training Program (i.e. split training), on 31 March 2009 for a period of 8 years. He attended basic combat training from 17

June to 29 August 2009 and advanced individual training from 15 July to 6 October 2010.

4. The applicant provided a DA Form 2173 showing he was involved in a motor vehicle accident (rollover) on 10 June 2016 while returning to Tactical Assembly Area Ward, Fort Hunter Liggett, CA, resulting in a concussion. The injury was considered to have been incurred in line of duty.

5. The applicant provided, and his records contain, orders published on 4 April 2017 by Headquarters, 81st Regional Support Command, directing his discharge from the USAR effective 11 April 2017 (Note: after completing 8 years and 12 days of USAR service) with an under honorable conditions (general) character of service. The orders contain the following entry: "Soldier was held beyond normal discharge date through no fault of the Soldier." The reason for the applicant receiving a general discharge instead of honorable is unknown.

6. The applicant provided medical records related to his motor vehicle accident medical evaluation, diagnosis, and treatment. He also provided a VA summary of benefits letter indicating he is receiving service-connected disability compensation for undisclosed conditions with a combined service-connected evaluation of 100%. The letter also shows that the effective date of when he became totally and permanent disabled due to his service-connected disabilities is 25 June 2016.

7. MEDICAL REVIEW:

1. 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 change in reason for separation to retirement due to physical disability. He indicated that PTSD and TBI conditions were related to his request.

2. The ABCMR ROP summarized the applicant’s available record and circumstances surrounding the case. The applicant enlisted in the Army Reserve 31Mar2009. His MOS was 74D Chemical Operations Specialist. Among other periods of active service, he participated in active-duty training from 04Jun2016 to 24Jun2016. When returning to the site, he sustained injury during a rollover motor vehicle accident (MVA). After initial treatment and stabilization, he was ultimately discharged from the US Army Reserve on 11Apr2017. At the time, he had been incarcerated in Calhoun County since 13Jan2017. He had been given multiple continuances and there was no date set for release. He was reportedly released from incarceration on 19Jul2017. His service was characterized as Under Honorable Conditions (General); however, the applicant’s

discharge paperwork is incomplete—the exact reason he was not given an Honorable discharge is unknown. Some reported civil infractions are listed below.

3. Summary of initial treatment after the accident.

a. 09Jun2016 Natividad Medical Center Emergency Department. The 24-year-old applicant was brought in by EMS with complaint primarily of head pain after rollover MVA as a restrained right rear passenger. The car left the road at low speed and rolled over multiple times down an embankment. He also reported neck and back pain. The Glasgow Coma Scale score was 14 out of 15— he was slow to respond. CT scan including the head, neck, chest, abdomen, and pelvis were all negative. It was noted that he had a history of using Percocet (a narcotic) for pain and he endorsed that both Tylenol and Ibuprofen had been less effective in the past. He was discharged home to self-care.

b. 10Jun2016 Statement of Medical Examination and Duty Status. When returning to TAA Ward as a passenger in a vehicle, the applicant sustained a head injury during a rollover incident. He was medevacked to a local hospital. The location of injury was Fort Hunter Liggett, CA.

c. 13Jun2016 Twin Cities Community Hospital. The applicant was seen for persistent headache status post SUV multiple rollover incident down a ravine. He reported loss of consciousness and some amnesia for the incident. He also reported, photophobia, forgetfulness and back and neck pain. He was given quarters for 72 hours.

d. 16Jun2016 Chronological Record of Medical Care, Fort Hunter Liggett Medical Aid Station and 18Jun2016 Individual Sick Slip. He reported no improvement in headache, sensitivity to light and dizziness. He still had neck and back pain. He also reported difficulty sleeping due to nightmares and dreams and difficulty finding words to say as well. His neck had full ROM. Poor effort was noted during parts of the examination. He was given pain medication. He was permitted use of sunglasses (outside and indoors). It was advised that he be sent home from training to facilitate brain rest.

4. Behavioral Health: Major Depressive Disorder, Recurrent, Severe without Psychotic Features. Initially, while in service, the diagnosis was Adjustment Disorder with Mixed Anxiety and Depressed Mood. After discharge, he was diagnosed with PTSD.

a. 12Jul2016 Rehab and Physical Medicine Eisenhower Gordon AMC (EGAMC) (and Case Management Note). The applicant reported difficulty with sleep initiation and maintenance, averaging 2 hours, and being awakened by the slightest sound. He described mood Issues including increased anxiety, and not wanting to be around

people. He had married in February although he had not been living with his wife and he had not contacted her about his current situation. He had a daughter who was 2 1/2 years old and lived with her mother. It was noted that he had few friends, and he was estranged from his family of origin. The provider prescribed Melatonin for his sleep issues.

b. 07Sep2016 Fox-Redstone Arsenal AHC (FRAAHC). He inquired about INCAP pay since he was not able to work and since he had to drop out of school he had no money. He continued to stay with a friend in Fort Payne, AL

c. 17Oct2016-19Oct2016, he had an inpatient psychiatric admission to Crestwood Medical Center for major depression with psychotic features, intractable pain, and possible suicide ideation. He was discharged on aripiprazole 5mg daily and lamotrigine 25mg but declined follow-up.

d. 04Nov2016 and 22Nov2016 (Primary Care) FRAAHC. He was taking trazodone for insomnia due night terrors, and characteristic PTSD symptoms. Diagnosis: Anxiety Disorder, Unspecified.

e. 16Dec2016 (Primary Care Flight Surgeon) FRAAHC. Trazodone was controlling his sleep related issues. However, he reported increased anxiety and depression. He failed a trial of Cymbalta (prescribed in October); however, no new medication was started as he had an appointment with a new off-post psychiatric provider in one week.

f. 16Dec2016 Case Management Clinic FRAAHC. He stated that he was 'seeing things' but would not describe what he was seeing. He kept insisting that the 3 other passengers in the car accident had died (his persistent delusion) even though he was told that no one had died in the accident. Diagnosis: Major Depressive Disorder, Single Episode, Severe with Psychotic Features.

g. 03Jan2017 (Primary Care) FRAAHC. The applicant was under the care of a. new BH provider closer to home who had prescribed Prozac. Despite not having filled the prescription yet, his BH Major Depressive Disorder, Recurrent, Severe without Psychotic Features condition appeared stable at the time.

5. TBI, Post Concussion Syndrome, and Headaches

a. 28Jun2016 Stringfellow Memorial Hospital. The applicant was seen and treated for headache accompanied by photophobia, blurred vision, and dizziness. He also reported memory loss and posterior neck pain. Diagnosis: Post Concussion Syndrome.

b. 30Jun2016 Neuropsychology Clinic FRAAHC. The applicant was in school

(civilian) having difficulty focusing.

c. 12Jul2016 Rehab and Physical Medicine EGAMC (and Case Management Note). This note indicated that on 07Jul2016, Neuropsychological Testing was performed and yielded DSM-5 diagnostic impressions Mild Neurocognitive Disorder Due to Traumatic Brain Injury, and Adjustment Disorder with Mixed Anxiety and Depressed Mood. A multidisciplinary TBI treatment was proposed. He was to have an escort for the next 30 days. He was on a temporary 90-day profile for concussion at the time.

d. 13Jul2016 Rehab and Physical Medicine EGAMC. Evaluation by Speech: His receptive and expressive language was within functional limits for purposes of communication. His oral motor skills were within normal limits.

e. 24Aug2016 (Primary Care) FRAAHC. He reported prior treatment of headaches with Naprosyn and Maxalt did not help. The narcotic pain medication was also not helping. He was advised to take the anti-inflammatory regularly (not as needed) and avoid narcotic use (to prevent rebound headaches and dependence)

f. 25Aug2016 Polytrauma Case Manager Note VAMC. Current symptoms directly related to his concussion include posttraumatic migraine headache; dizziness upon exertional movement; lack of focus and concentration; forgetfulness and recent memory impairment; slower processing; word finding/verbal expression difficulties; fatigue; sleep disturbance with dreams/nightmares; depression; anxiety; irritability. His case was reviewed, and he met criteria for inpatient admission for TBI rehab.

g. 18Oct2016 Neuropsychology Clinic FRAAHC. The applicant was expressing thoughts of suicide and frustration with not getting the care he needed. EMS was called to pick him up from the clinic for him to be taken to the ER. From there, he was admitted to Crestwood Hospital for inpatient psychiatric care. He was released 19Oct2016.

h. 04Nov2016 (Primary Care-Flight Surgeon) FRAAHC. He had just found a place to live. He was not working. He continued to experience post-concussive symptoms. Primary Care was strongly suggesting ASAP placement into inpatient rehab program and then followed by MEB. Currently, his LOD was approved, and he was awaiting placement into an inpatient treatment program. The question of proceeding with a MEB was going to depend on results of consultation with the IDES director.

6. Headache Treatment

a. 12Jul2016 Rehab and Physical Medicine EGAMC. The applicant reported that he had daily headaches since the MVA on June 9. Headaches were rated 7-8/10, located bi-temporally up across the forehead, occipitally and at the top of his head,

described as achy. He had light and sound sensitivity. The headaches were accompanied by nausea and vomiting. The provider noted prior treatment with muscle relaxers and narcotic pain meds. They advised that these agents likely have deleterious effects on already problematic memory/cognition. They ordered physical therapy evaluation and treatment for training in myofascial release for the tension type headaches. And for abortive type medication for post-traumatic migraine type headaches, they ordered Naproxen 500mg every 12 hours, Maxalt 10 mg as needed for up to 2 days a week and magnesium 40 mg at bedtime.

b. 15Jul2016 Rehab and Physical Medicine EGAMC. He received a Toradol injection (anti-inflammatory) and anti-nausea injection with some relief.

c. 24Aug2016 (Primary Care) FRAAHC. The applicant was advised against use of narcotics for headache. Amitriptyline was prescribed for headache prevention/maintenance.

d. 07Sep2016 Neuropsychology Clinic Case Manager FRAAHC. He stated that he. was still having headaches; however, he was not currently taking prescription medication.

7. Neck and Back Pain

a. 14Sep2016 (Primary Care) FRAAHC. He was seen for neck and back pain. He stated that his neck was very stiff and did not have full ROM. He denied numbness or tingling to extremities. Functionally, gait and stance were normal, and he was able to bend over in the chair to get something from his bag. However, cervical spine and lumbar spine ROM were not full. The provider advised him that opioids were no longer appropriate for his treatment. The provider refilled the Flexeril (muscle relaxant) and given him a trial of Naprosyn (anti-inflammatory).

b. 07Oct2016 Physical Therapy FRAAHC. Palpation of the paracervical and upper back musculature produced exaggerated responses by the patient suggestive of Waddell's signs. This suggests a BH contribution to his pain complaints/presentation. He reported a pain level of 10/10 which was not supported by his posture movements and mannerisms.

c. 11Oct2016 Physical Therapy FRAAHC. The applicant did not tolerate minimal attempts of therapy with using electrical stimulation or a stationary bike. He also deferred reclining on the treatment table due to concerns of increased pain.

d. 17Oct2016 lumbar spine series revealed anterior wedging of T11 of unknown chronicity— it could have been of congenital origin. The thoracic spine was normal.

e. 22Nov2016 and 16Dec2016 (Primary Care, Flight Surgeon) FRAAHC. The applicant came for refills on pain medication which he stated was effective: Diclofenac (anti-inflammatory) and Oxycodone (narcotic) for breakthrough pain. He was scheduled to see pain management in one week.

8. Legal issues. The following notes were included because the unit reported that their decision to allow the applicant to ETS was impacted by the applicant's incarceration at the time. It should also be noted that the information is based on what the applicant reported to providers at the time. No court records/citations were available for this review.

a. 22Jul2016 Rehab and Physical Medicine Case Management EGAMC. On 19Jul2016 the judge allowed a continuance to permit TBI rehab. However, on 20Jul2016, he was arrested on an outstanding warrant in another county. The unit was not sure when he would be released.

b. 25Aug2016 Polytrauma Case Manager Note VAMC. The applicant had 2 felony charges in different counties. One charge was for theft of government property (currently on continuance) and the second charge was for possession of Class II substance (the trial was pending).

c. 25Aug2016 (Primary Care) Case Manager Note FRAAHC. The applicant and his wife filed for a continuance (for the second offence) so that he could be allowed treatment. This note indicated that he had been released from jail after one month.

d. 03Mar2017 Case Management Clinic FRAAHC. The applicant was incarcerated in Calhoun County on 13Jan2017 reportedly for alleged DUI (a new third offence).

e. 24Jul2017 Homeless Program Note VAMC. The note documented that during a 20Jul2017 hotline call, the applicant reported he was released from jail the day prior.

f. 20Jun2018 MH OSAC Clinic Note. The applicant presented for his 1st court ordered admission to OSAC for opioid/alcohol abuse. He reported that he received a DUI in January 2017 while driving under the influence of his prescribed oxycodone. He stated that he was jailed for 6 months for refusing a breathalyzer test. He denied having a substance use problem.

g. He participated regularly in the intense outpatient MH OSAC services June, July, August, and through September 2016. He was completely compliant with the program. He completed the other phases of the program also.

9. Summary/Opinion

a. After the rollover MVA, the applicant reported memory loss and other cognitive issues. In addition, he reported severe amounts of head, neck, and back pain for which he was referred for physical therapy. He participated in physical therapy for a short time in October 2016 due to intolerance to even minimal modalities. His limited efforts with physical rehab were thought to be due to untreated mental health symptoms at least in part due to chronic pain from the accident. There were also significant life stressors: Marital, financial, academic, stable housing, legal and occupational. It was recommended that the focus should be BH treatment and TBI rehab first, and secondly the neck and back pain. He had been scheduled to consult with pain management services. It is unclear if the appointment took place— the record was not found in the military treatment case file.

b. For his BH condition ultimately diagnosed in military service as Major Depressive Disorder, Recurrent, Severe without Psychotic Features; the applicant consistently took Trazadone which controlled the sleep symptoms. Otherwise, regular use of psychotropic agents while in service was minimal. He was just beginning treatment by an outside BH specialist (with Prozac) when he became incarcerated. After discharge from service, the applicant declined prescription for regular use of psychiatric medication (13Dec2017 Mental Health Outpatient Consult). Except for the 2-day inpatient psychiatric hospitalization in October 2016, there was no documentation of psychiatric hospitalization. There were brief episodes of psychosis manifested by hallucination and delusion on 17Oct2016 and 16Dec2016. There was no history of suicide attempt, mania, or violence while in service.

c. The applicant was pending inpatient rehab for TBI. Afterwards, he would be referred for a MEB or ETS. While waiting for inpatient treatment, he was seen by multidisciplinary follow-up (speech, behavioral, physical therapy, etc.). Entry into the inpatient program was delayed pending approval of the LOD so that he could be placed back on orders to allow for treatment. By the time the LOD was approved, he was incarcerated pending criminal cases that would not have dispositions prior to 31Mar2017. Command indicated that 'Due to the circumstances and the fact that we cannot hold him past his ETS, we will be submitting an ETS packet on him. This will allow the courts to take care of his legal issues, us to process him out of the Reserves, and him to still receive treatment through the approved formal LOD[s].' He was reportedly released from incarceration on 19Jul2017.

d. Immediately after release from incarceration, the applicant established care at the VA. During the 12Oct2017 Primary Care Note VAMC visit, he reported neck and back pain and headaches. The neck and back both had full ROM and were not tender to palpation. He was given an anti-inflammatory and muscle relaxant for back pain as needed. He was advised that his request for opioid medication would be denied until after his scheduled pain services consultation. Pain services in turn required updated imaging and management/consultation with physical therapy or orthopedics first. The

applicant declined physical therapy appointment (13Dec2017) and did not show for the 09Jan2018 MRI appointment. The visit with pain services clinic did not take place.

e. The applicant was referred to VAMC TBI Outpatient Clinic and Neurology Clinic Consult (13Dec2017) but there was no timely follow up. There was another series of attempts starting 19Mar2018 through 11May2018; however, there was again no follow up. He was offered counseling services but did not follow up (27Dec2017 Social Work Telephone Encounter Note). The applicant did not engage in TBI rehab or BH services within the first 12 months after discharge release from incarceration although he did engage in other services at the VA. For the headaches, he was started on Elavil on 02Jan2018 and topiramate on 19June 2018. The condition was not evaluated by neurology yet.

f. The applicant was diagnosed with Mild Cognitive Disorder, and it was noted that memory and concentration issues contributed to his dropping out of school during the initial TBI recovery period. It was also noted that his TBI recovery was complicated by chronic pain, BH symptoms, and opiate use/dependance. Narcotic use can have a profound impact on cognitive functioning. His preference for use of narcotic for pain management predated the TBI in June 2016 and impacted his relationship with providers trying to treat his chronic pain (20Jun2018 MH OSAC Clinic Note). He also suffered legal consequences due to use of narcotics. At the time of separation from military service, the applicant was navigating his medical appointments/treatments, operating his own vehicle over varying distances, and renting a living space. The head CT 09Jun2016 and 14Nov2016 brain MRI (Crestwood Medical Center) were normal. CT of the neck was normal. CT of the back did not show acute pathology.

g. At the time of separation from military service, he was not on a permanent level 3 physical profile. Based on review of military treatment records as well as records from the first 12 -18 months following his release from incarceration; there was insufficient evidence to determine that he had conditions which failed retention standards of AR 40-501 chapter 3.

h. Liberal Consideration guidance was examined. The applicant has been diagnosed with PTSD and TBI conditions. Both PTSD and TBI are mitigating conditions under Liberal Consideration. However, the less than fully Honorable discharge cannot be mitigated as the offence(s) is not known. The Board may consider whether that applicant's discharge merits upgrade for another reason, such as due to his not being able to complete treatment while in service.

10. Kurta Questions:

(1) Did the applicant have a condition or experience that may excuse or mitigate the discharge? Yes. The applicant has been diagnosed with PTSD and TBI.

(2) Did the condition exist, or did the experience occur during military service? Yes. The applicant has been diagnosed with PTSD with the stressor being an in-service motor vehicle accident. He sustained TBI during the rollover accident.

(3) Does the condition or experience actually excuse or mitigate the discharge? Unknown. The exact offence for which the applicant received the Under Honorable Conditions (General) is unknown; therefore, the presumed but unknown offence cannot be mitigated at this time.

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 and standard review based on law, policy and regulation. Upon review of the applicant's petition, available military records and medical review, the Board concurred with the advising opinion finding after review of military treatment records as well as records from the first 12 -18 months following his release from incarceration; there was insufficient evidence to determine that he had conditions which failed retention standards of AR 40-501 chapter 3. The opine noted that the less than fully Honorable discharge cannot be mitigated as the offence(s) is not known. Based on the medical opine and preponderance of evidence, the Board denied relief.

2. Consideration was given to the Kurta Questions:

(1) Did the applicant have a condition or experience that may excuse or mitigate the discharge? Yes. The applicant has been diagnosed with PTSD and TBI.
(2) Did the condition exist, or did the experience occur during military service? Yes. The applicant has been diagnosed with PTSD with the stressor being an in-service motor vehicle accident. He sustained TBI during the rollover accident.

(3) Does the condition or experience actually excuse or mitigate the discharge? Unknown. The exact offence for which the applicant received the Under Honorable Conditions (General) is unknown; therefore, the presumed but unknown offence cannot be mitigated at this time.

3. 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
XXX	XXX	XXX	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.

X //SIGNED//

CHAIRPERSON

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. Title 10, U.S. Code, section 1552(b), provides that applications for correction of military records must be filed within 3 years after discovery of the alleged error or injustice. This provision of law also allows the ABCMR to excuse an applicant's failure to timely file within the 3-year statute of limitations if the ABCMR determines it would be in the interest of justice to do so.

2. Army Regulation (AR) 40-501 (Standards of Medical Fitness) provides that for an individual to be found unfit by reason of physical disability, he or she must be unable to perform the duties of his or her office, grade, rank or rating. Performance of duty despite impairment would be considered presumptive evidence of physical fitness.

3. AR 635-40 (Disability Evaluation for Retention, Retirement, or Separation) prescribes the Army Disability Evaluation System (DES) 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.

a. The objectives are to maintain an effective and fit military organization with maximum use of available manpower; provide benefits to eligible Soldiers whose military service is terminated because of a service-connected disability; provide prompt disability evaluation processing ensuring the rights and interests of the Government and Soldier are protected; and, establish the Military Occupational Specialty Administrative Retention Review (MAR2) as an Army pre-DES evaluation process for Soldiers who require a P3 or P4 (permanent profile) for a medical condition that meets the medical retention standards of AR 40-501.

b. Public Law 110-181 defines the term, physical DES, as a system or process of the Department of Defense for evaluating the nature and extent of disabilities affecting members of the Armed Forces that is operated by the Secretaries of the military departments and is composed of medical evaluation boards, physical evaluation boards, counseling of Soldiers, and mechanisms for the final disposition of disability evaluations by appropriate personnel.

c. The DES begins for a Soldier when either of the events below occurs:

(1) The Soldier is issued a permanent profile approved in accordance with the provisions of AR 40-501 and the profile contains a numerical designator of P3/P4 in any of the serial profile factors for a condition that appears not to meet medical retention standards in accordance with AR 40–501. Within (but not later than) 1 year of diagnosis, the Soldier must be assigned a P3/P4 profile to refer the Soldier to the DES.

(2) The Soldier is referred to the DES as the outcome of MAR2 evaluation.

d. A medical evaluation board is convened to determine whether a Soldier's medical condition(s) meets medical retention standards per AR 40-501. This board may determine a Soldier's condition(s) meet medical retention standards and recommend the Soldier be returned to duty. This board must not provide conclusions or recommendations regarding fitness determinations.

e. The physical evaluation board determines fitness for purposes of Soldiers' retention, separation, or retirement for disability under Title 10, U.S. Code, chapter 61, or separation for disability without entitlement to disability benefits under other than Title 10, U.S. Code, chapter 61. The physical evaluation board also makes certain administrative determinations that may benefit implications under other provisions of law.

f. Unless reserved for higher authority, the U.S. Army Physical Disability Agency approves disability cases for the Secretary of the Army and issues disposition instructions for Soldiers separated or retired for physical disability.

g. The Chief, Army Reserve will ensure eligible Soldiers of the USAR Ready Reserve are referred for evaluation by MAR2 and DES, as applicable, in a timely manner, and in accordance with this regulation.

h. Unit commanders will ensure medical profiles containing a P3/P4 or temporary (T) 3/T4 in one of the serial profile factors are reviewed according to the standards of AR 40-501. Among the duties required, a unit commander will provide a non-medical assessment by completing DA Form 7652 (DES Commander's Performance and Functional Statement).

4. AR 15-185 (ABCMR) provides Department of the Army policy, criteria, and administrative instructions regarding an applicant's request for the correction of a military record. Paragraph 2-11 states applicants do not have a right to a hearing before the ABCMR. The Director or the ABCMR may grant a formal hearing whenever justice requires.

5. Section 1556 of Title 10, U.S. Code, requires the Secretary of the Army to ensure that an applicant seeking corrective action by 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 ABCMR applicants (and/or their counsel) prior to adjudication.

//NOTHING FOLLOWS//