

ARMY BOARD FOR CORRECTION OF MILITARY RECORDS

RECORD OF PROCEEDINGS

IN THE CASE OF: [REDACTED]

BOARD DATE: 13 August 2025

DOCKET NUMBER: AR20240010381

APPLICANT REQUESTS:

- physical disability discharge in lieu of discharge under honorable conditions (general) due to a pattern of misconduct or
- upgrade of his character of service to honorable

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

DD Form 149 (Application for Correction of Military Record)

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:

a. During his enlistment, he had a multitude of seizures and multiple sclerosis (MS) that were found by a magnetic resonance imaging (MRI) at Ramstein Air Force Base. Due to these conditions, he could not perform his duties and had trouble differentiating between what was right and wrong. He asked for a medical hearing from his staff sergeant, but was denied and told he would just be discharged.

b. He had no help from his superiors to navigate his illnesses. His superiors did not like it when he went to sick call or to doctors' appointments to get the right diagnosis and he would be reprimanded.

c. The Department of Veterans Affairs (VA) has stated that had his MS and epilepsy been handled at Ramstein, in other words had he been allowed to go without repercussions, he would have received a medical discharge. His neurologist has reviewed all of his records and found that all of this was viewable from the MRI scans produced during his time in service and his superiors handled the information

negligently. He asks the Board to take this into consideration and either change his discharge to a medical discharge or to an honorable one.

3. The acronym "PUHLES" describes the following six physical factors used in the profiling system to classify medical readiness: "P" (Physical capacity or stamina), "U" (Upper extremities), "L" (Lower extremities), "H" (Hearing), "E" (Eyes), and "S" (Psychiatric). Physical profile ratings are permanent (P) or temporary (T). A service member's level of functioning under each factor is represented by the following numerical designations: 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.
4. A DD Form 2808 (Report of Medical Examination) shows the applicant underwent medical examination on 26 August 2008 for the purpose of Regular Army Enlistment and was found qualified for enlistment with a PULHES of 111111.
5. A DD Form 4 (Enlistment/Reenlistment Document) shows the applicant enlisted in the Regular Army on 12 November 2008.
6. The complete facts and circumstances surrounding the applicant's discharge are unknown as his discharge packet is not in his available records for review.
7. The applicant's DD Form 214 (Certificate of Release or Discharge from Active Duty) shows he was given a general discharge under honorable conditions on 22 July 2011, under the provisions of Army Regulation 635-200 (Active Duty Enlisted Administrative Separations), chapter 14, due to a pattern of misconduct, with corresponding Separation Code JKA. He was credited with 2 years, 8 months, and 11 days of net active service.
8. An email from the Army Review Boards Agency (ARBA), 29 May 2025, shows the applicant was requested to provide the agency with a copy of any medical documents supporting his medical issues, but he did not respond.

9. 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 discharge from Under Honorable Conditions, General to medical discharge or Honorable. He specifically mentioned that his medical conditions Multiple Sclerosis and Epilepsy impacted his discharge. His mental health conditions were reviewed by ARBA Medical Reviewer with mental health expertise under separate cover.

2. The ABCMR ROP summarized the applicant's record and circumstances surrounding the case. The applicant enlisted into the Army Reserve 10Sep2008 and into the Regular Army 12Nov2008. His MOS was 12N Horizontal Construction. He served 2 years in Germany. He was discharged 22Jul2011 under provisions of AR 635-200, para 14-12B for pattern of misconduct. The complete circumstances of his discharge were not known—the separation documents indicating the offences for which the applicant was discharged were not submitted/available for this review.

3. During the 26Aug2008 Report of Medical Examination (DD Form 2808) for entry into service, the physical exam was normal except the applicant had signs of a respiratory illness that was not disqualifying. After 2 and three quarters years of service, he had a complicated medical history. During termination physical/chapter physical, he endorsed numerous symptoms/conditions (Report of Medical History DD Form 2807). However, at the time he only indicated that back problems currently limited his ability to work in his primary MOS or required geographic or assignment limitations (15Mar2011 Report of Medical Assessment, DD Form 2697). He also indicated that he had questions/concerns about a Medical Board. His PULHES was 111111. He was cleared for chapter separation. The physical exam documented the following summary of defects: Chronic Low Back Pain; Bipolar Disorder; Seizure Disorder; Kidney Stone Disease; and Bilateral Mild Hearing Loss.

4. During separation processing, he was seeking treatment for several conditions. Although the applicant was actively seeking treatment (to include surgery) for Bilateral Mild Hearing Loss during the final months of service, the condition was not reviewed below because it did not require extensive profiling or absence from duty. The remaining significant diagnoses for which he was actively seeking treatment during separation processing, were reviewed below except for the mental health condition which was reviewed under separate cover.

5. Chronic Low Back Pain

- a. 24Mar2009 TMC ER Module. The applicant strained his back (exercising).
- b. Between 01Apr2009 and 13Apr2009, the applicant underwent physical therapy. He had a profile from 02Apr2009 to 09Apr2009.
- c. 06May2010 lumbar MRI showed multilevel degenerative disease, most notably at L4/L5 and L5/S1.
- d. 04Jun2010 172 1/2ND INF Bamberg AHC. Profiled for lower back pain again.
- e. 19Jan2011 172 1/2ND BDE. He was given another profile for lower back pain.
- f. 15Mar2011 Primary Care Schweinfurt AHC. The applicant underwent facet injections (4 total) from April 2010 to August 2010 which he said were not helpful. He shared that he may be chaptered out of the Army. Diagnosis: Chronic Low Back Pain, likely musculoskeletal etiology. The back condition had some features of sciatica; however, in a non-anatomical pattern which made that diagnosis less likely. He was on profile until mid-April which sufficiently limited his activity to a manageable level. The provider extended the profile 30 days. He was prescribed Mobic (anti-inflammatory). He was also referred for physical therapy for further assessment. *There was no follow-on physical therapy consultation/treatment associated with this visit.*
- g. 01Jun2011 Primary Care Schweinfurt AHC. He was seen for severe back pain with report of blood in urine, however, the workup did not reveal a kidney stone. He was currently on profile for running at own pace and distance; the provider noted that a decision should be made soon about whether he would need a P3 and a MEB. He was given a pain shot (anti-inflammatory) and he was again referred to physical therapy. *There was no follow-on physical therapy consultation/treatment.*
- h. 18Nov2011 Spine C&P Exam VAMC. This exam was completed 4 months after discharge from service. Back flexion was to 70 degrees (normal, 90 degrees); and extension was to 20 degrees (normal, 30 degrees). He had pain with motion. There was no muscle weakness, spasms or guarding. His gait was normal. There was no history of incapacitating episodes of back pain. Current treatment included narcotic pain medication as needed for flares. Response to treatment was good.
- i. 01Feb2012 Pain Consult VAMC. During this visit, 7 months after discharge from service, the applicant reported intermittent back pain. He noted some benefit with Motrin and Aleve. He was prescribed a narcotic for severe pain. He had received 4 facet injections. He endorsed having undergone physical therapy in Germany (2009)

with some relief. He endorsed that he had not tried TENS, chiropractic or acupuncture management. A surgical option was discussed; however, the applicant preferred to continue conservative management.

- j. 03May2015, he underwent right L5-S1 laminectomy and foraminotomy.

Summary/Opinion. Based on current available records, in the ARBA Medical Reviewer's opinion, this condition did not fail retention standards of AR 40-501 chapter 3, at the time of discharge: The chronic back pain was intermittent. He had good functional back ROM. The applicant noted some benefit with Motrin and Aleve. He took a narcotic for severe pain. The plan at the time of discharge, was to continue conservative treatment with another round of physical therapy. After discharge, during pain management consultation, the applicant stated that he had not tried TENS, chiropractic or acupuncture management (01Feb2012 Pain Consult). His most recent course of physical therapy was in 2009 from which he endorsed some relief. And finally, it was noted that several months after discharge, he was advised a third time to complete a (second) round of physical therapy (01Feb2012 Pain Consult). Evidence supports that conservative treatment had not been maximized.

6. Seizure Disorder/Transient Alteration of Awareness

- a. 03Mar2010 LSL Neurology. The applicant experienced a spell a few weeks prior. His motor and neurologic exams were normal. The neurologist recommended duty limitations when the unit went to the field: He should work in the TOC, or the aid station as opposed to the field. He was also given seizure safety precautions.

- b. 12Mar2010 LSL Neurology. The applicant underwent a sleep deprived EEG procedure to rule out/in epilepsy. The EEG was normal.

- c. 06May2010 brain MRI revealed several areas of non-enhancing foci. The radiologist stated that the constellation of findings was worrisome for a demyelination process.

- d. 09Sep2010 LSL Neurology Phone Call. The applicant called describing onset of a syncopal episode when he was brushing teeth. Per his wife, she found him in the hallway with a knot forming on his right temple. Diagnosis: Transient Alteration of Awareness.

- e. 18Nov 2010 EEG was normal.

f. 01Dec2010 LSL Neurology. He believed that he had a seizure the evening prior, witnessed by his wife. On 09Dec2010, he was given a profile for no driving/operating heavy machinery pending evaluation by Neurology on 13Dec. *It should be noted that in March 2011, the applicant endorsed that his last seizure was in 02Sep2010.*

g. 13Dec2010 LSL Neurology. The applicant reported a prior history of head trauma with 2 concussions with loss of consciousness (LOC): In Feb 2009, he experienced LOC for 4-5 minutes (? cause); during childhood, he was hit in the head with a baseball bat and experienced LOC for "a while". He reported having experienced 9-10 episodes of LOC/altered consciousness since June 2009. During one episode, he bit his tongue. He was not on seizure medication or profile. Diagnosis: Seizures, Recurrent. A trial of Keppra (anticonvulsant) was started. And he was placed on a seizure profile which included no driving.

h. 01Feb2011 LSL Neurology. Profile and related restrictions were continued until 09Mar2011. He was non-deployable until 09Sep2011 one year from the last seizure.

i. 07Mar2011 LSL Neurology Phone Call. The applicant clarified that the date of the last seizure was 02Sep2010 (6 months prior). He wanted to come off profile so that he could drive again. Keppra and the seizure profile were discontinued.

j. 14Jun2011 Primary Care Bavaria MEDDAC. The applicant reported 3 seizures the evening prior after no seizure activity for 8 months (since September 2010). Since his last visit with neurology, he had been placed on medications for mental health which may have contributed to the new seizures. An anti-convulsant was not restarted yet pending neurology re-consult. *He was discharged from service the following month.*

k. 21Oct2011 Neurology Consult VAMC. EEG was within normal limits.

l. On 23Feb2012, the applicant had experienced his first seizure after discharge From service. The brain CT was essentially normal. He was restarted on Keppra. He remained seizure free on Keppra until 15Jul2015. The 14Sep2015 EEG was within normal limits.

Summary/Opinion. It was unclear initially if the applicant was experiencing syncopal episodes or seizures. The EEG was negative multiple times. A seizure disorder was ultimately diagnosed. There was good control while on his anticonvulsant. Neurology did not indicate that there was any cognitive impairment attributable to this condition. Based on records available for review, at the time of discharge the seizure condition did not fail medical retention standards of AR 40-501 chapter 3.

7. Multiple Sclerosis

- a. 06May2010 brain MRI revealed several areas of non-enhancing foci. The MRI was obtained as part of the workup for his seizures. There were 3 foci of aberrant T2 signals. The radiologist stated that the constellation of findings in the MRI was worrisome for a demyelination process.
- b. 18Nov2010, the brain MRI was repeated to assess for interval change. The prior findings were still present. The differential diagnoses included infectious, inflammatory, and demyelinating. The radiologist favored demyelinating, suspecting multiple sclerosis.
- c. 13Dec2010 LSL Neurology. The applicant denied any history of vision loss, unexplained numbness, weakness, coordination problems, bowel/bladder problems. He did endorse occasional paresthesias in his fingertips. Diagnosis: Abnormal Imaging of the Brain – concerning for demyelinating disease. Plan: Ten plus lab tests were ordered to rule in/out infectious, inflammatory, or demyelinating disease. They were unable to compare the November 2010 study with the May 2010 imaging studies as the May study was not from LRMC. The applicant was asked to bring in images from his prior study in May 2010 for comparison. Further work-up was to be decided after reviewing MRI comparison and lab results. There was some reluctance to pursue a lumbar puncture at the time given his significant lower back problems. The plan was to have follow up by phone in January after his leave.
- d. 21Jan2011 LSL Neurology Phone Call. The May 2010 MRI was located. *The MRI was uploaded later. The labs drawn on 24Jan2011 were all negative.*
- e. 23Feb2012 brain CT (completed for seizure work up at the VA) did not capture signs of demyelinating disease *and is generally not the study of choice for it.*
- f. Four years after discharge from service, on 25August 2015 and 02Sep2015 (Neurology Consult VAMC), multiple sclerosis was again suspected and this time, the diagnosis was confirmed by clinical picture, MRI findings and lumbar puncture. During interviewing he reported a persistent headache, pain behind the left eye, memory problems, balance problems, incoordination and swallowing difficulties. The MRI scan at the time, was abnormal— it was suggestive of a demyelinating disease, with several T2 intensities scattered throughout the brain. There had been progression since the first scan in 2010. The multiple MRI results confirmed demyelinating disease and were separated both time and space. Lumbar puncture findings helped to definitively diagnose Multiple Sclerosis.

Summary/Opinion. It should be stated that there is no one test to identify MS. The diagnosis is based on a combination of clinical symptoms, MRI imaging findings and results of cerebral spinal fluid testing (obtained through lumbar puncture). It should also

be stated that although MS was not diagnosed until 4 years after discharge, VAMC neurology endorses that the condition was likely present while in service based on the suspicious findings in the 2010 brain MRIs, also noted by the DoD radiologist. During the clinical evaluation at the time (13Dec2010) by neurology, they did not indicate that the applicant was exhibiting signs/symptoms that were worrisome for demyelinating disease. It is unknown if a lumbar puncture at the time would have confirmed the diagnosis. Based on AR 40-501 chapter 3-30e, a diagnosis of Multiple Sclerosis IS cause for referral for a MEB. While a confirmed MS diagnosis warrants a MEB, MEB referral does not guarantee that the condition would have been found unfitting for continued service by the PEB, as there was no evidence that the condition significantly impacted function or performance of duties while in service. Referral for MEB/PEB processing is not recommended.

8. Kidney Stone, Recurrent and Hematuria (blood in urine)

a. 18Aug2010 172 1/2ND BDE CAS. The applicant noticed blood in his urine a couple of times the day prior. There was no significant increase in the frequency, but urgency was drastically increased. Follow up 26Aug urine sample was clear— there was no blood. However, with the accompanying back pain and lower abdominal pain coupled with blood in urine; a kidney or ureter stone was suspected.

b. 11Feb2011 US Health Clinic Schweinfurt. He was admitted 02Feb2011 to 04Feb2011 with severe colic type left flank pain with microhematuria. A left ureteral stone was diagnosed by 02Feb2011 excretion urogram. A left ureteral stent was placed. While admitted, he also had stone(s) surgically removed. He passed 2 stones spontaneously. Diagnosis: Left Ureter Stone.

c. 16Feb2011 Primary Care Schweinfurt AHC. He reported having had visible blood in his urine for one day. He was pending surgery for renal calculi on 17Feb2011.

d. 16Mar2011 US Health Clinic Schweinfurt. He was admitted 16Mar to 17Mar for syncope, abdominal pain and residual after renal colic, left side.

e. 23May2011 Primary Care Schweinfurt AHC. The applicant was seen for hematuria (blood in urine) and 10/10 left flank pain.

f. 24May2011 US Health Clinic Schweinfurt. He was admitted until 26May2011. He was treated with pain medication (anti-inflammatory and narcotic) and an antibiotic. It should be noted that the 24Mar2011 Kidney Ultrasound was unremarkable. The 25May2011 Excretion Urogram showed no evidence of nephrolithiasis. The 26May2011 CT of the abdomen showed no evidence of nephrolithiasis. He had been treated empirically with antibiotics for a urinary tract infection before the urine test result came back as negative for signs of infection. The urine was also negative for blood.

Opinion. The undersigned did not find visits for kidney/ureter stones after discharge from service. The applicant was not on profile for kidney/ureter stones at the time of discharge. Based on evidence available for review, this condition did not fail medical retention standards of AR 40-501 chapter at the time of discharge.

9. Concerning the applicant's request for discharge upgrade, Liberal Consideration guidance was reviewed. *As previously stated, the mental health condition(s) were reviewed under separate cover.* The applicant contended that his medical conditions contributed to the reason for his discharge. It was not possible to assess whether there was a nexus between the applicant's medical conditions and the offences which resulted in his early involuntary separation from service, without knowing the nature of the offences. It can be stated that none of the applicant's medical conditions appeared to cause any cognitive impairment or would likely cause any impairment in the ability to discern right from wrong and prevent him from adhering to right. It can also be stated that during the applicant's last year of service, multiple medical conditions were being evaluated. These were significant medical condition requiring multiple tests, follow up testing and specialty consultations. Moreover, this review did not include all of his conditions. And finally, it should be noted that in his final 12 months of service, he had in excess of 50 medical encounters with 2 hospitalizations for the kidney condition and 1 for syncope/abdominal pain. It seems possible that these many absences from duty coupled with the 6-month profile prohibiting driving, would cause some consternation for his superiors and fellow soldiers especially the driving and operating heavy equipment restriction given his MOS 12N Horizontal Construction. That notwithstanding, no recommendation for mitigation is given because the nature and timing of the offences are unknown.

BEHAVIORAL HEALTH REVIEW:

a. Background: The applicant is applying to the ABCMR requesting consideration of an upgrade to his characterization of service from under honorable conditions (general) to honorable or a medical discharge.

b. The specific facts and circumstances of the case can be found in the ABCMR Record of Proceedings (ROP). Pertinent to this advisory are the following:

- The applicant enlisted into the Regular Army on 12 November 2008.
- The complete facts and circumstances surrounding the applicant's discharge are unknown as his discharge packet is not in his available records for review.
- The applicant's DD Form 214 shows he was given a general discharge under honorable conditions on 22 July 2011, under the provisions of Army Regulation 635-200, chapter 14, due to a pattern of misconduct, with corresponding

Separation Code JKA. He was credited with 2 years, 8 months, and 11 days of net active service.

c. Review of Available Records: The Army Review Board Agency (ARBA) Behavioral Health Advisor reviewed the supporting documents contained in the applicant's file. The applicant asserts he had seizures and multiple sclerosis and could not perform his duties, and he had trouble differentiating between what was right and wrong. A Report of Medical Examination dated 26 August 2008 showed the applicant was qualified for service at his enlistment. The application did not contain any mental health or medical records. There was insufficient evidence that the applicant was diagnosed with a psychiatric condition while on active service.

d. The Joint Legacy Viewer (JLV), which includes medical and mental health records from DoD and VA, was also reviewed and showed the applicant initiated mental health treatment through the DoD on 7 August 2009 and reported symptoms of depression. He described a history of significant childhood abuse/trauma as well as suicide attempts in his early adolescence. He was diagnosed with Major Depression and started on medication and psychotherapy. Therapy shifted to couples therapy, and he had some medication changes. Records showed an EEG was done on 12 March 2010 due to the applicant having experienced seizure-like activity, but the test was normal. Documentation from April 2010 showed that the applicant had been hospitalized for one week following increased stress and report of hearing voices, and one week later, he reported a second seizure. His medication was switched to an antipsychotic only, and his diagnosis was Atypical Depressive Disorder, Psychosis not otherwise specified (NOS), and possible somatoform disorder (pseudoseizures). On 29 June 2010, the applicant's psychiatric profile was expired, and it was noted that his symptoms had resolved without need of medication. Documentation by neurology on 1 February 2011 showed that the applicant's seizures were stable with medication, and he had not had a seizure since 2 September 2010, which meant that he was considered non-deployable until September 2011. On 13 April 2011, the applicant had a chapter evaluation, and it was noted that the applicant was not distressed about the process. He was deemed fit for duty and worldwide deployable from a psychiatric standpoint. A Phase II Chapter physical was completed on 15 April 2011. On 5 May 2011, the applicant reengaged with mental health and reported he was being chaptered out of the Army secondary to work performance problems, which he attributed to his physical health. He expressed his belief that he should have an MEB. On 19 May 2011 he was seen by his previous psychiatrist and reported auditory hallucinations and significant distress associated with the chapter process. He was restarted on an antipsychotic medication and given an anxiolytic. However, on 14 June 2011, he reported having another seizure the night before, and he was restarted on seizure medication and placed on a profile again. Documentation showed that the applicant initiated healthcare through the VA in September 2011, and he initially engaged with mental health in August 2016 where he reported symptoms of depression, irritability, and feelings of worthlessness associated

with his physical health problems (multiple sclerosis). He received medication management, and after another initial intake in November 2018, he was referred for a PTSD evaluation where he reported military-related trauma exposure. He was not diagnosed with PTSD. The applicant's most recent encounter with mental health was in October 2024. He is 80% service connected for several physical health conditions, but there is no indication of disability for any mental health diagnoses.

e. Based on the available information, it is the opinion of the Agency Behavioral Health Advisor that there is insufficient evidence to support that the applicant had a mental health condition that warrants a referral to the Disability Evaluation System. The documentation during the applicant's time in service does not support that the applicant was psychiatrically unfit at the time of discharge for any boardable mental health condition as he did not have persistent or reoccurring symptoms requiring extended or recurrent psychiatric hospitalization or persistent and reoccurring symptoms that interfered with duty performance or necessitated duty limitations (AR 40-501, para 3-33). To his request for consideration of an upgrade to the characterization of his discharge, there is insufficient evidence to fully opine on this change because of the absence of the specific facts and circumstances surrounding his discharge processing.

f. Kurta Questions:

(1) Did the applicant have a condition or experience that may excuse or mitigate the discharge? Yes. The applicant asserts he had an undiagnosed physical health condition that impaired his ability to distinguish right from wrong at the time of his discharge. A review of his mental health records showed that he was diagnosed with Major Depressive Disorder, Atypical Depressive Disorder, and Psychosis NOS. However, his symptoms resolved, and he discontinued mental health treatment in June 2010. A Mental Status Evaluation conducted on 13 April 2011 showed no indication of any altered mental status, and the applicant was deemed to be fit for duty and worldwide qualified.

(2) Did the condition exist or experience occur during military service? Yes, the applicant asserts he was experiencing a potentially mitigating condition while on active service.

(3) Does the condition or experience actually excuse or mitigate the discharge? NA. Without knowledge of the basis for separation, no opinion regarding mitigation under liberal consideration can be made. However, the applicant's assertion of an undiagnosed condition as a mitigating factor, per Liberal Consideration, warrants consideration by the board.

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 request, supporting documents, evidence in the records, and published Department of Defense guidance for liberal consideration of discharge upgrade requests. The complete facts and circumstances surrounding the applicant's discharge are unknown. The Board found no error or injustice in the separation proceedings and designated characterization of service.

2. The Board considered the following Kurta Questions:

(1) Did the applicant have a condition or experience that may excuse or mitigate the discharge? Yes. The applicant asserts he had an undiagnosed physical health condition that impaired his ability to distinguish right from wrong at the time of his discharge. A Mental Status Evaluation conducted on 13 April 2011 showed no indication of any altered mental status, and the applicant was deemed to be fit for duty and worldwide qualified.

(2) Did the condition exist or experience occur during military service? Yes, the applicant asserts he was experiencing a potentially mitigating condition while on active service.

(3) Does the condition or experience actually excuse or mitigate the discharge? N/A. Without knowledge of the basis for separation, no opinion regarding mitigation under liberal consideration can be made.

3. The Board concurred with the medical advisor's review finding insufficient evidence to support that the applicant had a mental health condition that warrants referral to the Disability Evaluation System. The Board concluded that the characterization of service the applicant received upon separation was not in error or unjust.

BOARD VOTE:

| <u>Mbr 1</u> | <u>Mbr 2</u> | <u>Mbr 3</u> | |
|--------------|--------------|--------------|----------------------|
| : | : | : | 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. 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 his/her 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 his or her 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. Army Regulation 635-200 (Active Duty Enlisted Administrative Separations) or (Personnel Separations – Enlisted Personnel) sets forth the basic authority for the separation of enlisted personnel.

a. Chapter 14 (Separation for Misconduct) establishes policy and prescribes procedures for separating members for misconduct. Specific categories include minor disciplinary infractions, a pattern of misconduct, commission of a serious offense, use of illegal drugs, and convictions by civil authorities. Action will be taken to separate a member for misconduct when it is clearly established that rehabilitation is impracticable or is unlikely to succeed. A discharge under other than honorable conditions is normally considered appropriate for a Soldier discharged under this chapter.

b. Chapter 3 (Character of Service and Description of Separation) provides:

(1) An honorable discharge is a separation with honor. The honorable characterization is appropriate when the quality of the Soldier's service generally has met the standards of acceptable conduct.

(2) A general discharge is a separation from the Army under honorable conditions. When authorized, it is issued to a Soldier whose military record is satisfactory, but not sufficiently meritorious to warrant an honorable discharge.

5. 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.

6. 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. The ABCMR begins its consideration of each case with the presumption of administrative regularity. The applicant has the burden of proving an error or injustice by a preponderance of the evidence.

//NOTHING FOLLOWS//