SERVICE TREATMENT RECORD (STR) CERTIFICATION

(Read Instructions on back before completing form.)

TO:

Veterans Benefits Administration,VA Regional Office

1. DATE OF CERTIFICATION *(YYYYMMDD)*

2. FROM *(Sending Organization and complete mailing address)*

This information is made available to Department of Veterans Affairs (VA) for utilization in potential claims processing. Please utilize information as appropriate.

The information herein is For Official Use Only (FOUO) and must be protected under the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act (HIPAA). These records should be handled with confidentiality to ensure the veteran/patient's privacy. Unauthorized disclosure or misuse of this personal information may result in criminal and/or civil penalties.

3. SERVICE MEMBER IDENTIFICATION

a. NAME *(Last, First, Middle Initial)*

b. SSN *(Last 4 digits)***/DoD ID NO.**

4. CERTIFICATION

(Insert type of document.)

A thorough review of all known DoD or United States Coast Guard (USCG) systems, as appropriate, has been accomplished as directed by DoDI 6040.45. As such, other than the records being enclosed herein, it has been concluded that no further records exist for the service member, and the STR is complete as of the certification date of this form. In the event additional documentation is discovered, it will immediately be made available to VA for utilization in potential claims processing.

COMMENTS:
**NOTE: If separating member has served less than 180 days, enter "Entry Level Separation" in comments area below.

5. OFFICE OF PRIMARY RESPONSIBILITY

a. OFFICE NAME AND ADDRESS

b. POINT OF CONTACT NAME *(Last, First, Middle Initial)*

c. EMAIL ADDRESS

d. TELEPHONE NUMBER *(Include Area Code/DSN)*

Controlled by: OUSD(P&R)
CUI Category: PRVCY
Distribution/Dissemination Control: FEDCON
POC: osd.pentagon.ousd-p-r.mbx.forms@mail.mil

INSTRUCTIONS FOR COMPLETING DD FORM 2963, SERVICE TREATMENT RECORD (STR) CERTIFICATION

(See DoDI 6040.45)

BLOCK 1. DATE OF CERTIFICATION ***(YYYYMMDD)*****.**
Enter date of certification.

BLOCK 2. FROM ***(Sending Organization and Complete Mailing Address)*****.**
Enter sender's or Command address.

BLOCK 3. SERVICE MEMBER INFORMATION.
3.a. NAME *(Last, First, Middle Initial)*. Enter Service member's legal name.
3.b. SSN *(Last 4 digits)*/DoD ID No. Enter the last 4 digits of Service member's SSN, or DoD Identification Number.

If Certifying a Complete STR:

BLOCK 4. CERTIFICATION. Select "Complete STR (Medical and Dental)."
COMMENTS. Enter comments as needed.
NOTE: Select Complete STR (Medical and Dental) if the records are consistent with requirements for an STR as directed by DoDI 6040.45.

If Certifying Medical Records Only:

BLOCK 4. CERTIFICATION. Select "Medical Record."
COMMENTS. Enter comments as needed.
NOTE: If separating member has served less than 180 days, enter "Entry Level Separation" in Comments area.

If Certifying Dental Records Only:

BLOCK 4. CERTIFICATION. Select "Dental Record."
COMMENTS. Enter comments as needed.
NOTE: If separating member has served less than 180 days, enter "Entry Level Separation" in Comments area.

BLOCK 5. OFFICE OF PRIMARY RESPONSIBILITY.
Enter requested information of the Office of Primary Responsibility or Point of Contact (POC):
5.a. Enter name and address of Medical Treatment Facility (MTF) or Dental Treatment Facility (DTF).
5.b. POINT OF CONTACT NAME *(Last, First, Middle Initial)*. Enter POC name.
5.c. EMAIL ADDRESS. Enter POC email address.
5.d. TELEPHONE NUMBER *(Include Area Code)*. Enter commercial telephone number of MTF or DTF.