OMB Approved No. 2900-0776
Respondent Burden: 30 Minutes
Expiration Date: 03/31/2021

Department of Veterans Affairs

HEART CONDITIONS (INCLUDING ISCHEMIC AND NON-ISCHEMIC HEART DISEASE, ARRHYTHMIAS, VALVULAR DISEASE AND CARDIAC SURGERY) DISABILITY BENEFITS QUESTIONNAIRE

NOTE: For coronary artery disease, myocardial infarction, or hypertensive disease, complete VA Form 21-0960A-1, Ischemic Heart Disease Disability Benefits Questionnaire.

IMPORTANT - THE DEPARTMENT OF VETERANS AFFAIRS (VA) ***WILL NOT PAY*** OR ***REIMBURSE*** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

___ – ___ – ____

NOTE TO PHYSICIAN: Your patient is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the veteran's claim. VA reserves the right to confirm the authenticity of ALL DBQ's completed by private health care providers.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH A HEART CONDITION?

☐ YES ☐ NO *(If "Yes," complete Item 1B)*

1B. SELECT THE VETERAN'S HEART CONDITION(S) *(Check all that apply):*

☐ Acute, subacute, or old myocardial infarction	ICD Code: _____	Date of diagnosis: _____
☐ Atherosclerotic cardiovascular disease	ICD Code: _____	Date of diagnosis: _____
☐ Coronary artery disease	ICD Code: _____	Date of diagnosis: _____
☐ Stable angina	ICD Code: _____	Date of diagnosis: _____
☐ Unstable angina	ICD Code: _____	Date of diagnosis: _____
☐ Coronary spasm, including Prinzmetal's angina	ICD Code: _____	Date of diagnosis: _____
☐ Congestive heart failure	ICD Code: _____	Date of diagnosis: _____
☐ Supraventricular arrhythmia	ICD Code: _____	Date of diagnosis: _____
☐ Ventricular arrhythmia	ICD Code: _____	Date of diagnosis: _____
☐ Heart block	ICD Code: _____	Date of diagnosis: _____
☐ Valvular heart disease	ICD Code: _____	Date of diagnosis: _____
☐ Heart valve replacement	ICD Code: _____	Date of diagnosis: _____
☐ Cardiomyopathy	ICD Code: _____	Date of diagnosis: _____
☐ Hypertensive heart disease	ICD Code: _____	Date of diagnosis: _____
☐ Heart transplant	ICD Code: _____	Date of diagnosis: _____
☐ Implanted cardiac pacemaker	ICD Code: _____	Date of diagnosis: _____
☐ Implanted automatic implantable cardioverter defibrillator (AICD)	ICD Code: _____	Date of diagnosis: _____
☐ Infectious heart conditions (including active valvular infection, rheumatic heart disease, endocarditis, pericarditis or syphilitic heart disease)	ICD Code: _____	Date of diagnosis: _____
☐ Pericardial adhesions	ICD Code: _____	Date of diagnosis: _____
☐ Other heart condition, specify below		
Diagnosis #1: _____	ICD Code: _____	Date of diagnosis: _____
Diagnosis #2: _____	ICD Code: _____	Date of diagnosis: _____

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO HEART CONDITIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S HEART CONDITION(S) *(brief summary):*

2B. DO ANY OF THE VETERAN'S HEART CONDITIONS QUALIFY WITHIN THE GENERALLY ACCEPTED MEDICAL DEFINITION OF ISCHEMIC HEART DISEASE (IHD)?

☐ YES ☐ NO *(If "Yes," list the conditions that qualify):*

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION II - MEDICAL HISTORY *(Continued)*

2C. PROVIDE THE ETIOLOGY, IF KNOWN, OF EACH OF THE VETERAN'S HEART CONDITIONS, INCLUDING THE RELATIONSHIP/CAUSALITY TO OTHER HEART CONDITIONS, PARTICULARLY THE RELATIONSHIP/CAUSALITY TO THE VETERAN'S IHD CONDITIONS, IF ANY:

Heart condition #1 (provide etiology): _____

Heart condition #2 (provide etiology): _____

2D. IF THERE ARE ADDITIONAL HEART CONDITIONS, PROVIDE ETIOLOGY AND LIST USING THE ABOVE FORMAT:

2E. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF THE VETERAN'S HEART CONDITION?

☐ YES ☐ NO

(If, "Yes," list medications required for the veteran's heart condition (include name of medication and heart condition it is used for, such as atenolol for myocardial infarction or atrial fibrillation):

SECTION III - MYOCARDIAL INFARCTION (MI)

3A. HAS THE VETERAN HAD A MYOCARDIAL INFARCTION (MI)?

☐ YES ☐ NO *(If, "Yes," complete the following):*

MI #1: Date and treatment facility: _____ _____

MI #2: Date and treatment facility: _____ _____

3B. IF THE VETERAN HAS HAD ADDITIONAL MIs, LIST USING ABOVE FORMAT:

SECTION IV - CONGESTIVE HEART FAILURE (CHF)

4A. HAS THE VETERAN HAD CONGESTIVE HEART FAILURE (CHF)?

☐ YES ☐ NO *(If "Yes," complete Item 4B)*

4B. DOES THE VETERAN HAVE CHRONIC CHF?

☐ YES ☐ NO

4C. HAS THE VETERAN HAD ANY EPISODES OF ACUTE CHF IN THE PAST YEAR?

☐ YES ☐ NO

(If, "Yes," specify the number of episodes of acute CHF the veteran has had in the past year):

☐ 0 ☐ 1 ☐ More than 1 *Provide date of most recent episode of acute CHF:* _____

4D. WAS THE VETERAN ADMITTED FOR TREATMENT OF ACUTE CHF?

☐ YES ☐ NO *(If, "Yes," indicate name of treatment facility):* _____

SECTION V - ARRHYTHMIA

5A. HAS THE VETERAN HAD A CARDIAC ARRHYTHMIA?

☐ YES ☐ NO *(If "Yes," complete Item 5B)*

5B. SELECT TYPE OF ARRHYTHMIA *(Check all that apply):*

☐ Atrial fibrillation

(If checked, indicate frequency): ☐ Constant ☐ Intermittent (paroxysmal)

(If "Intermittent," indicate number of episodes in the past 12 months): ☐ 0 ☐ 1 - 4 ☐ More than 4

(Indicate how these episodes were documented.) (Check all that apply):

☐ EKG ☐ Holter ☐ Other, specify: _____

☐ Atrial flutter

(If checked, indicate frequency): ☐ Constant ☐ Intermittent (paroxysmal)

(If "Intermittent," indicate number of episodes in the past 12 months): ☐ 0 ☐ 1 - 4 ☐ More than 4

(Indicate how these episodes were documented.) (Check all that apply):

☐ EKG ☐ Holter ☐ Other, specify: _____

☐ Supraventricular tachycardia

(If checked, indicate frequency): ☐ Constant ☐ Intermittent (paroxysmal)

(If "Intermittent," indicate number of episodes in the past 12 months): ☐ 0 ☐ 1 - 4 ☐ More than 4

(Indicate how these episodes were documented.) (Check all that apply):

☐ EKG ☐ Holter ☐ Other, specify: _____

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION V - ARRHYTHMIA *(Continued)*

5B. SELECT TYPE OF ARRHYTHMIA *(Check all that apply) (Continued)*

☐ Atrioventricular block ☐ I degree ☐ II degree ☐ III degree

☐ Ventricular arrhythmia (sustained)

(Indicate date of hospital admission for initial evaluation and medical treatment in Section IX, Procedures)

☐ Other cardiac arrhythmia, specify: _____

(If checked, indicate frequency): ☐ Constant ☐ Intermittent (paroxysmal)

(If "Intermittent," indicate number of episodes in the past 12 months): ☐ 0 ☐ 1 - 4 ☐ More than 4

(Indicate how these episodes were documented.) (Check all that apply):

☐ EKG ☐ Holter ☐ Other, specify: _____

SECTION VI - HEART VALVE CONDITIONS

6A. HAS THE VETERAN HAD A HEART VALVE CONDITION?

☐ YES ☐ NO *(If "Yes," complete Item 6B)*

6B. SELECT HEART VALVES AFFECTED *(Check all that apply):*

☐ Mitral ☐ Tricuspid ☐ Aortic ☐ Pulmonary

6C. DESCRIBE TYPE OF HEART VALVE CONDITION FOR EACH CHECKED VALVE:

SECTION VII - INFECTIOUS HEART CONDITIONS

7A. HAS THE VETERAN HAD ANY INFECTIOUS CARDIAC CONDITIONS, INCLUDING ACTIVE VALVULAR INFECTION (INCLUDING RHEUMATIC HEART DISEASE), ENDOCARDITIS, PERICARDITIS OR SYPHILITIC HEART DISEASE?

☐ YES ☐ NO *(If "Yes," complete Item 7B)*

7B. HAS THE VETERAN UNDERGONE OR IS THE VETERAN CURRENTLY UNDERGOING TREATMENT FOR ANY ACTIVE INFECTION?

☐ YES ☐ NO

(If, "Yes," describe treatment and site of infection being treated):

7C. HAS TREATMENT FOR AN ACTIVE INFECTION BEEN COMPLETED?

☐ YES ☐ NO

(If, "Yes," provide date completed): _____

7D. HAS THE VETERAN HAD A SYPHILITIC AORTIC ANEURYSM?

☐ YES ☐ NO *(If "Yes," ALSO complete VA Form 21-0960A-2, Artery and Vein Conditions Disability Benefits Questionnaire)*

SECTION VIII - PERICARDIAL ADHESIONS

8A. HAS THE VETERAN HAD PERICARDIAL ADHESIONS?

☐ YES ☐ NO *(If "Yes," complete Item 8B)*

8B. SELECT ETIOLOGY OF PERICARDIAL ADHESIONS:

☐ Pericarditis ☐ Cardiac surgery/bypass ☐ Other, describe: _____

SECTION IX - PROCEDURES

9A. HAS THE VETERAN HAD ANY NON-SURGICAL OR SURGICAL PROCEDURES FOR THE TREATMENT OF A HEART CONDITION?

☐ YES ☐ NO *(If "Yes," complete Item 9B)*

9B. INDICATE THE NON-SURGICAL OR SURGICAL PROCEDURES THE VETERAN HAS HAD FOR THE TREATMENT OF HEART CONDITIONS *(Check all that apply):*

☐ Percutaneous coronary intervention (PCI) (angioplasty)

Indicate date of treatment or date of admission if admitted for treatment and name of treatment facility: _____

_____

☐ Coronary artery bypass surgery

Indicate date of admission for treatment and name of treatment facility: _____ _____

☐ Heart valve replacement

Specify valve(s) replaced and type of valve(s): _____

Indicate date of admission for treatment and name of treatment facility: _____ _____

☐ Heart transplants

Indicate date of admission for treatment and name of treatment facility: _____ _____

☐ Implanted cardiac pacemaker

Indicate date of admission for treatment and name of treatment facility: _____ _____

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION IX - PROCEDURES *(Continued)*

9B. INDICATE THE NON-SURGICAL OR SURGICAL PROCEDURES THE VETERAN HAS HAD FOR THE TREATMENT OF HEART CONDITIONS *(Continued)*
(Check all that apply):

☐ Implanted automatic implantable cardioverter defibrillator (AICD)
Indicate date of admission for treatment and name of treatment facility: _____ _____

☐ Valve replacement
If checked indicate valve(s) that have been replaced *(check all that apply):*
☐ Mitral ☐ Tricuspid ☐ Aortic ☐ Pulmonary
Indicate date of admission for treatment and name of treatment facility for each checked valve:
_____

☐ Ventricular aneurysmectomy
Indicate date of admission for treatment and name of treatment facility: _____ _____

☐ Other surgical and/or non-surgical procedures for the treatment of a heart condition, describe: _____
Indicate date of admission for treatment and name of treatment facility: _____ _____
Indicate the condition that resulted in the need for this procedure/treatment: _____

SECTION X - HOSPITALIZATIONS

10. HAS THE VETERAN HAD ANY OTHER HOSPITALIZATIONS FOR THE TREATMENT OF HEART CONDITIONS (OTHER THAN FOR NON-SURGICAL AND SURGICAL PROCEDURES DESCRIBED ABOVE)?

☐ YES ☐ NO *(If "Yes," provide the following):*

Date of admission for treatment and name of treatment facility: _____ _____

Condition that resulted in the need for hospitalization: _____

SECTION XI - PHYSICAL EXAM

11. PHYSICAL EXAM:

Heart rate: _____

Rhythm: ☐ Regular ☐ Irregular
Point of maximal impact: ☐ Not palpable ☐ 4th intercostal space ☐ 5th intercostal space ☐ Other, specify: _____
Heart sounds: ☐ Normal ☐ Abnormal, specify: _____
Jugular-venous distension: ☐ Yes ☐ No
Auscultation of the lungs: ☐ Clear ☐ Bibasilar rales ☐ Other, describe: _____
Peripheral pulses:
Dorsalis pedis: ☐ Normal ☐ Diminished ☐ Absent
Posterior tibial: ☐ Normal ☐ Diminished ☐ Absent
Peripheral edema:
Right lower extremity: ☐ None ☐ Trace ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+
Left lower extremity: ☐ None ☐ Trace ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+

Blood pressure: _____

SECTION XII - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS

12A. DOES THE VETERAN HAVE ANY SCARS *(surgical or otherwise)* RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

☐ YES ☐ NO

(If "Yes," are any of the scars painful and/or unstable, or is the total area of all related scars greater than or equal to 39 square cm (6 square inches)?)

☐ YES ☐ NO *(If "Yes," ALSO complete VA Form 21-0960F-1, Scars/Disfigurement Disability Benefits Questionnaire)*

12B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

☐ YES ☐ NO *(If "Yes," describe - brief summary):*

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION XIII - DIAGNOSTIC TESTING

NOTE: For VA purposes, exams for all heart conditions require a determination of whether or not cardiac hypertrophy or dilatation is present. The suggested order of testing for cardiac hypertrophy/dilatation is EKG, then chest x-ray (PA and lateral), then echocardiogram. An echocardiogram to determine heart size is only necessary if the other two tests are negative. Also for VA purposes, if LVEF testing is not of record, but available medical information sufficiently reflects the severity of the veteran's cardiovascular condition, LVEF testing is not required.

13A. IS THERE EVIDENCE OF CARDIAC HYPERTROPHY?

☐ YES ☐ NO

(If "Yes," indicate how this condition was documented):

☐ EKG ☐ Chest x-ray ☐ Echocardiogram Date of test: _____

13B. IS THERE EVIDENCE OF CARDIAC DILATATION?

☐ YES ☐ NO

(If "Yes," indicate how this condition was documented):

☐ Chest x-ray ☐ Echocardiogram Date of test: _____

13C. SELECT ALL TESTING COMPLETED AND PROVIDE MOST RECENT RESULTS WHICH REFLECT THE VETERAN'S CURRENT FUNCTIONAL STATUS
(Check all that apply):

☐ EKG
Date of EKG: _____
Result of EKG:
☐ Normal
☐ Arrhythmia, describe: _____
☐ Hypertrophy, describe: _____
☐ Ischemic, describe: _____
☐ Other, describe: _____

☐ Chest x-ray
Date of CXR: _____
Result of CXR:
☐ Normal
☐ Abnormal, describe: _____

☐ Echocardiogram
Date of echocardiogram: _____
Left ventricular ejection fraction (LVEF): _____ %
Wall motion: ☐ Normal ☐ Abnormal, describe: _____
Wall thickness: ☐ Normal ☐ Abnormal, describe: _____

☐ Holter monitor
Date of holter monitor test: _____
Result:
☐ Normal
☐ Abnormal, describe: _____

☐ MUGA
Date of MUGA: _____
Left ventricular ejection fraction (LVEF): _____ %
Result:
☐ Normal
☐ Abnormal, describe: _____

☐ Coronary artery angiogram
Date of angiogram: _____
Result:
☐ Normal
☐ Abnormal, describe: _____

☐ CT angiography
Date of CT angiography: _____
Result:
☐ Normal
☐ Abnormal, describe: _____

☐ Other test, specify:
_____
_____
Date of test: _____
Result: _____

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION XIV - METs TESTING

NOTE: For VA purposes, all heart exams require METs testing (either exercise-based or interview-based) to determine the activity level at which symptoms such as dyspnea, fatigue, angina, dizziness, or syncope develop (except exams for supraventricular arrhythmias.)

If a laboratory determination of METs by exercise testing cannot be done for medical reasons (e.g. chronic CHF or multiple episodes of acute CHF within the past 12 months), or if exercise-based METs test was not completed because it is not required as part of the veteran's treatment plan, or if exercise stress test results do no reflect veteran's current cardiac function, perform an interview-based METs test based on the veteran's responses to a cardiac activity questionnaire and provide the results below.

14A. INDICATE ALL TESTING COMPLETED PROVIDING ONLY MOST RECENT RESULTS WHICH REFLECT THE VETERAN'S CURRENT FUNCTIONAL STATUS. *(Check all that apply):*

☐ Exercise stress test

Date of most recent exercise stress test: _____

Results: _____

METs level the veteran performed, if provided: _____

☐ Interview-based METs test

Date of interview-based METs test: _____

Symptoms during activity:
The METs level checked below reflects the lowest activity level at which the veteran reports any of the following symptoms *(check all symptoms that the veteran reports at the indicated METs level of activity)*:

☐ Dyspnea ☐ Fatigue ☐ Angina ☐ Dizziness ☐ Syncope

☐ Other, describe: _____

Results:

METs level on most recent interview-based METs test:

☐ (1-3 METs) This METs level has been found to be consistent with activities such as eating, dressing, taking a shower, slow walking (2 mph) for 1-2 blocks

☐ (>3-5 METs) This METs level has been found to be consistent with activities such as light yard work (weeding), mowing lawn (power mower), brisk walking (4 mph)

☐ (>5-7 METs) This METs level has been found to be consistent with activities such as walking 1 flight of stairs, golfing (without cart), mowing lawn (push mower), heavy yard work (digging)

☐ (>7-10 METs) This METs level has been found to be consistent with activities such as climbing stairs quickly, moderate bicycling, sawing wood, jogging (6 mph)

☐ The veteran denies experiencing above symptoms with any level of physical activity

14B. IF THE VETERAN HAS HAD BOTH AN EXERCISE STRESS TEST AND INTERVIEW-BASED METs TEST, INDICATE WHICH RESULTS MOST ACCURATELY REFLECT THE VETERAN'S CURRENT CARDIAC FUNCTIONAL LEVEL:

☐ Exercise stress test ☐ Interview-based METs test ☐ N/A

14C. IS THE METs LEVEL LIMITATION DUE SOLELY TO THE HEART CONDITIONS?

☐ YES ☐ NO

(If "No," estimate the percentage of the METs level limitation that is due solely to the heart condition(s)):

☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90%

☐ The limitation in METs level is due to multiple factors; it is not possible to accurately estimate this percentage.

14D. IN ADDITION TO THE HEART CONDITION(S), DOES THE VETERAN HAVE OTHER NON-CARDIAC MEDICAL CONDITIONS *(such as musculoskeletal or pulmonary conditions)* LIMITING THE METs LEVEL?

☐ YES ☐ NO

(If "Yes," identify each condition and describe how each non-cardiac medical condition limits the veteran's METs level):

Other medical condition #1: _____ Effect on METs level: _____

Other medical condition #2: _____ Effect on METs level: _____

14E. IF THERE ARE ADDITIONAL MEDICAL CONDITIONS AFFECTING METs LEVEL, LIST USING ABOVE FORMAT:

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION XV - FUNCTIONAL IMPACT

15. DOES THE VETERAN'S HEART CONDITION(S) IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe impact of each of the veteran's heart conditions, providing one or more examples)*

SECTION XVI - REMARKS

16. REMARKS *(If any)*

SECTION XVII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

CERTIFICATION - To the best of my knowledge, the information contained herein is accurate, complete and current.

17A. PHYSICIAN'S SIGNATURE	17B. PHYSICIAN'S PRINTED NAME	17C. DATE SIGNED

17D. PHYSICIAN'S PHONE AND FAX NUMBER	17E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	17F. PHYSICIAN'S ADDRESS

NOTE: VA may obtain additional medical information, including an examination, if necessary to complete VA's review of the veteran's application.

IMPORTANT - Physician please fax the completed form to _____
(VA Regional Office FAX No.)

NOTE: A list of VA Regional Office FAX Numbers can be found at **www.benefits.va.gov/disabilityexams** or obtained by calling 1-800-827-1000.

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58/VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to determine entitlement to benefits (38 U.S.C. 501). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information, and complete the form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.