

VETERAN'S AUTHORIZATION FOR DISABILITY RECORD

Instructions to Veteran: Complete PART A and send this form to the Department of Veterans Affairs where your disability claim is on file. That office will then complete PART B and return to the address above.

PART A (To be completed by Disabled Veteran)

Examination Title: _____ **Exam Number:** _____

Applicant's Name: _____ **Soc Sec No:** ___/___/_____

Mailing Address: _____
Street Address or PO Box City State Zip

Legal Residence: _____
Street Address or PO Box City State Zip

V.A. Claim Number: _____ **Service Serial Number:** _____

I hereby authorize the Department of Veterans Affairs to furnish the Town of Colonie with the data requested in **PART B** below pertaining to my disability status. The office is released from all liability in complying with this request. It is understood that all information furnished will be treated as confidential.

X _____ **Date Signed** _____
Signature of Veteran

PART B (To be completed by Department of Veterans Affairs)

Dept of Veterans Affairs Office: _____ Claim Number: _____

1. Does the above-named veteran now have a war-incurred disability? ___ Yes ___ No

If yes, please enter date disability was sustained: ___/___/_____

2. Percentage of such disability now in existence: _____%

3. Describe the disability: _____

4. Date of last medical examination by Medical Officer in connection with such disability: ___/___/_____ (If less than one year ago, **do not** answer questions 5 and 6.)

5. Does the Department of Veterans Affairs state affirmatively that a permanent stabilized condition of disability exists, even though claimant has not been examined by the Dept of Veterans Affairs Medical Officer within one year? ___Yes___No

6. Date of next scheduled examination by the Dept of Veterans Affairs: ___/___/_____

7. Additional remarks: _____

x _____ **Date signed** _____
Signature of Adjudication Officer