

1 TO BE COMPLETED BY DISABLED VETERAN:

To Manager, Veterans Administration _____, N.Y.

I hereby authorize you to furnish the Westchester County Department of Human Resources with the data requested in Section 2, below, pertaining to my disability status. You are released from all liability in complying with this request. It is understood that all information furnished with be treated as confidential.

Date: _____ Veteran's Signature _____

PRINT FULL NAME	VA CLAIM NO.	SERIAL NO.
ADDRESS	NO. AND TITLE OF EXAMINATION(S) FOR WHICH CREDIT IS CLAIMED	

2 TO BE COMPLETED BY VETERANS ADMINISTRATION:

Please return original to: Recruitment and Selection Unit
 Westchester County Department of Human Resources
 148 Martine Avenue, Suite 100, White Plains, NY 10601

DATE	CLAIM NO.	REGIONAL V.A. OFFICE
a.	Does the above-named veteran now have war-disability? If "Yes" please enter date disability was sustained.	
	<input type="checkbox"/> YES <input type="checkbox"/> NO	
b.	Is this veteran receiving disability payments from the V.A. for such disability?	
	<input type="checkbox"/> YES <input type="checkbox"/> NO	
c.	State percentage of such disability.	
	%	
d.	Describe the disability.	
e.	Date of last medical examination by the V.A. Medical Officer in Connection with such disability: <small>[IF LESS THAN ONE YEAR AGO, DO NOT ANSWER (f.) and (g.)]</small>	
f.	Does the V.A. state affirmatively that a permanent stabilized condition of disability exists to an extent of 10% or more, even though claimant has been examined by V.A. Medical Officer within on year?	
	<input type="checkbox"/> YES <input type="checkbox"/> NO	
g.	Date of next examination by the V.A.	
h.	Remarks:	

Signature of Adjudication Officer: _____