

INSTRUCTIONS

Applicant must complete Section I. (Type or write with ink.) Forward to Regional Office of Veterans Administration where disability claim is now on file.

MUNICIPAL CIVIL SERVICE COMMISSION CITY OF MOUNT VERNON, N. Y.

Authorization For Disability Record

Veterans Administration retain one copy and forward duplicate to the

Municipal Civil Service Commission CITY OF MOUNT VERNON, N. Y.

Section I

Date:.....

To: Manager, Veterans Administration, New York.

I hereby authorize you to furnish the Municipal Civil Service Commission named above, with my medical and disability record. You are released from all liability in complying with this request. It is understood that all information furnished will be treated as confidential.

Veteran's Signature:

Print full name here:

First Middle Last

Address:

Street City State

Veterans Administration Claim No.:

Service Serial No.:

Examination or eligible list for which preference is claimed:

Title: No.

Title: No.

Title: No.

Section II - TO BE FILLED OUT BY THE VETERANS ADMINISTRATION

Date:.....

Veterans Administration Claim No.:.....

- 1. Does the above veteran have a war-incurred disability now in existence? Yes () No ()
2. Is he receiving disability payments from the V. A. for such disability? Yes () No ()
3. State percentage of war-incurred disability now in existence
4. Description of such disability
5. Date of last medical examination by the V. A. Medical Officer in connection with such disability
6. Does the V. A. state affirmatively that a permanent stabilized condition of disability exists to an extent of 10% or more, notwithstanding the fact that such claimant has not been examined by a medical officer of the V. A. within one year? Yes () No ()
7. Date of next scheduled medical examination by the V. A.
8. REMARKS:

Adjudication Officer Signature

Regional V. A. Office

