



PARALYZED VETERANS OF AMERICA MEMBERSHIP APPLICATION PROFILE

801 Eighteenth Street, NW * Washington, DC 20006-3517
800-424-8200 ext. 658 * 202-416-7658 * (202) 416-7622 TTY

Chapter Name: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: ____/____/____ Social Security Number: _____

Male Female Are you an United States citizen? Yes No

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Other Phone: (____) _____ Email: _____

VETERAN STATUS INFORMATION

| DATE(S) OF MILITARY SERVICE | | TYPE OF SEPARATION <i>Discharge (D) or Retirement (R)</i> | BRANCH OF SERVICE |
|-----------------------------|-----------------|--|---|
| <i>Start Date</i> | <i>End Date</i> | | |
| | | <input type="checkbox"/> D or <input type="checkbox"/> R | <input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Coast Guard |
| | | <input type="checkbox"/> D or <input type="checkbox"/> R | <input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Coast Guard |

Have you ever been discharged under conditions that are less than honorable? Yes No

Is your spinal cord injury or spinal cord disease service connected? Yes No

DISABILITY CLASSIFICATION

SPINAL CORD INJURY

(Complete ONLY if you have a traumatic spinal cord injury)

Date of Injury: ____/____/____

Injury Level: C01-C08 Cervical T01-T12 Thoracic
 L01-L05 Lumbar S01-S05 Sacral

Cause of SCI:

- Vehicular (*auto, motorcycle, aircraft, bicycle, etc*)
- Violence (*gunshot, stabbing, explosion, etc*)
- Pedestrian an (*hit by car etc.*)
- Sports or recreation (*swimming, diving, etc.*)
- Flying or falling object
- Medical/surgical complications
- Other traumatic injury _____
- Unknown

SPINAL CORD DISEASE

(Complete ONLY if you have a nontraumatic spinal cord disease)

Date of diagnosis/onset of condition: ____/____/____

Specific disease:

- Multiple sclerosis
- Poliomyelitis
- Amyotrophic diseases lateral *sclerosis, transverse myelitis*)
- Syringomyelia
- Other (specify) _____

LEVEL OF FUNCTION

Indicate your level of function

Paraplegia Quadriplegia Hemiplegia No paralysis at this time

GENERAL INFORMATION

Please check the appropriate box or fill in the blank in EACH of the categories that best describes your **present** status. This important information enables the Paralyzed Veterans of America to compile data for the effective implementation and support of our programs.

Education (Highest Level)

- Less than high school graduate
- High school graduate/GED
- Some college or trade school
- Associate's degree
- Bachelor's degree
- Attended graduate school
- Graduate degree
- Other _____

Current Employment Status

- Employed full time
- Employed part time
- Self-employed
- Unemployed
- Unemployed due to disability
- Retired
- Other _____

Marital Status

- Divorced
- Married
- Never married
- Separated
- Widowed

Race/Ethnicity

- Asian or Pacific Islander
- Black, not Hispanic/Latino origin
- Hispanic/Latino
- Native American or Alaskan Native
- White, not Hispanic/Latino origin
- Other _____

Type of Residence

- Apartment
- Assisted living facility
- Single-family home/condominium
- State/veterans retirement home
- Nursing home
- VA hospital
- VA nursing home
- Other _____

Source(s) of Income

(Check all that apply)

- Employment
- Gifts/Other _____
- Private Pension
- Social Security
- VA compensation
- VA pension
- Worker's Compensation

NEXT OF KIN INFORMATION

Relationship: _____

Name: _____

Same as member address on front of form

Address: _____

City: _____

State: _____ Zip: _____

Home Phone (_____) _____

BENEFITS ASSISTANCE

The Veterans Benefits Department advocates for quality health care for our members and ensure that appropriate benefits are available as a result of your military service.

Is PVA presently your benefits representative?

Yes No

Applicant's signature is required for processing

Applicant's Signature: _____ Date: ____/____/____

The information supplied above will be held in strictest confidence by the Paralyzed Veterans of America.

NATIONAL OFFICE USE ONLY

Membership Identification Number _____

Processed by _____

DATE RECEIVED

Process Date ____/____/____