

Delaware County Personnel Office  
1 Courthouse Square, Suite #2  
Delhi, New York 13753

**AUTHORIZATION FOR DISABILITY RECORD**

**1. TO BE COMPLETED BY DISABLED VETERAN**

Complete two copies on typewriter or print in ink. Then send both copies to Office of Veterans Administration where your disability claim is on file.

**To Manager, Veterans Administration \_\_\_\_\_, New York**

I hereby authorize you to furnish the above Personnel Office 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 will be treated as confidential.

Veteran's Signature \_\_\_\_\_ Date \_\_\_\_\_

PRINT FULL NAME

VA CLAIM NO.

SERVICE SERIAL NO.

SOCIAL SECURITY NUMBER

NO. AND TITLE OF EXAMINATION FOR WHICH CREDIT IS CLAIMED

ADDRESS

**2. TO BE COMPLETED BY VETERANS ADMINISTRATION**

Please return original to the Delaware County Personnel Office

DATE

CLAIM NO.

REGIONAL V.A. OFFICE

a. Does the above named veteran now have a war incurred disability?  YES  NO  
If "Yes" please enter date disability was sustained \_\_\_\_\_ (Month, day, year)

b. Is this veteran receiving disability payments from the V.A. for such disability?  YES  NO

c. State percentage of such disability now in existence. \_\_\_\_\_ %

d. Describe the disability.

e. Date of last medical examination by the V.A. Medical Officer in connection with such disability.  
(IF LESS THAN ONE YEAR AGO DO NOT ANSWER f AND g. \_\_\_\_\_ (Month, day, year)

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 not been examined by V.A. Medical Officer within one year?  YES  NO

g. Date of next scheduled examination by the V.A. \_\_\_\_\_ (Month, day, year)

h. Remarks

Signature of Adjudication Officer: \_\_\_\_\_