



# MEMBERSHIP/CERTIFICATION APPLICATION

An individual is eligible for membership by meeting the following criteria: (1) is a citizen of the United States; (2) was regularly enlisted, inducted or commissioned for active duty service in the Army, Navy, Marine Corps, Air Force, or Coast Guard of the United States, or our allies as evidenced by other-than-dishonorable character of service documented by a verifiable DD-214 or DD-215 (entry-level separation not acceptable); (3A) was separated from the service in the Armed Forces under conditions other than dishonorable; or (3B) is on active duty or must continue to serve after the cessation of hostilities; and (4) has suffered a spinal cord injury or disease (such as MS, ALS), whether or not service connected in origin. Membership is free. **Complete and return application to the chapter or by mail, email, or fax to:** Paralyzed Veterans of America Membership Department, 801 Eighteenth Street, NW, Washington, DC 20006; (E) ChristiH@pva.org; (F) 202.416.1250. Providing the requested information is entirely voluntary but required for membership with Paralyzed Veterans of America.

**Chapter Name:** \_\_\_\_\_

**First Name:** \_\_\_\_\_ **Middle Initial:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_ / \_\_\_ / \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_  Male  Female

**Race/Ethnicity:**

- Asian/Pacific Islander                       African American/Descent       Hispanic/Latino
- Native American/Alaskan Native       Caucasian

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

**State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Other Phone:** \_\_\_\_\_

## VETERAN STATUS INFORMATION

**Please submit the following with application:**

- Proof of U.S. or U.S. Territorial Citizenship (Birth Certificate, Passport, INS Form, or Voter’s Registration Form).
- DD214 showing character of discharge.
- Medical evidence of spinal cord injury or involvement (medical records or physician’s statement).

***Proof of active duty status must be verified prior to membership approval.***

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

If yes, please explain: \_\_\_\_\_

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

## DISABILITY CLASSIFICATION

***Injury or diseases involving the brain but not the spinal cord do not qualify.***

**SPINAL CORD INJURY**

Complete only if you have a traumatic spinal cord injury.

**Date of Injury:** \_\_\_ / \_\_\_ / \_\_\_\_\_

**Cause of Spinal Cord Injury:**

- Vehicular (car, motorcycle, aircraft, etc.)
- Violence (gunshot, explosion, etc.)
- Flying/Falling object
- Sport/Recreation (swimming, diving, etc.)
- Pedestrian (car accident, etc.)
- Unknown
- Other traumatic injury: \_\_\_\_\_

**SPINAL CORD DISEASE**

Complete only if there is no spinal cord injury.

**Date of Diagnosis/Onset of Condition:** \_\_\_ / \_\_\_ / \_\_\_\_\_

**Specific Disease Involving Spinal Cord:**

- Multiple Sclerosis (involving bowel & bladder)
- Poliomyelitis
- Syringomyelia
- Amyotrophic diseases  
(lateral sclerosis, transverse myelitis)
- Other: \_\_\_\_\_



**Paralyzed Veterans  
of America**

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The Veterans Benefits Department advocates for quality health care for our members and can assist you to obtain the appropriate benefits available as a result of your military service.

Is Paralyzed Veterans of America presently your accredited representative?  Yes  No

*If yes, I hereby request that my eligibility for membership in the Paralyzed Veterans of America be certified. I consent to process my submitted medical documentation to a confidential review by a member of the Paralyzed Veterans of America National Medical Staff, to validate that my condition presents as having spinal cord involvement and to allow official Certification by the Paralyzed Veterans of America National Secretary. I have no objection and hereby permit Paralyzed Veterans of America Service Officers to provide information to the Paralyzed Veterans of America National Membership Department that pertains to my qualifications for membership/certification.*

*I declare that I have read and meet the qualifications. I understand that my membership/certification could be denied or revoked if any information provided is inaccurate.*

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_ / \_\_\_ / \_\_\_\_\_

**I do not wish to become a certified member**

## OFFICE USE ONLY

### CAUTION TO ANYONE HAVING ACCESS TO THESE DOCUMENTS

The documents provided by the requester are personal in nature and are for membership eligibility and certification only. Information contained within these documents shall be treated with extreme confidentiality and released only to those employees of Paralyzed Veterans of America authorized to access.

I certify that I have personally examined the documents provided by the requester and find him/her to be eligible for membership/certification.

**National Secretary's Signature:** \_\_\_\_\_

**Date Received:** \_\_\_ / \_\_\_ / \_\_\_\_\_ **Date Acted Upon:** \_\_\_ / \_\_\_ / \_\_\_\_\_

**Member ID Number:** \_\_\_\_\_

**Date Received:** \_\_\_ / \_\_\_ / \_\_\_\_\_ **Date Processed:** \_\_\_ / \_\_\_ / \_\_\_\_\_