



# PARALYZED VETERANS OF AMERICA

## MEMBERSHIP 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, and was accepted for or on active duty, in the Army, Navy, Marine Corps, Air Force, or Coast Guard of the United States or an ally of the United States; (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 mail the application to: PVA Membership Department, 801 18th Street, NW, Washington, DC 20006 or to the chapter of choice.  
800-424-8200 • www.pva.org

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

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

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
month date year

Male  Female

Are you a 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	BRANCH OF SERVICE
Start Date <small>month/date/year</small>	End Date <small>month/date/year</small>	Discharge (D) or Retirement (R)	
		<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:  C1-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 (hit by car, etc.)
- Sport or recreation (swimming, diving, etc.)
- Flying or falling object
- Medical-surgical complications
- Other traumatic injury \_\_\_\_\_
- Unknown

#### SPINAL CORD DISEASE

*(Complete ONLY if you have non-traumatic 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 of each of the categorical that best describes your present status. This important information enables the PVA 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: \_\_\_\_\_

Phone: \_\_\_\_\_

## OTHER CONTACT INFORMATION

*(someone other than next of kin)*

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

The Veterans Benefits Department advocates for quality health care for our members and can assist you obtain the appropriate benefits available as a result of your military service. Is PVA presently your benefits representative?  Yes  No

If yes, I have no objection and hereby permit PVA Service Officers to provide information to the PVA National Membership Department that pertains to my qualifications for membership.

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

\_\_\_\_\_  
*Applicant's Signature*

\_\_\_\_\_  
*Date*

*Office Use Only*

*Date Received:* \_\_\_\_\_

*Member ID#:* \_\_\_\_\_

*Processed Date:* \_\_\_\_\_