



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: Gateway Chapter PVA #27

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 to 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: _____