



**Paralyzed Veterans  
of America**

# CERTIFICATION OF MEMBERSHIP ELIGIBILITY

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

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

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_

**Please submit the following with application:**

- Proof of U.S. or U.S. Territorial Citizenship (Birth Certificate, Passport, USCIS Form or DD Form 214 showing citizenship)
- DD Form 214 showing character of discharge
- Medical evidence of spinal cord injury or involvement (medical records or physician's statement)

*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: \_\_\_\_/\_\_\_\_/\_\_\_\_

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## OFFICE USE ONLY

**CAUTION TO ANYONE HAVING ACCESS TO THESE DOCUMENTS**

The documents provided by the requester are personal in nature and are for 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: \_\_\_\_/\_\_\_\_/\_\_\_\_