Disabled Veteran Status Verification

Full Name:

[   ]

Social Security Number (Last 4 digits):

[   ]

Date of Birth:

[   ]

Branch of Service:

[   ]

Service Dates:

[   ]

Percentage of Disability:

[   ]

VA Claim Number (if available):

[   ]

Attach Official VA Disability Verification Document:

[Choose File] No file selected

☐ I certify that the information provided is true and accurate to the best of my knowledge.

[Submit]