Paralyzed Veterans of America

CERTIFICATION OF MEMBERSHIP ELIGIBILITY

Chapter Name: Oregon Paralyzed Veterans of America, 3700 Silverton Rd NE, Salem, OR 97305

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).
- DD214 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**:____/____/_____

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:** ____/____/_____

Physician's Statement Form

_____ is a veteran who has a spinal cord injury or disease.

His/her diagnosis is:

- ☐ Paraplegia
- ☐ Quadriplegia
- ☐ Brown Sequard Syndrome
- ☐ Cauda Equina Syndrome
- ☐ ALS
- ☐ Multiple Sclerosis (involving the spinal cord)
- ☐ Transverse Myelitis
- ☐ Other (please specify) _____

_____
Physician’s Signature

_____
Physician’s Name

_____
Physician’s Title

_____
Physician's Phone/Email

_____
Date Signed