OMB Control No. 2900-0321
Respondent Burden: 5 Minutes
Expiration Date: 02/28/2022

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPOINTMENT OF INDIVIDUAL AS CLAIMANT'S REPRESENTATIVE

IMPORTANT: Please read the Privacy Act and Respondent Burden on Page 2 before completing the form.

NOTE: If you prefer to have a veterans service organization assist you with your claim instead of an individual please complete VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative.* When completed you can mail ***or*** fax this form to the appropriate intake center address shown on page 3. VA forms are available at www.va.gov/vaforms.

SECTION I: VETERAN'S INFORMATION

NOTE: You can *either* complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing of the form.

1. VETERAN'S NAME *(First, Middle Initial, Last)*

W i l l i a m

2. VETERAN'S SOCIAL SECURITY NUMBER *(SSN)* – –

3. VA FILE NUMBER *(If applicable)*

4. VETERAN'S DATE OF BIRTH Month – Day – Year

5. VETERAN'S SERVICE NUMBER *(If applicable)*

6. BRANCH OF SERVICE
☐ ARMY ☐ NAVY ☐ AIR FORCE ☐ MARINE CORPS ☐ COAST GUARD
☐ OTHER (*Specify*)

7. VETERAN'S MAILING ADDRESS (*Number and street or rural route, city or P.O., State and ZIP Code*)
No. & Street
Apt./Unit Number City
State/Province Country ZIP Code/Postal Code –

8. VETERAN'S TELEPHONE NUMBER *(Include Area Code)*

9. VETERAN'S EMAIL ADDRESS *(Optional)*

SECTION II: CLAIMANT'S INFORMATION (If other than veteran)

10. CLAIMANT'S NAME *(First, Middle Initial, Last)*

11. CLAIMANT'S MAILING ADDRESS (*Number and street or rural route, city or P.O., State and ZIP Code*)
No. & Street
Apt./Unit Number City
State/Province Country ZIP Code/Postal Code –

12. CLAIMANT'S TELEPHONE NUMBER *(Include Area Code)*

13. CLAIMANT'S EMAIL ADDRESS *(Optional)*

14. RELATIONSHIP TO VETERAN

SECTION III: SERVICE ORGANIZATION INFORMATION

15A. NAME OF INDIVIDUAL APPOINTED AS REPRESENTATIVE

Errol Sayin, Claims Agent# 21154

15B. INDIVIDUAL IS *(check appropriate box)*

☐ ATTORNEY ☐ AGENT ☐ INDIVIDUAL PROVIDING REPRESENTATION UNDER SECTION 14.630 *(*See required statement below. Signatures are required in Items 16A and 17A)*

☐ SERVICE ORGANIZATION REPRESENTATIVE(*Specify organization below*)

***INDIVIDUALS PROVIDING REPRESENTATION UNDER SECTION 14.630**

(Skip to Item 18, if the box for "Individual Providing Representation Under Section 14.630" was not checked in Item 15B)

The appointment of the individual named in Item 15A (the representative) authorizes that person to represent the individual named in Item 1 or 10 for a particular claim pursuant to the provisions of 38 CFR 14.630. By our signatures below, we, the representative and the veteran/claimant, attest that no compensation will be charged by or paid to the individual named in Item 15A.

16A. SIGNATURE OF REPRESENTATIVE NAMED IN ITEM 15A

16B. DATE OF SIGNATURE *(MM/DD/YYYY)*

17A. SIGNATURE OF INDIVIDUAL NAMED IN ITEM 1 OR 10

17B. DATE OF SIGNATURE *(MM/DD/YYYY)*

18. ADDRESS OF INDIVIDUAL APPOINTED AS CLAIMANT'S REPRESENTATIVE *(Number and street or rural route, city or P.O., State, and ZIP code)*

P.O. Box 1066, Riverside, CA 92502

VETERAN'S SOCIAL SECURITY NO. [ ] – [ ] – [ ]

SECTION IV: AUTHORIZATION INFORMATION

19. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C. -
Unless I check the box below, I do not authorize VA to disclose to the individual named in Item 15A any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

☐ I **authorize** the VA facility having custody of my VA claimant records to disclose to the individual named in Item 15A all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Redisclosure of these records by my representative, other than to VA or the Court of Appeals for Veterans Claims, is not authorized without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the individual named in Item 15A, either by explicit revocation or the appointment of another representative.

20. LIMITATION OF CONSENT. My consent in Item 19 for the disclosure of records relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia is limited as follows:

21. AUTHORIZATION FOR REPRESENTATIVE TO ACT ON CLAIMANT'S BEHALF TO CHANGE CLAIMANT'S ADDRESS -
Unless I check the box below, I do not authorize the individual named in Item 15A to act on my behalf to change my address in my VA records.

☐ I **authorize** the individual named in Item 15A to act on my behalf to change my address in my VA records. This authorization does not extend to any other individual with out my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the individual named in Item 15A, either by explicit revocation or the appointment of another representative.

CONDITIONS OF APPOINTMENT

I, the person named in Item 1 or 10, hereby **appoint** the individual named in Item 15A as my representative to prepare,present, and prosecute my claims for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. If the individual named in Item 15A is an accredited agent or attorney, the scope of representation provided before VA may be limited by the agent or attorney as indicated below in Item 23. If the individual indicated in Item 15A is providing representation under 14.630, such representation is limited to a particular claim only. I authorize VA to release any and all of my records (other than as provided in Items 19 and 20) to that individual appointed as my representative, and if the individual in Item 15A is an accredited agent or attorney, this authorization includes the following individually named administrative employees of my representative:

Signed and accepted subject to the foregoing conditions.

22A. SIGNATURE OF CLAIMANT *(Do Not Print)*	22B. DATE OF SIGNATURE *(MM/DD/YYYY)*

23. LIMITATIONS ON REPRESENTATION - AGENTS OR ATTORNEYS ONLY *(Unless limited by an agent or attorney, this power of attorney revokes all previously existing powers of attorney)*

24A. SIGNATURE OF REPRESENTATIVE	24B. DATE OF SIGNATURE *(MM/DD/YYYY)*

FEES: Section 5904, Title 38, United States Code, contains provisions regarding fees that may be charged, allowed, or paid for services of agents or attorneys in connection with a proceeding before the Department of Veterans Affairs with respect to benefits under laws administered by the Department.

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement of a material fact, knowing it to be false or for the fraudulent acceptance of any payment to which you are not entitled.

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records -VA, published in the Federal Register. Your obligation to respond is voluntary. However, failure to respond provide the requested information could impede the recognition of your representative and/or identification of disclosable records. Except for information protected by 38 U.S.C. 7332, your representative is not prohibited from redisclosing records. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to recognize the individuals appointed by claimants to act on their behalf in the preparation, presentation, and prosecution of claims for VA benefits (38 U.S.C. 5902, 5903, and 5904) and for those individuals to accept appointment. We will also use the information to verify consent for disclosure of VA records to the appointed representative (38 U.S.C. 5701(b) and 7332) Title 38, United States Code, allows us to ask for this information. We estimate that claimants and individuals appointed for purposes of representation will each need an average of 5 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. A Valid OMB control number can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

FOR ALL **COMPENSATION** CLAIMS MAIL OR FAX THIS FORM TO THE FOLLOWING ADDRESS:

Mail your form to:
Department of Veterans Affairs
Claims Intake Center
P.O. Box 4444
Janesville, WI 53547- 4444
Or fax your form to:
Toll Free: (844) 531- 7818
Local: 248-524-4260

FOR **VETERANS PENSION** AND **SURVIVOR BENEFIT** CLAIMS MAIL OR FAX THIS FORM TO THE APPROPRIATE ADDRESS SHOWN BELOW:

Mail your form to:
Department of Veterans Affairs
Claims Intake Center
Attn: Milwaukee Pension Center
P.O. Box 5192
Janesville, WI 53547-5192
Or fax your form to:
Toll Free: (844) 655-1604

This Pension Center Serves The Following:

Alabama	Arkansas	Illinois	Indiana
Kentucky	Louisiana	Michigan	Mississippi
Missouri	Ohio	Tennessee	Wisconsin

Mail your form to:
Department of Veterans Affairs
Claims Intake Center
Attn: Philadelphia Pension Center
P.O. Box 5206
Janesville, WI 53547-5206
Or fax your form to:
Toll Free: (844) 655-1604

This Pension Center Serves The Following:

Connecticut	Delaware	Florida	Georgia
Maine	Maryland	Massachusetts	New Hampshire
New Jersey	New York	North Carolina	Pennsylvania
Rhode Island	South Carolina	Vermont	Virginia
West Virginia	District of Columbia	Puerto Rico	Canada
Countries outside of North, Central or South America			

Mail your form to:
Department of Veterans Affairs
Claims Intake Center
Attn: St. Paul Pension Center
P.O. Box 5365
Janesville, WI 53547-5365
Or fax your form to:
Toll Free: (844) 655-1604

This Pension Center Serves The Following:

Alaska	Arizona	California	Colorado
Hawaii	Idaho	Iowa	Kansas
Minnesota	Montana	Nebraska	Nevada
New Mexico	North Dakota	Oklahoma	Oregon
South Dakota	Texas	Utah	Washington
Wyoming	Mexico	Central America	South America
Caribbean			