

PTSD Service Connection Claim

21-0781

VA DATE STAMP

Do not write in this space



We've got your Six!

Every member of the U.S. Armed Services plays a critical role in keeping our country safe. We're thankful for your service and your sacrifice, and we want to make sure you have all the care and support you need.

Filling out this form is the first step to getting it!



Personal Information

First Name

Middle Name

Last Name

VA File Number

☐ **Have you sought out psychiatric treatment for cases other than combat?**

Seeking care through the VA will not affect your general records.

What kind of claim are you submitting?

☐ **Combat Related**

We will match your claim to available combat records.

Fill out: A

☐ **Non-Combat Related**

You can provide other information to help us verify your claim (e.g. accidents, sexual assault, etc.)

Fill out: A + B



Symptoms

Ut id consectetur magna. Quisque volutpat augue enim, pulvinar lobortis nibh lacinia at. Vestibulum nec erat ut mi sollicitudin porttitor id sit amet risus.

☐ **Anxiety**

☐ **Depression**

☐ **Panic Attacks**

☐ **Hyper-Vigilance**

☐ **Drug or Alcohol Abuse**

☐ **Volatility**

☐ **Other**

☐ **Poor Sleep**

☐ **Social Detachment**

☐ **Mistrust**

☐ **Over/Under-eating**

☐ **Increased Use of Medication**

☐ **Disinterest**

Privacy Act Notice: **The information you give us is private and confidential. The VA will not share it with anyone else other than the ones authorized under** the Privacy Act of 1974 or Code of Federal Regulations 1.576. The information you provide will help us research your case and help you get your benefits.

Questions? For more information, call **1-800-GET-HELP** or visit **www.VAmentalhealthsupport.gov**

A

Incident Details

Please provide the following information:

Date Incident Occurred

 / /

MM

DD

YYYY

Location of Incident (Please fill out only applicable fields)

City

State

Province

Landmark or Military Installation

Unit Assignment During Incident

e.g. Division, Wing, Battalion, Calvary, Ship, etc.

Date Range of Unit Assignment

 / / To / /

MM

DD

YYYY

MM

DD

YYYY

Who was involved?

If you have information about more than one serviceperson involved in the incident, please attach an additional page to this form.

Name of Serviceperson

Rank

First Name

Middle Name

Last Name

Date Of Injury or Death

 / /

MM

DD

YYYY

Unit Assignment During Incident

e.g. Division, Wing, Battalion, Calvary, Ship, etc.

☐ Wounded in Action

☐ Killed in Action

☐ Injured Non-Battle

☐ Killed Non-Battle

B

References

Please list the name(s) and contact information for anyone who can support your claim.

Name of Reference

Address

I certify that the informationi statement(s) are true and correct to the best of my knowledge and belief.

Signature

Today's Date

 / /

MM

DD

YYYY

Telephone Numbers

) - () -

(

Daytime

Evening

Next steps — now what?

Fusce vehicula dolor arcu, sit amet blandit dolor mollis nec. Donec viverra eleifend lacus, vitae ullamcorper metus. Sed sollicitudin ipsum quis nunc sollicitudin ultrices. Donec euismod scelerisque ligula. Maecenas eu varius risus, eu aliquet arcu. Curabitur fermentum suscipit est, tincidunt mattis lorem luctus id. Donec eget massa a diam condimentum pretium. Aliquam erat volutpat. Integer ut tincidunt orci. Etiam tristique, elit ut consectetur iaculis, metus lectus mattis justo, vel mollis eros neque quis augue. Sed lobortis ultrices lacus, a placerat metus rutrum sit amet. Aenean ut suscipit justo.