REQUEST FOR COPY OF
MILITARY DISCHARGE FORM

_____COUNTY

Number of copies requested_____

PLEASE PRINT

VETERAN'S INFORMATION

1. Full Name of Person on Record	**First Name**	**Middle Name**		**Last Name**
2. Date of Discharge	**Month**	**Day**	**Year**	3. Gender
4. Date of Birth	**Month**	**Day**	**Year**	**City/County/State**
5. Social Security Number (if known)				

6. Requestor's name_____

7. Telephone #: _(_____)_____ **(MON-FRI 8:00A.M.-5:00P.M.)**

8. Mailing Address: _____
STREET ADDRESS **CITY** **STATE** **ZIP**

9. Relationship to person named in item 1:_____

9. Purpose for obtaining this record: _____

10. Identifying information for discharge record: ID#:_____

11. If copy is to be mailed to some other person, please complete:

Name _____ Street Address _____

City _____ State _____ Zip Code _____

_____ _____
Your Signature **Date of Application**

OFFICE USE ONLY

Vol./Page_____ Certificate #_____

Date Issued_____ By _____