



Membership Application

*An individual is eligible for membership by meeting the following criteria: (1) is a citizen of the United States; (2) was regularly enlisted, inducted or commissioned for active duty service in the Army, Navy, Marine Corps, Air Force, or Coast Guard of the United States, or our allies as evidenced by other-than-dishonorable character of service documented by a verifiable DD-214 or DD-215 (entry-level separation not acceptable); (3A) was separated from the service in the Armed Forces under conditions other than dishonorable; or (3B) is on active duty or must continue to serve after the cessation of hostilities; and (4) has suffered a spinal cord injury or disease (such as MS, ALS), whether or not service connected in origin. Membership is free. **Complete and return application to the chapter of choice or by mail/email to:** Paralyzed Veterans of America Membership Department, 1875 Eye Street, NW, Suite 1100, Washington, DC 20006; (E) members@pva.org. Providing the requested information is entirely voluntary but required for membership with Paralyzed Veterans of America.*

Chapter Name: _____

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Date of Birth: ____ / ____ / ____ **Social Security Number:** _____ ☐ Male ☐ Female

Race/Ethnicity:

- ☐ Asian/Pacific Islander ☐ African American/Descent ☐ Hispanic/Latino
☐ Native American/Alaskan Native ☐ Caucasian

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Email:** _____

Home Phone: _____ **Cell Phone:** _____

VETERAN STATUS INFORMATION

Please submit the following with application:

- DD Form 214 showing character of discharge.
- Medical evidence of spinal cord injury or involvement (medical records or physician's statement).
- Proof of U.S. or U.S. Territorial Citizenship (Birth Certificate, Passport, USCIS Form or DD Form 214 showing citizenship)

**Proof of active-duty status must be verified prior to membership approval.*

Have you been discharged under conditions that are less than honorable? ☐ Yes ☐ No

If yes, please explain: _____

Are you a United States citizen? ☐ Yes ☐ No

Do you have a spinal cord injury or disease? ☐ Yes ☐ No

Is your spinal cord injury or spinal cord disease service connected? ☐ Yes ☐ No

Please specify your paralysis type, if applicable:

- ☐ Hemiplegia
☐ Paraplegia
☐ Tetraplegia
☐ No Paralysis

Please specify your specific disease, if applicable:

- ☐ ALS
☐ Multiple Sclerosis
☐ Cauda Equina Syndrome

☐ Spinal Stenosis

If other, please specify.

Veterans with a SCI/D (excluding those with MS and ALS) must have an associated neurological impairment to be eligible for PVA membership. Please specify your neurological impairment.

☐ Bowel/Bladder Dysfunction

☐ Complete Paralysis

☐ Partial Paralysis

☐ Sensory Loss

How did you hear about us?

☐ Referral from a friend/colleague

☐ Referral from a medical center

☐ Referral from a PVA representative

☐ Online

☐ Local event

If you heard about us from a source not listed above, please specify.

If Paralyzed Veterans of America is your accredited representative, do you permit PVA Service Officers to provide information to PVA National Membership Department relative to your membership eligibility? ☐ Yes ☐ No

I declare under penalty of perjury that the foregoing is true and correct, that I have read and meet the qualifications, and I understand that my membership could be denied or revoked if any information provided is inaccurate.

Applicant Signature: _____ **Date:** ____/____/____

Witness Signature: _____ **Date:** ____/____/____



Physician's Statement Form

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

His/her diagnosis is:

- ☐ Paraplegia
- ☐ Tetraplegia
- ☐ Brown Sequard Syndrome
- ☐ Cauda Equina Syndrome
- ☐ ALS
- ☐ Multiple Sclerosis
- ☐ Transverse Myelitis
- ☐ Other (please specify)

Veterans with a SCI/D (excluding those with MS and ALS) must have an associated neurological impairment (such as bowel/bladder dysfunction, complete or partial paralysis, sensory loss) to be eligible for PVA membership. Please specify their neurological impairment.

Neurological impairment:

Physician's Signature

Physician's Name

Physician's Title

Physician's Phone/Email

Date Signed