



Department of Veterans Affairs

VA DATE STAMP
DO NOT WRITE IN THIS SPACE

**STATEMENT IN SUPPORT OF CLAIM FOR SERVICE CONNECTION
FOR POST-TRAUMATIC STRESS DISORDER (PTSD)**

IMPORTANT: If you or someone you know is in crisis, call the Veterans Crisis Line at 1-800-273-8255 and press 1, or visit <https://www.veteranscrisisline.net/> to chat online, or send a text message to 838255 to receive confidential support 24 hours a day, 7 days a week, 365 days a year. Support for **deaf and hard of hearing** individuals is available.

INSTRUCTIONS: List the stressful incident or incidents that occurred in service that you feel contributed to your current condition. For each incident, provide a description of what happened, the date, the geographic location, your unit assignment and dates of assignment, and the full names and unit assignments of you know of who were killed or injured during the incident. Please provide dates within at least a 60-day range and do not use nicknames. It is important that you complete the form in detail and be as specific as possible so that research of military records can be thoroughly conducted. If more space is needed, attach a separate sheet, indicating the item number to which the answers apply.

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

NOTE: You can *either* complete the form online or by hand. Please print the information requested in ink, neatly and legibly to help process the form.

| | | |
|-----------------------------------------------|-----------------------------------------|--------------------------------------------------------------------------------------|
| 1. VETERAN NAME (First, Middle Initial, Last) | | |
| <input type="text"/> | | |
| 2. SOCIAL SECURITY NUMBER | 3. VA FILE NUMBER (If applicable) | 4. DATE OF BIRTH (MM/DD/YYYY) |
| <input type="text"/> | <input type="text"/> | Month Day Year <input type="text"/> - <input type="text"/> - <input type="text"/> |
| 5. VETERAN'S SERVICE NUMBER (If applicable) | 6. TELEPHONE NUMBER (Include Area Code) | |
| <input type="text"/> | <input type="text"/> | |
| 7. E-MAIL ADDRESS (Optional) | | |
| <input type="text"/> | | |

SECTION II: STRESSFUL INCIDENTS

| | | |
|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| 8A. DATE FIRST INCIDENT OCCURRED (MM/DD/YYYY) | 8B. DATES OF UNIT ASSIGNMENT (MM/DD/YYYY) | |
| Month Day Year <input type="text"/> - <input type="text"/> - <input type="text"/> | FROM: Month Day Year <input type="text"/> - <input type="text"/> - <input type="text"/> | TO: Month Day Year <input type="text"/> - <input type="text"/> - <input type="text"/> |
| 8C. LOCATION OF INCIDENT (City, State, Country, Province, landmark or military installation) | | |
| <input type="text"/> | | |
| <input type="text"/> | | |
| <input type="text"/> | | |
| 8D. UNIT ASSIGNMENT DURING INCIDENT (Such as, DIVISION, WING, BATTALION, CAVALRY, SHIP) | | |
| <input type="text"/> | | |
| <input type="text"/> | | |
| <input type="text"/> | | |
| 8E. DESCRIPTION OF THE INCIDENT | | |
| <input type="text"/> | | |
| <input type="text"/> | | |
| 8F. MEDALS OR CITATIONS YOU RECEIVED BECAUSE OF THE INCIDENT | | |
| <input type="text"/> | | |
| <input type="text"/> | | |

SECTION II: STRESSFUL INCIDENTS (Continued)

NOTE: Information about persons who were killed or injured during the first incident (*attach a separate sheet if more space is needed.*)

9A. NAME OF PERSON (First, Middle Initial, Last)
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|----------------------------------|-------------------------------------------------------------------------------------|-----------------------------------------|------------------------------------------|-----------------------------|
| 9B. RANK (If applicable) □□□□ | 9C. DATE OF INJURY/DEATH (MM/DD/YYYY) Month Day Year □□ - □□ - □□□□ | 9D. PLEASE CHECK ONE | | |
| | | <input type="radio"/> KILLED IN ACTION | <input type="radio"/> WOUNDED IN ACTION | <input type="radio"/> OTHER |
| | | <input type="radio"/> KILLED NON-BATTLE | <input type="radio"/> INJURED NON-BATTLE | □□□□ |

9E. UNIT ASSIGNMENT DURING INCIDENT (*Such as, DIVISION, WING, BATTALION, CAVALRY, SHIP*)
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10A. NAME OF PERSON (First, Middle Initial, Last)
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|-----------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------|------------------------------------------|-----------------------------|
| 10B. RANK (If applicable) □□□□ | 10C. DATE OF INJURY/DEATH (MM/DD/YYYY) Month Day Year □□ - □□ - □□□□ | 10D. PLEASE CHECK ONE | | |
| | | <input type="radio"/> KILLED IN ACTION | <input type="radio"/> WOUNDED IN ACTION | <input type="radio"/> OTHER |
| | | <input type="radio"/> KILLED NON-BATTLE | <input type="radio"/> INJURED NON-BATTLE | □□□□ |

10E. UNIT ASSIGNMENT DURING INCIDENT (*Such as, DIVISION, WING, BATTALION, CAVALRY, SHIP*)
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|------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------|--|--|--|--|
| 11A. DATE SECOND INCIDENT OCCURRED (MM,DD,YYYY) Month Day Year □□ - □□ - □□□□ | 11B. DATES OF UNIT ASSIGNMENT (MM/DD/YYYY) | | | | | |
| | FROM: Month Day Year □□ - □□ - □□□□ | TO: Month Day Year □□ - □□ - □□□□ | | | | |

11C. LOCATION OF INCIDENT (*City, State, Country, Province, landmark or military installation*)
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11D. UNIT ASSIGNMENT DURING INCIDENT (*Such as, DIVISION, WING, BATTALION, CAVALRY, SHIP*)
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11E. DESCRIPTION OF THE INCIDENT
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11F. MEDALS OR CITATIONS YOU RECEIVED BECAUSE OF THE INCIDENT
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