

**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
5. Social Security Number (if known)	City/County/State		

6. Requestor's name \_\_\_\_\_

7. Telephone #: (\_\_\_\_) \_\_\_\_\_ (MON-FRJ 8:00A.M.-5:00P.M.)

8. Mailing Address: \_\_\_\_\_  
 STREET ADDRESS CITY STATE ZIP

9. Relationship to person named in item 1: \_\_\_\_\_

10. Purpose for obtaining this record: \_\_\_\_\_

11. Identifying information for discharge record: ID#: \_\_\_\_\_

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

Name \_\_\_\_\_ Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Your Signature \_\_\_\_\_

Date of Application \_\_\_\_\_

<b>OFFICE USE ONLY</b>	
Vol./Page _____	Certificate # _____
Date Issued _____	By _____