REQUEST FOR CERTIFIED COPY OF MILITARY DISCHARGE ATASCOSA COUNTY

NUMBER OF COPIES REQUESTED_____

PLEASE PRINT

VETERAN'S INFORMATION

1. Full name of person on record_____
   First Middle Last

2. Date of Discharge_____
   Month Day Year

3. Gender: MALE or FEMALE

4. Date of Birth_____
   Month Day Year

5. Social Security Number (if known)_____

6. Requestor's name_____

7. Telephone Number_____

8. Mailing address_____
   Street Address City State Zip

9. Purpose for obtaining the record_____

10. Identifying information for discharge record:_____

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

    Name_____

    Address_____

    City_____State_____Zip Code_____

    _____ _____
    Your Signature Date of Application

OFFICE USE ONLY

Vol./Page_____ Certificate #_____

Date Issued_____ By_____