OMB Control No. 2900-0065
Respondent Burden: 15 minutes
Expiration Date: 7/31/2024

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

REQUEST FOR EMPLOYMENT INFORMATION IN CONNECTION WITH CLAIM FOR DISABILITY BENEFITS

1. NAME AND ADDRESS OF EMPLOYER OF VETERAN *(Complete)*	RETURN TO	2. ADDRESS *(Complete)*

INSTRUCTIONS: The veteran named in Item 3 has filed a claim for veterans disability benefits and has stated that he/she was recently employed by you. In order to arrive at a fair decision in this case, we need the information requested below. Please complete Sections II, III and IV and return to this office at the address below. Please be sure to sign and date this form in Items 23A and 23B. For free help in completing this form, call VA toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal number is 711.

Where to Send Correspondence - After completing the form, mail to:
Department of Veterans Affairs
Evidence Intake Center
P.O. Box 4444
Janesville, WI 53547-4444

SECTION I - IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly, insert one letter per box, and completely fill in each applicable circle to help expedite processing of the form.

3. VETERAN/BENEFICIARY'S NAME (First, Middle Initial, Last)

4. SOCIAL SECURITY NUMBER	5. VA FILE NUMBER (If applicable)	6. DATE OF BIRTH
___ – ___ – ____		Month ___ Day ___ Year ____

SECTION II - EMPLOYMENT INFORMATION *(To be completed by employer)*

7. BEGINNING DATE OF EMPLOYMENT	8. ENDING DATE OF EMPLOYMENT	9. TYPE OF WORK PERFORMED
Month ___ Day ___ Year ____	Month ___ Day ___ Year ____	

10. AMOUNT EARNED DURING 12 MONTHS PRECEDING LAST DATE OF EMPLOYMENT (BEFORE DEDUCTIONS)	11. TIME LOST DURING 12 MONTHS PRECEDING LAST DATE OF EMPLOYMENT (DUE TO DISABILITY)
$ ___,___.__	

12A. NUMBER OF HOURS WORKED (Daily)	12B. NUMBER OF HOURS WORKED (Weekly)

13. CONCESSIONS (if any) MADE TO EMPLOYEE BY REASON OF AGE OR DISABILITY

14A. IF VETERAN IS NOT WORKING, STATE THE REASON FOR TERMINATION OF EMPLOYMENT: (IF RETIRED ON DISABILITY, PLEASE SPECIFY)	14B. DATE LAST WORKED Month ___ Day ___ Year ____

15A. DATE OF LAST PAYMENT	15B. GROSS AMOUNT OF LAST PAYMENT	16A. WAS LUMP SUM PAYMENT MADE?	16B. DATE PAID
Month ___ Day ___ Year ____	$	◯ YES ◯ NO GROSS AMOUNT PAID $	Month ___ Day ___ Year ____

SECTION III - RESERVE OR NATIONAL GUARD DUTY STATUS

(*Only complete if claimant is currently serving in the Reserve or National Guard)*

17A. WHAT IS THE VETERAN'S CURRENT DUTY STATUS?

17B. DOES THE VETERAN HAVE ANY DISABILITIES THAT PREVENT THEM FROM PERFORMING THEIR MILITARY DUTIES?

◯ YES ◯ NO

VETERAN'S SOCIAL SECURITY NO. ___ – ___ – ____

SECTION IV - INFORMATION ON BENEFIT ENTITLEMENT AND/OR PAYMENTS *(To be completed by employer)*

18. IS VETERAN RECEIVING OR ENTITLED TO RECEIVE, AS A RESULT OF HIS/HER EMPLOYMENT WITH YOU, SICK, RETIREMENT OR OTHER BENEFITS?

◯ YES ◯ NO *(If "Yes," complete Items 19 through 21C)*

19. TYPE OF BENEFIT

20. GROSS MONTHLY AMOUNT OF BENEFIT

$ ___,___.__

21A. DATE BENEFIT BEGAN	21B. DATE FIRST PAYMENT ISSUED	21C. DATE BENEFIT WILL STOP *(If known)*
Month – Day – Year	Month – Day – Year	Month – Day – Year

22. REMARKS

I CERTIFY THAT the statements made in this form are true and complete to the best of my knowledge and belief.

23A. SIGNATURE OF EMPLOYER OR SUPERVISOR ***(Required)***	23B. DATE SIGNED *(MM/DD/YYYY)*
	05/22/2024

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a meterial fact, knowing it to be false, or for fraudulent acceptance of any payment to which you are not entitled.

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education and Veteran Readiness and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to determine eligibility for disability benefits based on unemployability (38 U.S.C. 1521). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.