

**NORTHAMPTON COUNTY VETERANS' COURT**  
**Court of Common Pleas**  
**Third Judicial District**  
**669 Washington Street**  
**Easton, PA 18042**

**VETERANS' COURT PROGRAM APPLICATION**  
**UPON COMPLETION, PLEASE SUBMIT TO THE OFFICE OF JUDGE SLETVOLD.**

**DEMOGRAPHIC INFORMATION**

Arraignment Date (New Charges) \_\_\_/\_\_\_/\_\_\_

Applicant's Name: \_\_\_\_\_ OTN/Docket #: \_\_\_\_\_

Aliases (if any): \_\_\_\_\_ Charges: \_\_\_\_\_

Address: \_\_\_\_\_

(STREET)

(CITY)

(STATE)

(ZIP)

United States Citizen:  Y  N Phone \_\_\_\_\_  
(CIRCLE ONE)

Birthdate: \_\_\_/\_\_\_/\_\_\_ Birthplace: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Name of Attorney, if applicable: \_\_\_\_\_ Attorney Phone \_\_\_\_\_

Gender:  M  F  Other Race: \_\_\_\_\_ Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_  
(CIRCLE ONE)

Last 4 of Social Security #: \_\_\_\_\_ Identifying Marks, Tattoos \_\_\_\_\_

**DRIVING INFORMATION**

Driver's License/State ID #: \_\_\_\_\_ Issuing State: \_\_\_\_\_ License Status:  Valid  Suspended  
(CIRCLE ONE) (CIRCLE ONE)

Vehicle Make & Model: \_\_\_\_\_ Year: \_\_\_\_\_ Color: \_\_\_\_\_

**FAMILY INFORMATION**

Marital Status: \_\_\_\_\_ Name of Significant Other: \_\_\_\_\_

Children:  Y  N Child Support Obligation?  Y  N Amount: \_\_\_\_\_ Current?  Y  N

**Child's Name Gender Date of Birth**

_____	Full Custody	Shared Custody	No Custody	Terminated
_____	Full Custody	Shared Custody	No Custody	Terminated
_____	Full Custody	Shared Custody	No Custody	Terminated
_____	Full Custody	Shared Custody	No Custody	Terminated
_____	Full Custody	Shared Custody	No Custody	Terminated

Other Family Resources (please list name, relationship, and address): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PRIOR CRIMINAL RECORD**

Do you have a prior criminal record? Y N Prior Record Score if known (counsel, please calculate): \_\_\_\_\_

**MILITARY SERVICE**

\_\_\_\_\_  
(BRANCH) (DATES OF SERVICE)

\_\_\_\_\_  
(HIGHEST RANK ATTAINED) (NATURE OF DISCHARGE)

Combat Experience Y N If "yes," please indicate: \_\_\_\_\_

Military Incarceration Y N If "yes," please specify \_\_\_\_\_

Military Sexual Trauma Y N Suffering from Traumatic Brain Injury Incident to Service Y N

Eligible for VA Benefits Y N If "yes," Receiving VA Benefits Y N

Participating in VA Services Y N If "yes" please list \_\_\_\_\_

**EDUCATION, EMPLOYMENT AND INCOME SOURCES**

Highest Level of Education Completed & Institution: \_\_\_\_\_

Employer: \_\_\_\_\_  
(NAME) (ADDRESS)

Job Title: \_\_\_\_\_ FT PT SCHEDULE \_\_\_\_\_

If unemployed, please provide the following information about your most recent employer:

\_\_\_\_\_  
(NAME) (ADDRESS) DATES OF EMPLOYMENT

Income Sources other than Wages/Amount./Frequency \_\_\_\_\_

Health Insurance Provider: \_\_\_\_\_ Is this Public Health Insurance: Y N

**MEDICAL HISTORY**

Medical Providers

PHYSICIAN NAME	ADDRESS	TELEPHONE NUMBER	SPECIALTY

Medical diagnoses, including mental health and substance use disorder diagnoses: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL CONDITION TREATMENT HISTORY** (including inpatient and outpatient treatment, facility, dates, and indicate successful or unsuccessful completion if applicable):

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**MEDICATIONS**

NAME	DOSAGE	FREQUENCY	PRESCRIBER
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MEDICAL MARIJUANA CARD HOLDER?      Y      N

**OTHER**

IF YOU HAVE A SUBSTANCE USE DISORDER, PLEASE ANSWER THE FOLLOWING QUESTIONS:

Have you used Medication Assisted Treatment? Y      N I DON'T KNOW If "yes," type: \_\_\_\_\_

Substance Use Disorder Treatment History

FACILITY	LEVEL OF CARE	DATES	SUCCESSFULLY COMPLETED: Y OR N
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If there is any other information that you believe is relevant to your application that you wish to share with the Veterans' Court Team, please summarize below:

**VERIFICATION:** I \_\_\_\_\_, being duly sworn according to law do depose and say that the facts set forth in the foregoing are true and correct to the best of my knowledge, information and belief and I acknowledge that any false statements contained herein are punishable pursuant to 18 Pa. C.S.A. §4904(b) relating to Unsworn Falsification to Authorities.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

**IN THE COURT OF COMMON PLEAS OF NORTHAMPTON COUNTY,  
PENNSYLVANIA  
CRIMINAL DIVISION**

COMMONWEALTH OF PENNSYLVANIA :  
 :  
 v. : C-0048-CR-  
 :  
 \_\_\_\_\_, :  
 Defendant. :

**VETERANS' COURT ADMISSION COLLOQUY**

**I. Rules and Rights.**

By execution of this colloquy, I understand and agree to the following:

\_\_\_\_\_ I understand that the Veterans' Court program is premised on open and honest communication, and I will be forthright in all of my communications with the Judge, my Specialized Probation Officer ("SPO"), all members of the Veterans' Court team, and my treatment providers.

\_\_\_\_\_ I will not knowingly supply false information to any member of the Veterans' Court Team.

\_\_\_\_\_ I will inform my SPO if I commit any infractions of Veterans' Court rules, and I will provide full and true information about any such infraction.

\_\_\_\_\_ I will report to my SPO as directed.

\_\_\_\_\_ I will report to the Court as directed.

\_\_\_\_\_ I will reside at the address provided to my SPO and maintain a valid telephone number, which I will also provide to my SPO. I will not move without prior approval from my SPO, and I will advise my SPO as to any changes in my telephone number within twenty-four (24) hours.

\_\_\_\_\_ Unless placed in a program out of the county by the approval of the Court, I will reside in Northampton County throughout my enrollment in the Veterans' Court program.

\_\_\_\_\_ I will abide by the rules of this program, and I will abide by the laws of any jurisdiction where I am present. If I am arrested, questioned, or stopped by law enforcement for any reason, I will advise my SPO within forty-eight (48) hours. If arrested in another state, I agree to waive extradition back to Pennsylvania. I understand that obtaining new charges or failing to report police contact of any kind constitutes a program violation.

\_\_\_\_\_ I will authorize the Veterans' Court Team to obtain information necessary to my treatment and participation in the program and I agree to complete any documentation necessary for said authorization.

\_\_\_\_\_ I will attend all scheduled appointments as required, and I will arrive on time. I understand that late appearances and missed appointments constitute program violations.

\_\_\_\_\_ I will dress appropriately for all court appearances. If I have questions about appropriate attire, I will ask my SPO or another member of the Veterans' Court Team.

\_\_\_\_\_ I will not leave the Commonwealth of Pennsylvania without first obtaining the permission of my SPO.

\_\_\_\_\_ As directed, I will maintain employment, and I will notify my SPO within seventy-two (72) hours if I lose my job. If I am not employed, I will seek employment if doing so is a part of my Integrated Case Management Plan. If directed to attend employment counseling or educational programming, including GED classes, I agree to do so.

\_\_\_\_\_ I will abide by all Veterans' Court policies, procedures, and program requirements.

\_\_\_\_\_ I understand the 5-Phase Veterans' Court program structure and agree to abide by the requirements thereof.

\_\_\_\_\_ I understand that phase advancement is dependent upon my successful attainment of phase goals.

\_\_\_\_\_ I understand that if I fail to attain the goals of the program and satisfy requirements, I will be subject to sanction, up to and including program discharge, following notice and an opportunity to be heard at a due process hearing.

\_\_\_\_\_ I will attend and participate in all clinically recommended treatment until discharged.

\_\_\_\_\_ I will support my dependents as I may be required by law.

\_\_\_\_\_ I will refrain from the use of illegal substances as directed, and also refrain from the use of any drug that is not lawfully prescribed to me.

\_\_\_\_\_ I will refrain from the unlawful possession or sale of illegal drugs.

\_\_\_\_\_ I will take all medications as prescribed by my treating physicians, and upon request, I will submit my medications for examination by my SPO or another Veterans' Court team member.

\_\_\_\_\_ I will provide all discharge summaries, treatment instructions, and other medical documentation to my SPO as requested.

\_\_\_\_\_ I will submit to random urinalysis as may be directed.

\_\_\_\_\_ I understand that I cannot own or possess any firearms or other weapons during my participation in the program.

\_\_\_\_\_ I will refrain from any assaultive or threatening behavior toward others while I am in the program.

\_\_\_\_\_ I understand and agree that I must pay my treatment costs and make payments on my fines, costs, restitution, and supervision fees, as directed, in accordance with program rules.

\_\_\_\_\_ I agree that if I violate any of these rules or become aware of any violation of these rules by another Veterans' Court member, I will report such violation to my SPO within twenty-four (24) hours.

\_\_\_\_\_ I understand that Veterans' Court rules and requirements may change from time to time, and I agree to abide by all directives of the Veterans' Court program not expressly set forth herein.

\_\_\_\_\_ I understand that if I abscond from the Veterans' Court program, a bench warrant will be issued for my arrest and detainment.

\_\_\_\_\_ I understand that any statement, made verbally or in writing on behalf of the Veterans' Court with respect to phase length is merely an average provided as a guideline, and I cannot rely on my phase length following this timeline, as the program is individualized and measured by needs and goal attainment.

\_\_\_\_\_ I understand and agree to abide by the foregoing requirements.

## II. Affirmation and Certification

I HEREBY AFFIRM THAT I HAVE READ OR HAVE HAD THIS DOCUMENT READ TO ME, I UNDERSTAND IT, I HAVE HAD A FULL AND FAIR OPPORTUNITY TO ASK ALL QUESTIONS I HAVE REGARDING THIS DOCUMENT. I AGREE TO THE TERMS OF THIS DOCUMENT, AND BY MY SIGNATURE BELOW, I AFFIRM AND CERTIFY THAT I AM KNOWINGLY, INTELLIGENTLY, AND VOLUNTARILY SEEKING ADMISSION INTO THE NORTHAMPTON COUNTY VETERANS' COURT PROGRAM.

\_\_\_\_\_  
APPLICANT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS (ATTORNEY, IF APPLICABLE)

\_\_\_\_\_  
DATE

**NORTHAMPTON COUNTY VETERANS' COURT**  
**Court of Common Pleas**  
**Third Judicial District**  
**669 Washington Street**  
**Easton, PA 18042**

**APPLICANT RELEASE AND AUTHORIZATION**

Attendant with my application in the Northampton County Veterans' Court, I, \_\_\_\_\_ do hereby authorize the Northampton County Veterans' Court Team to receive and review my application and any supporting material, including past treatment information that may be known or made available to the team by any source, to include:

\_\_\_\_\_ My treatment and attendance records

\_\_\_\_\_ My diagnosis, prognosis, and progress reports setting forth my compliance with treatment

\_\_\_\_\_ Discharge Summary

By this Release and Authorization, I grant the Northampton County Veterans' Court team, identified as the Northampton County Adult Probation Department (Jennifer Dodwell or their designee), Veteran Mentor Personnel (Christopher Yarnell, Freddie Reed, John Kukitz or their designee) Veterans' Justice Outreach personnel (Lori Miller or their designee) Certified Recovery Specialist Personnel (Jason Moyer or their designee), Midatlantic Rehabilitation Services (Betsy Martellucci or their designee), NorthEast Treatment Centers (Ryan Flynn or their designee), Pyramid Healthcare (Andrea Smith or their designee), the Presiding Judge (Judge Jennifer Sletvold or their designee), the Problem Solving Court Coordinator (Stephanie Steward or their designee), the District Attorney's Office (Daniel Polanski or their designee), the Public Defender's Office (Chandra Bleice or their designee), the Northampton County Prison Veterans' Court Liaison (Thomas Herstitch or their designee), (collectively "Authorized Agents") the following information relative to my request for admission to the Northampton County Veterans' Court:

I understand and agree that the sole purpose of the disclosure permitted by this Release and Authorization is to inform the Authorized Entities to review my application to the Northampton County Veterans' Court, and for the Presiding Judge to make a determination regarding said application to the Court. I understand that my treatment records are protected under state law at The Pennsylvania Drug and Alcohol Abuse Control Act (71 P.S. § 1690.101 et seq.) and 4 Pa. Code § 255.5, as well as by federal regulations governing confidentiality of alcohol and drug abuse patient records at 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 & 164. I understand that this consent satisfies the requirements of 42 C.F.R. § 2.31 and 2.35. I also understand that I may revoke this Release and Authorization at any time except to the extent that action has been taken in reliance on it. I further acknowledge that if I am admitted to the Northampton County Veterans' Court program, I agree to execute a Release and Authorization involving the same "Authorized Agents," permitting them to obtain and share with one another my treatment and program information, and the same will be a requirement of my participation in the Northampton County Veterans' Court. I recognize that if I am admitted to the program, I will participate in regular review hearings which, pursuant to prevailing law, are held in an open and public courtroom. I further recognize that it is therefore possible that an observer could be made aware of my treatment and participation in the Northampton County Veterans' Court and I understand that my participation in the program will be contingent upon my consent to the same. I acknowledge that I have been advised of my rights, I have been offered and refused a received a copy of this consent, I have had the benefit of legal counsel in reviewing this consent, I am not presently under the influence of any substance that would affect my judgment, I fully understand my rights, and I am voluntarily signing this Release and Authorization.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

THIS RELEASE EXPIRES UPON MY ADMISSION TO OR DENIAL FROM THE NORTHAMPTON COUNTY VETERANS' COURT.



REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPERWORK REDUCTION ACT INFORMATION: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. The execution of this form does not authorize the release of information other than that specifically described below.

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS (Name and Location of the VA Health Care Facility)

Wilkes Barre VA Medical Center
1111 East End Blvd
Wilkes Barre, PA 18711

LAST NAME- FIRST NAME- MIDDLE NAME

DATE OF BIRTH (mm/dd/yyyy)

PATIENT'S MAILING ADDRESS (including City, State and Zip Code)

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Northampton County Veteran Treatment Court, PAJCIS (PA Adult/Juvenile Court Information System) and all affiliated, jail, pretrial, adult probation

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

- TREATMENT BENEFITS LEGAL EMPLOYMENT OTHER (Please specify below):

Eligibility verification, TX Plan summary and progress, including UDS for TX purposes

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

- HEALTH SUMMARY (Prior 2 Years)
PATIENT MEDICAL RECORDS (Dates):
INPATIENT DISCHARGE SUMMARY (Dates):
PROGRESS NOTES:
SPECIFIC CLINICS (Name & Date Range):
SPECIFIC PROVIDERS (Name & Date Range):
DATE RANGE:
OPERATIVE/CLINICAL PROCEDURES (Name & Date):
LAB RESULTS:
SPECIFIC TESTS (Name & Date):
DATE RANGE:
RADIOLOGY REPORTS (Name & Date):
LIST OF ACTIVE MEDICATIONS:
VACCINATION (Dose, Lot Number, Date & Location):
ADMINISTRATIVE RECORDS:
OTHER (Describe): Eligibility Verification, TX plan summary and progress, UDS for TX purpose



LAST NAME- FIRST NAME- MIDDLE NAME		DATE OF BIRTH (mm/dd/yyyy)
<b>SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.</b> I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization. <input checked="" type="checkbox"/> DRUG ABUSE <input checked="" type="checkbox"/> ALCOHOLISM OR ALCOHOL ABUSE <input type="checkbox"/> SICKLE CELL ANEMIA <input type="checkbox"/> HUMAN IMMUNODEFICIENCY VIRUS (HIV) I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked <u>unless</u> I indicate by checking the box below that I do not want this information released for this specific disclosure. <input type="checkbox"/> I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.		
<b>AUTHORIZATION:</b> I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.		
<b>EXPIRATION:</b> Without my express revocation, the authorization will automatically expire (select one of the following): <input type="checkbox"/> AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED <input type="checkbox"/> ON (mm/dd/yyyy) _____ (enter a future date other than date signed by patient) <input checked="" type="checkbox"/> UNDER THE FOLLOWING CONDITION(S): <u>Successful completion or termination of the program</u>		
PATIENT SIGNATURE (Sign in ink)		DATE (mm/dd/yyyy)
LEGAL REPRESENTATIVE SIGNATURE (if applicable) (Sign in ink)		DATE (mm/dd/yyyy)
PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT	
<b>FOR VA USE ONLY</b>		
TYPE AND EXTENT OF MATERIAL RELEASED Weekly reports as well as updates on medications, treatment plan changes, and treatment compliance		
DATE RELEASED (mm/dd/yyyy)	RELEASED BY:	

## INSTRUCTION AND INFORMATION SHEET FOR SF 180, REQUEST PERTAINING TO MILITARY RECORDS

**1. General Information.** The Standard Form 180, Request Pertaining to Military Records (SF180) is used to request information from military records. Certain identifying information is necessary to determine the location of an individual's record of military service. Please try to answer each item on the SF 180. If you do not have and cannot obtain the information for an item, show "NA," meaning the information is "not available". Include as much of the requested information as you can. Incomplete information may delay response time. To determine where to mail this request see Page 2 of the SF180 for record locations and facility addresses.

Online requests may be submitted to the National Personnel Records Center (NPRC) by a veteran or deceased veteran's next-of-kin using eVetRecs at <http://www.archives.gov/veterans/military-service-records/>.

**2. Personnel Records/Military Human Resource Records/Official Military Personnel File (OMPF) and Medical Records/Service Treatment Records (STR).** Personnel records of military members who were discharged, retired, or died in service **LESS THAN 62 YEARS AGO** and medical records are in the legal custody of the military service department and are administered in accordance with rules issued by the Department of Defense and the Department of Homeland Security (DHS, Coast Guard). STRs of persons on active duty are generally kept at the local servicing clinic. After the last day of active duty, STRs should be requested from the appropriate address on page 2 of the SF 180. (See item 3, Archival Records, if the military member was discharged, retired or died in service more than 62 years ago.)

a. **Release of information:** Release of information is subject to restrictions imposed by the military services consistent with Department of Defense regulations, the provisions of the Freedom of Information Act (FOIA) and the Privacy Act of 1974. The service member (either past or present) or the member's legal guardian has access to almost any information contained in that member's own record. The authorization signature of the service member or the member's legal guardian is needed in Section III of the SF180. Others requesting information from military personnel records and/or STRs must have the release authorization in Section III of the SF 180 signed by the member or legal guardian. If the appropriate signature cannot be obtained, only limited types of information can be provided. If the former member is deceased, the surviving next-of-kin may, under certain circumstances, be entitled to greater access to a deceased veteran's records than a member of the general public. The next-of-kin may be any of the following: unremarried surviving spouse, father, mother, son, daughter, sister, or brother. Requesters **MUST provide proof of death, such as a copy of a death certificate, newspaper article (obituary) or death notice, coroner's report of death, funeral director's signed statement of death, or verdict of coroner's jury.**

b. **Fees for records:** There is no charge for most services provided to service members or next-of-kin of deceased veterans. A nominal fee is charged for certain types of service. In most instances, service fees cannot be determined in advance. If your request involves a service fee, you will receive an invoice with your records.

**3. Archival Records.** Personnel records of military members who were discharged, retired, or died in service **62 OR MORE YEARS AGO** have been transferred to the legal custody of NARA and are referred to as "archival records".

a. **Release of Information:** Archival records are open to the public. The Privacy Act of 1974 does not apply to archival records, therefore, written authorization from the veteran or next-of-kin is not required. In order to protect the privacy of the veteran, his/her family, and third parties named in the records, the personal privacy exemption of the Freedom of Information Act (5 U.S.C. 552 (b) (6)) may still apply and may preclude the release of some information.

b. **Fees for Archival Records:** Access to archival records are granted by offering copies of the records for a fee (44 U.S.C. 2116 (c)). If a fee applies to the photocopies of documents in the requested record, you will receive an invoice. Photocopies will be sent after payment is made. For more information see <http://www.archives.gov/st-louis/archival-programs/military-personnel-archival/ompf-archival-requests.html>.

**4. Where reply may be sent.** The reply may be sent to the service member or any other address designated by the service member or other authorized requester. If the designated address is NOT registered to the addressee by the U.S. Postal Service (USPS), provide BOTH the addressee's name AND "in care of" (c/o) the name of the person to whom the address is registered on the NAME line in Section III, item 3, on page 1 of the SF 180. The COMPLETE address must be provided, INCLUDING any apartment/suite/unit/lot/space/etc. number.

**5. Definitions and abbreviations.** DISCHARGED -- the individual has no current military status; SERVICE TREATMENT RECORD (STR) -- The chronology of medical, mental health, and dental care received by service members during the course of their military career (does not include records of treatment while hospitalized); TDRL -- Temporary Disability Retired List.

**6. Service completed before World War I.** National Archives Trust Fund (NATF) forms must be used to request these records. Obtain the forms by e-mail from [inquire@nara.gov](mailto:inquire@nara.gov) or write to the Code 6 address on page 2 of the SF 180.

### PRIVACY ACT OF 1974 COMPLIANCE INFORMATION

The following information is provided in accordance with 5 U.S.C. 552a(e)(3) and applies to this form. Authority for collection of the information is 44 U.S.C. 2907, 3101, and 3103, and Public Law 104-134 (April 26, 1996), as amended in title 31, section 7701. Disclosure of the information is voluntary. If the requested information is not provided, it may delay servicing your inquiry because the facility servicing the service member's record may not have all of the information needed to locate it. The purpose of the information on this form is to assist the facility servicing the records (see the address list) in locating the correct military service record(s) or information to answer your inquiry. This form is then retained as a record of disclosure. The form may also be disclosed to Department of Defense components, the Department of Veterans Affairs, the Department of Homeland Security (DHS, U.S. Coast Guard), or the National Archives and Records Administration when the original custodian of the military health and personnel records transfers all or part of those records to that agency. If the service member was a member of the National Guard, the form may also be disclosed to the Adjutant General of the appropriate state, District of Columbia, or Puerto Rico, where he or she served.

### PAPERWORK REDUCTION ACT PUBLIC BURDEN STATEMENT

Public burden reporting for this collection of information is estimated to be five minutes per request, including time for reviewing instructions and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of the collection of information, including suggestions for reducing this burden, to National Archives and Records Administration (ISSD), 8601 Adelphi Road, College Park, MD 20740-6001. **DO NOT SEND COMPLETED FORMS TO THIS ADDRESS. SEND COMPLETED FORMS TO THE APPROPRIATE ADDRESS LISTED ON PAGE 2 OF THE SF 180.**

### REQUEST PERTAINING TO MILITARY RECORDS

Requests from veterans or deceased veteran's next-of-kin may be submitted online by using eVetRecs at <http://www.archives.gov/veterans/military-service-records/>  
To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. PLEASE PRINT LEGIBLY OR TYPE BELOW.

#### SECTION I - INFORMATION NEEDED TO LOCATE RECORDS (Furnish as much information as possible.)

1. NAME USED DURING SERVICE (last, first, full middle)		2. SOCIAL SECURITY #	3. DATE OF BIRTH	4. PLACE OF BIRTH		
5. SERVICE, PAST AND PRESENT (For an effective records search, it is important that ALL service be shown below.)						
	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE	-			<input type="checkbox"/>	<input type="checkbox"/>	
b. RESERVE	-			<input type="checkbox"/>	<input type="checkbox"/>	
c. STATE NATIONAL GUARD	-			<input type="checkbox"/>	<input type="checkbox"/>	

6. IS THIS PERSON DECEASED?  NO  YES - *MUST provide Date of Death if veteran is deceased:* \_\_\_\_\_

7. DID THIS PERSON RETIRE FROM MILITARY SERVICE?  NO  YES

#### SECTION II - INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU ARE REQUESTING:

**DD Form 214 or equivalent.** Year(s) in which form(s) issued to veteran: \_\_\_\_\_  
 This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next-of-kin, or other persons or organizations, if authorized in Section III, below. An UNDELETED DD214 is ordinarily required to determine eligibility for benefits. If you request a DELETED copy, the following items will be blacked out: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and, for separations after June 30, 1979, character of separation and dates of time lost.  
 An UNDELETED copy will be sent UNLESS YOU SPECIFY A DELETED COPY by checking this box:  I want a DELETED copy.

**Medical Records** Includes Service Treatment Records, Health (outpatient) and Dental Records. *IF HOSPITALIZED (inpatient) the FACILITY NAME and DATE (month and year) for EACH admission MUST be provided:* \_\_\_\_\_

**Other (Specify):** \_\_\_\_\_

2. **PURPOSE:** (Providing information about the purpose of the request is strictly voluntary; however, it may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.)

Benefits (explain)  Employment  VA Loan Programs  Medical  Genealogy  Correction  Personal  Other (explain)

Explain here: \_\_\_\_\_

#### SECTION III - RETURN ADDRESS AND SIGNATURE

1. **REQUESTER NAME:** \_\_\_\_\_

2.  I am the MILITARY SERVICE MEMBER OR VETERAN identified in Section I, above.  I am the VETERAN'S LEGAL GUARDIAN (*MUST submit copy of Court Appointment*) or AUTHORIZED REPRESENTATIVE (*MUST submit copy of Authorization Letter or Power of Attorney*)

I am the DECEASED VETERAN'S NEXT-OF-KIN (*MUST submit Proof of Death. See item 2a on instruction sheet.*)  OTHER

(Relationship to deceased veteran) (Specify type of Other)

3. **SEND INFORMATION/DOCUMENTS TO:**  
(Please print or type. See item 4 on accompanying instructions.)

Name \_\_\_\_\_

Street \_\_\_\_\_ Apt. \_\_\_\_\_

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

4. **AUTHORIZATION SIGNATURE:** I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct and that I authorize the release of the requested information. (See items 2a or 3a on accompanying instruction sheet. Without the Authorization Signature of the veteran, next-of-kin of deceased veteran, veteran's legal guardian, authorized government agent, or other authorized representative, only limited information can be released unless the request is archival. No signature is required if the request is for archival records.)

Signature Required - Do not print \_\_\_\_\_ Date \_\_\_\_\_

Daytime phone \_\_\_\_\_ Fax Number \_\_\_\_\_

Email address \_\_\_\_\_

\* This form is available at <http://www.archives.gov/veterans/military-service-records/standard-form-180.html> on the National Archives and Records Administration (NARA) web site. \*

The various categories of military service records are described in the chart below. For each category there is a code number which indicates the address at the bottom of the page to which this request should be sent. Please refer to the Instruction and Information Sheet accompanying this form as needed.

BRANCH	CURRENT STATUS OF SERVICE MEMBER	Personnel Record	Medical or Service Treatment Record
AIR FORCE	Discharged, deceased, or retired before 5/1/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 9/30/2004	14	11
	Discharged, deceased, or retired 10/1/2004 – 12/31/2013	1	11
	Discharged, deceased, or retired on or after 1/1/2014	1	13
	Active (including National Guard on active duty in the Air Force), TDRL, or general officers retired with pay	1	
	Reserve, IRR, Retired Reserve in non-pay status, current National Guard officers not on active duty in the Air Force, or National Guard released from active duty in the Air Force	2	
	Current National Guard enlisted not on active duty in the Air Force	2	13
COAST GUARD	Discharge, deceased, or retired before 1/1/1898	6	
	Discharged, deceased, or retired 1/1/1898 – 3/31/1998	14	14
	Discharged, deceased, or retired 4/1/1998 – 9/30/2006	14	11
	Discharged, deceased, or retired 10/1/2006 – 9/30/2013	3	11
	Discharged, deceased, or retired on or after 10/1/2013	3	14
	Active, Reserve, Individual Ready Reserve or TDRL	3	
MARINE CORPS	Discharged, deceased, or retired before 1/1/1895	6	
	Discharged, deceased, or retired 1/1/1905 – 4/30/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 12/31/1998	14	11
	Discharged, deceased, or retired 1/1/1999 – 12/31/2013	4	11
	Discharged, deceased, or retired on or after 1/1/2014	4	8
	Individual Ready Reserve	5	
	Active, Selected Marine Corps Reserve, TDRL	4	
ARMY	Discharged, deceased, or retired before 11/1/1912 (enlisted) or before 7/1/1917 (officer)	6	
	Discharged, deceased, or retired 11/1/1912 – 10/15/1992 (enlisted) or 7/1/1917 – 10/15/1992 (officer)	14	
	Discharged, deceased, or retired 10/16/1992 – 9/30/2002	14	11
	Discharged, deceased, or retired (including TDRL) 10/1/2002 – 12/31/2013	7	11
	Discharged, deceased, or retired (including TDRL) on or after 1/1/2014	7	9
	Current Soldier (Active, Reserve (including Individual Ready Reserve) or National Guard)	7	
NAVY	Discharged, deceased, or retired before 1/1/1886 (enlisted) or before 1/1/1903 (officer)	6	
	Discharged, deceased, or retired 1/1/1886 – 1/30/1994 (enlisted) or 1/1/1903 – 1/30/1994 (officer)	14	14
	Discharged, deceased, or retired 1/31/1994 – 12/31/1994	14	11
	Discharged, deceased, or retired 1/1/1995 – 12/31/2013	10	11
	Discharged, deceased, or retired on or after 1/1/2014	10	8
Active, Reserve, or TDRL	10		
PHS	Public Health Service - Commissioned Corps officers only	12	

**ADDRESS LIST OF CUSTODIANS and SELF-SERVICE WEBSITES (BY CODE NUMBERS SHOWN ABOVE) – Where to write/send this form**

1	Air Force Personnel Center HQ AFPC/DPSIRP 550 C Street West, Suite 19 Randolph AFB, TX 78150-4721	6	National Archives & Records Administration Research Services (RDT1R) 700 Pennsylvania Avenue NW Washington, DC 20408-0001	11	Department of Veterans Affairs Records Management Center ATTN: Release of Information P.O. Box 5020 St. Louis, MO 63115-5020
2	Air Reserve Personnel Center Records Management Branch (DPTSC) 18420 E. Silver Creek Avenue Building 390 MS 68 Buckley AFB, CO 80011	7	US Army Human Resources Command's web page: <a href="https://www.hrc.army.mil/TAGD/Accessine%20or%20Requesting%20Your%20Official%20Military%20Personnel%20File%20Documents">https://www.hrc.army.mil/TAGD/Accessine%20or%20Requesting%20Your%20Official%20Military%20Personnel%20File%20Documents</a> or 1-888-ARMYHRC (1-888-276-9472)	12	Division of Commissioned Corps Officer Support ATTN: Records Officer 1101 Wooton Parkway, Plaza Level, Suite 100 Rockville, MD 20852
3	Commander, Personnel Service Center (BOPS-C-MR) MS7200 US Coast Guard 2703 Martin Luther King Jr Ave SE Washington, DC 20593-7200 <a href="mailto:MR_CustomerService@uscg.mil">MR_CustomerService@uscg.mil</a>	8	Navy Medicine Records Activity (NMRA) BUMED Detachment St. Louis 4300 Goodfellow Boulevard, Building 103 St. Louis, MO 63120	13	AF STR Processing Center ATTN: Release of Information 3370 Nacogdoches Road, Suite 116 San Antonio, TX 78217
4	Headquarters U.S. Marine Corps Manpower Management Records & Performance (MMRP-10) 2008 Elliot Road Quantico, VA 22134-5030	9	AMEDD Record Processing Center 3370 Nacogdoches Road, Suite 116 San Antonio, TX 78217	14	National Personnel Records Center (Military Personnel Records) 1 Archives Drive St. Louis, MO 63138-1002  eVetRecs: <a href="http://www.archives.gov/veterans/military-service-records/">http://www.archives.gov/veterans/military-service-records/</a>
5	Marine Forces Reserve 2000 Opelousas Avenue New Orleans, LA 70146-5400	10	Navy Personnel Command (PERS-313) 5720 Integrity Drive Millington, TN 38055-3120		