|  |   |  | OMB Control No. 2900-0321<br>Respondent Burden: 5 minutes   |
|--|---|--|---|
| Department of Veterans Affairs   |   | OF VETERANS SERVICE<br>LAIMANT'S REPRESENT   | ORGANIZATION  |
| Note - If you would prefer to have an individual As Claimant's Representative.''   | idual assist you with your  |  |   |
| IMPORTANT - PLEASE READ THE PRIVACY ACT  | AND RESPONDENT BURDEN   |  | THE FORM.   |
| 1. LAST-FIRST-MIDDLE NAME OF VETERAN   |   | 2. VA FILE NUMBER (Include prefix)   |   |
| 3A. NAME OF SERVICE ORGANIZATION RECOGNIZED B  | BY THE DEPARTMENT OF VETER  | ANS AFFAIRS (See list on reverse side before s   | electing organization)  |
| 3B. JOB TITLE OF OFFICIAL REPRESENTATIVE AUTHOR  | RIZED TO ACT ON VETERAN'S BE  | HALF   |   |
| INSTF  | RUCTIONS - TYPE OR P  | RINT ALL ENTRIES   |   |
| 4. SOCIAL SECURITY NUMBER  |   | 5. INSURANCE NUMBER(S) (Include let  | ter prefix)   |
|  |   |  |   |
| 6A. SERVICE NUMBER(S)  |   | 6B. BRANCH OF SERVICE  |   |
| 7. NAME OF CLAIMANT (If other than veteran)  |   | 8. RELATIONSHIP (If other than veteran)  |   |
| O ADDRESS OF STAIMANT SY THE STAIR STAIR   | DO 6: 177DC 1   |  |   |
| 9. ADDRESS OF CLAIMANT (No. and street or rural route, city  | or P.O., State and ZIP Code)  | 10. CLAIMANT'S TELEPHONE   |   |
|  |   | A. DAYTIME   | B. EVENING  |
|  |   | ( )  | ( )   |
|  |   | 11. E-MAIL ADDRESS (If applicable)   |   |
|  |   | 12. DATE OF THIS APPOINTMENT   |   |
|  |   |  |   |
| 13. AUTHORIZATION FOR REPRESENTAT  Unless I check the box below, I do not at any records that may be in my file relating immunodeficiency virus (HIV), or sickle or I authorize the VA facility having custody records relating to drug abuse, alcoholism Redisclosure of these records by my serv not authorized without my further writter revoke this authorization by filing a writte either by explicit revocation or the appoint                       | uthorize VA to disclose to g to treatment for drug abuscell anemia.  y of my VA claimant records to a or alcohol abuse, infection wice organization representative a consent. This authorization en revocation with VA; or (2) tenent of another representative | the service organization named on e, alcoholism or alcohol abuse, information of disclose to the service organization of the human immunodeficiency virule, other than to VA or the Court of A will remain in effect until the earlier of I revoke the appointment of the service.   | this appointment form ection with the human named in Item 3A all treatment is (HIV), or sickle cell anemia. ppeals for Veterans Claims, is of the following events: (1) I ice organization named above, |
| 14. LIMITATION OF CONSENT - My consent in Item 1 abuse, infection with the human immunodeficiency vi   |   |  |   |
| I, the claimant named in Items 1 or 7, herely present and prosecute my claim for any and named in Item 1. I authorize the Departmer Federal tax information (other than as provid understood that no fee or compensation of attorney. I understand that the service organ time, subject to 38 CFR 20.608. Additional verification necessitated by an Internal Reveteran's representative is only valid for five Signed and accepted subject to the foregoing | all benefits from the Depart of Veterans Affairs to reded in Items 13 and 14), to whatsoever nature will be dization I have appointed as a ly, in those cases where a livenue Service verification is years from the date this for                              | the the third that service organization appointed that service organization appointed that service organization appointed that service rendered is my representative may revoke the veteran's income is being development, the assignment of the service match, the assignment of the service was a service or the | on the service of the veterand to include disclosure of myd as my representative. It is pursuant to this power of all power of attorney at any oped because of an income ervice organization as the     |

THIS POWER OF ATTORNEY DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC

15. SIGNATURE OF CLAIMANT (Do Not Print)

16. DATE SIGNED

VA VA FORM 21-22-1 SENT TO:
USE CER FILE EDU FILE INSURANCE FILE
ONLY CH. 30 DEA FILE LG FILE

NOTE: As long as this appointment is in effect, the organization named herein will be recognized as the sole agent for presentation of your claim before the Department of Veterans Affairs in connection with your claim or any portion thereof.

## RECOGNIZED SERVICE ORGANIZATIONS

Membership in an organization is not a prerequisite to appointment of the organization as claimant's representative.

The following is a listing of National Organizations recognized by the Secretary in the preparation and prosecution of claims under laws administered by the Department of Veterans Affairs.

African American PTSD Association

American Legion American Red Cross

**AMVETS** 

American Ex-Prisoners of War, Inc.

American Defenders of Bataan and Corregidor, Inc.

American GI Forum, National Veterans Outreach Program

Armed Forces Services Corporation

Army and Navy Union, USA

Blinded Veterans Association

Catholic War Veterans of the U.S.A.

Disabled American Veterans

Eastern Paralyzed Veterans Association

Fleet Reserve Association

Gold Star Wives of America, Inc.

Italian American War Veterans of the United States, Inc.

Jewish War Veterans of the United States

Legion of Valor of the United States of America, Inc.

Marine Corps League

Military Order of the Purple Heart

National Amputation Foundation, Inc.

National Association of County Veterans Service Officers, Inc.

National Association for Black Veterans, Inc. National Veterans Legal Services Program National Veterans Organization of America

Non Commissioned Officers Association of the USA

Navy Mutual Aid Association

Paralyzed Veterans of America, Inc.

Polish Legion of American Veterans, U.S.A.

Swords to Plowshares, Veterans Rights Organization, Inc.

The Retired Enlisted Association

The Veterans Assistance Foundation, Inc.

The Veterans of the Vietnam War, Inc. & The Veterans

Coalition

United Spanish War Veterans of the United States Veterans of Foreign Wars of the United States Veterans of World War I of the U.S.A., Inc.

Vietnam Era Veterans Association Vietnam Veterans of America

Although agency titles vary, the following States and possessions maintain veterans service agencies which are recognized to present claims.

| Alabama        | Guam          | Minnesota     | North Carolina           | South Dakota   |
|----------------|---------------|---------------|--------------------------|----------------|
| American Samoa | Hawaii        | Mississippi   | North Dakota             | Tennessee      |
| Arizona        | Idaho         | Missouri      | Northern Mariana Islands | Texas          |
| Arkansas       | Illinois      | Montana       | Ohio                     | Utah           |
| California     | Kansas        | Nebraska      | Oklahoma                 | Vermont        |
| Colorado       | Kentucky      | Nevada        | Oregon                   | Virginia       |
| Connecticut    | Louisiana     | New Hampshire | Pennsylvania             | Virgin Islands |
| Delaware       | Maine         | New Jersey    | Puerto Rico              | Washington     |
| Florida        | Maryland      | New Mexico    | Rhode Island             | West Virginia  |
| Georgia        | Massachusetts | New York      | South Carolina           | Wisconsin      |

**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 Vocational Rehabilitation Records-VA, published in the Federal Register. Your obligation to respond is voluntary. However, the requested information is considered relevant and necessary to recognize a service organization as your representative and/or identify disclosable records. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect. 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 recognize the service organization you name to act on your behalf in the preparation, presentation, and prosecution of claims for VA benefits (38 U.S.C. 5902). We will also use the information to identify any VA records that we may disclose to the service organization (38 U.S.C. 5701(b)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 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 <a href="https://www.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA">www.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA</a>. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

| Department of Veterans Affairs  |  | OF VETERANS SE<br>CLAIMANT'S REPRI                        | OMB Control No. 2900-0321 Respondent Burden: 5 minutes  RVICE ORGANIZATION ESENTATIVE |
|---|--|---|---|
| Note - If you would prefer to have an individu  |  |   |   |
| Individual As Claimant's Representative."   | E DEGROVIDENT DURDE  | N ON BEHEBBE BEFORE CO.                                   | ADVERTING THE FORM  |
| IMPORTANT - PLEASE READ THE PRIVACY ACT AN<br>1. LAST-FIRST-MIDDLE NAME OF VETERAN  | D RESPONDENT BURDE   | N ON REVERSE BEFORE COM<br>2. VA FILE NUMBER (Include     |   |
| I. E. C. I TING I WIEDEL IV WIL CITYLE IV WY  |  | 2. VIVI ILE NOMBER (Monde                                 | ac prenzy   |
| 3A. NAME OF SERVICE ORGANIZATION RECOGNIZED BY T  | HE DEPARTMENT OF VETE  | RANS AFFAIRS (See list on reverse                         | side before selecting organization)   |
| 3B. JOB TITLE OF OFFICIAL REPRESENTATIVE AUTHORIZE  | D TO ACT ON VETERAN'S I  | BEHALF  |   |
| INSTRU  | CTIONS - TYPE OR   | PRINT ALL ENTRIES   |   |
| 4. SOCIAL SECURITY NUMBER   |  | 5. INSURANCE NUMBER(S                                     | S) (Include letter prefix)  |
| 6A. SERVICE NUMBER(S)   |  | 6B. BRANCH OF SERVICE                                     |   |
| 7. NAME OF CLAIMANT (If other than veteran)   |  | 8. RELATIONSHIP (If other                                 | than veteran)   |
| ADDRESS OF CLAIMANT (No. and street or rural route, city or F   | O State and ZIP Code)  | 40 CLAIMANT'S TE  | TI EDUONE NUMBERS (trade Associate)   |
| or out and success runal round, only or r   | .o., state and En Code)  | A. DAYTIME  | ELEPHONE NUMBERS (Include Area Code) B. EVENING                                       |
|   |  | ( )   | ( )   |
|   |  | 11. E-MAIL ADDRESS (If ap                                 | oplicable)  |
|   |  | 12. DATE OF THIS APPOIN                                   | ITMENT  |
|   |  | 12. DATE OF THIS AFFOIR                                   | NT IVIENT   |
| 13. AUTHORIZATION FOR REPRESENTATIVE Unless I check the box below, I do not auth  | E'S ACCESS TO RECO   | DRDS PROTECTED BY SI<br>to the service organization in    | ECTION 7332, TITLE 38, U.S.C. named on this appointment form                          |
| Unless I check the box below, I do not auth any records that may be in my file relating to immunodeficiency virus (HIV), or sickle cell | anemia.  | ise, alconolism or alconol a                              | ibuse, infection with the numan   |
| ☐ I authorize the VA facility having custody of   |  |   |   |
| records relating to drug abuse, alcoholism or   |  |   |   |
| Redisclosure of these records by my service not authorized without my further written or  |  |   |   |
| revoke this authorization by filing a written in  |  |   |   |
| either by explicit revocation or the appointme  |  |   |   |
| 14. LIMITATION OF CONSENT - My consent in Item 13 for abuse, infection with the human immunodeficiency virus                            | or the disclosure of records r<br>(HIV), or sickle cell anemia | elating to treatment for drug abus is limited as follows: | e, alcoholism or alcohol  |
|   |  |   |   |
|   |  |   |   |
|   |  |   |   |
| I, the claimant named in Items 1 or 7, hereby   | annoint the service or   | ganization named in Item                                  | 3Δ as my representative to prepare  |
| present and prosecute my claim for any and all  |  |   |   |
| named in Item 1. I authorize the Department of  | of Veterans Affairs to   | release any and all of my                                 | records, to include disclosure of my  |
| Federal tax information (other than as provided   |  |   |   |
| understood that no fee or compensation of wh  |  |   |   |
| attorney. I understand that the service organizatime, subject to 38 CFR 20.608. Additionally,   |  |   |   |
| verification necessitated by an Internal Rever  |  |   |   |
| veteran's representative is only valid for five ye  |  |   |   |

Signed and accepted subject to the foregoing conditions. THIS POWER OF ATTORNEY DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC 15. SIGNATURE OF CLAIMANT (Do Not Print) 16. DATE SIGNED VA FORM 21-22-1 SENT TO: DATE SENT ACKNOWLEDGED REVOKED (Reason and date) **VA** (Date) ☐ INSURANCE FILE ☐ LG FILE CER FILE EDU FILE **USE ONLY** ☐ DEA FILE

NOTE: As long as this appointment is in effect, the organization named herein will be recognized as the sole agent for presentation of your claim before the Department of Veterans Affairs in connection with your claim or any portion thereof. VA FORM JUN 2009

|  | OMB Control No. 2900-0321<br>Respondent Burden: 5 minutes   |
|--|---|
|  | NT OF VETERANS SERVICE ORGANIZATION S CLAIMANT'S REPRESENTATIVE   |
| Note - If you would prefer to have an individual assist you with Individual As Claimant's Representative.''  | your claim, you may use VA Form 21-22a, " Appointment of  |
| IMPORTANT - PLEASE READ THE PRIVACY ACT AND RESPONDENT BU  | IRDEN ON REVERSE BEFORE COMPLETING THE FORM.  |
| 1. LAST-FIRST-MIDDLE NAME OF VETERAN   | 2. VA FILE NUMBER (Include prefix)  |
| 3A. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF   | VETERANS AFFAIRS (See list on reverse side before selecting organization)   |
| 3B. JOB TITLE OF OFFICIAL REPRESENTATIVE AUTHORIZED TO ACT ON VETERA   | AN'S BEHALF   |
|  | OR PRINT ALL ENTRIES  |
| 4. SOCIAL SECURITY NUMBER  | 5. INSURANCE NUMBER(S) (Include letter prefix)  |
| 6A. SERVICE NUMBER(S)  | 6B. BRANCH OF SERVICE   |
| 7. NAME OF CLAIMANT (If other than veteran)  | 8. RELATIONSHIP (If other than veteran)   |
| 9. ADDRESS OF CLAIMANT (No. and street or rural route, city or P.O., State and ZIP Code)   | 10. CLAIMANT'S TELEPHONE NUMBERS (Include Area Code)  |
|  | A. DAYTIME B. EVENING   |
|  |   |
|  | 11. E-MAIL ADDRESS (If applicable)  |
|  | 12. DATE OF THIS APPOINTMENT  |
|  |   |
| 13. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO R<br>Unless I check the box below, I do not authorize VA to discle<br>any records that may be in my file relating to treatment for drug<br>immunodeficiency virus (HIV), or sickle cell anemia.   | ose to the service organization named on this appointment form  |
| records relating to drug abuse, alcoholism or alcohol abuse, infect<br>Redisclosure of these records by my service organization represent<br>not authorized without my further written consent. This authori   | cords to disclose to the service organization named in Item 3A all treatmentation with the human immunodeficiency virus (HIV), or sickle cell anemia entative, other than to VA or the Court of Appeals for Veterans Claims, is ization will remain in effect until the earlier of the following events: (1) is; or (2) I revoke the appointment of the service organization named above entative.  |
| 14. LIMITATION OF CONSENT - My consent in Item 13 for the disclosure of recombuse, infection with the human immunodeficiency virus (HIV), or sickle cell and a sickle cell |   |
| present and prosecute my claim for any and all benefits from the named in Item 1. I authorize the Department of Veterans Affairs Federal tax information (other than as provided in Items 13 and 1 understood that no fee or compensation of whatsoever nature w attorney. I understand that the service organization I have appoin time, subject to 38 CFR 20.608. Additionally, in those cases with  | be organization named in Item 3A as my representative to prepare. Department of Veterans Affairs based on the service of the veterars to release any and all of my records, to include disclosure of my 4), to that service organization appointed as my representative. It is will be charged me for service rendered pursuant to this power of atted as my representative may revoke this power of attorney at any there a veteran's income is being developed because of an income cation match, the assignment of the service organization as the |
| veteran's representative is only valid for five years from the date Signed and accepted subject to the foregoing conditions.   | this form is signed for purposes restricted to the verification match.  |
| THIS POWER OF ATTORNEY DOES NOT REQU   | UIRE EXECUTION BEFORE A NOTARY PUBLIC   |
| 15. SIGNATURE OF CLAIMANT (Do Not Print)   | 16. DATE SIGNED   |

VA FORM 21-22-1 SENT TO: DATE SENT ACKNOWLEDGED REVOKED (Reason and date) VA (Date) ☐ INSURANCE FILE LG FILE CER FILE EDU FILE **USE** ONLY ☐ DEA FILE

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|  |  |  | OMB Control No. 2900-0321<br>Respondent Burden: 5 minutes  |
|--|--|--|--|
| Department of Veterans Affairs   |  | NT OF VETERANS S<br>S CLAIMANT'S REF   | SERVICE ORGANIZATION   |
| Note - If you would prefer to have an individ<br>Individual As Claimant's Representative.''  | lual assist you with   | your claim, you may use  | VA Form 21-22a, " Appointment of   |
| IMPORTANT - PLEASE READ THE PRIVACY ACT A  | AND RESPONDENT BUI   | RDEN ON REVERSE BEFORE   | COMPLETING THE FORM.   |
| 1. LAST-FIRST-MIDDLE NAME OF VETERAN   |  | 2. VA FILE NUMBER (  |  |
| 3A. NAME OF SERVICE ORGANIZATION RECOGNIZED BY   | THE DEPARTMENT OF V  | /ETERANS AFFAIRS (See list on re   | everse side before selecting organization)   |
|  | 755 TO 40T ON VETERAL  | NIO DELLA E  |  |
| 3B. JOB TITLE OF OFFICIAL REPRESENTATIVE AUTHORIZ  | ZED TO ACT ON VETERAL  | N'S BEHALF   |  |
| INSTR  | UCTIONS - TYPE (   | OR PRINT ALL ENTRIE  |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. INSURANCE NUMB  | ER(S) (Include letter prefix)  |
| 6A. SERVICE NUMBER(S)  |  | 6B. BRANCH OF SER  | VICE   |
| 7. NAME OF CLAIMANT (If other than veteran)  |  | 8. RELATIONSHIP (If o  | other than veteran)  |
| ADDRESS OF CLAIMANT (No. and street or rural route, city o   | r P O State and 7IP Code)  | 40 OLAMANIT  | TO TELEPHONE NUMBERS (C. 1.1.1   |
| 3. ADDITEOG OF OLIMINATY (140. and succe of fural found, city o  | 11.0., State and ZII Code)   | A. DAYTIME   | "S TELEPHONE NUMBERS (Include Area Code) B. EVENING  |
|  |  | A. DAYTIME   | B. EVENING   |
|  |  | ( )  | ( )  |
|  |  | 11. E-MAIL ADDRESS   | (If applicable)  |
|  |  | 12. DATE OF THIS AP  | POINTMENT  |
|  |  |  |  |
| records relating to drug abuse, alcoholism of Redisclosure of these records by my service not authorized without my further written revoke this authorization by filing a written either by explicit revocation or the appointment.  | thorize VA to discloto treatment for drugell anemia.  of my VA claimant record alcohol abuse, infector alcohol abuse, infector consent. This authorized revocation with VA; ment of another representations. | se to the service organization abuse, alcoholism or alcoholism or alcoholism or alcohords to disclose to the service tion with the human immunor nattive, other than to VA or cation will remain in effect u or (2) I revoke the appointmentative.   | ton named on this appointment form not abuse, infection with the human erorganization named in Item 3A all treatment deficiency virus (HIV), or sickle cell anemia, the Court of Appeals for Veterans Claims, is until the earlier of the following events: (1) I ent of the service organization named above, |
| 14. LIMITATION OF CONSENT - My consent in Item 13 abuse, infection with the human immunodeficiency viru  | for the disclosure of reco<br>us (HIV), or sickle cell and   | rds relating to treatment for drug<br>emia is limited as follows:  | abuse, alcoholism or alcohol   |
| I, the claimant named in Items 1 or 7, hereby present and prosecute my claim for any and a named in Item 1. I authorize the Department Federal tax information (other than as provide understood that no fee or compensation of v attorney. I understand that the service organizatime, subject to 38 CFR 20.608. Additionally verification necessitated by an Internal Rev veteran's representative is only valid for five y Signed and accepted subject to the foregoing control of the service of the service organization. | Il benefits from the I of Veterans Affairs and in Items 13 and 14 whatsoever nature with zation I have appoint by, in those cases whenue Service verific years from the date to                              | Department of Veterans A to release any and all of to that service organizatill be charged me for serviced as my representative in the area of the assignment of the assignmen | ffairs based on the service of the veteran<br>my records, to include disclosure of my<br>tion appointed as my representative. It is<br>vice rendered pursuant to this power of<br>may revoke this power of attorney at any<br>being developed because of an income<br>tent of the service organization as the  |

THIS POWER OF ATTORNEY DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC

15. SIGNATURE OF CLAIMANT (Do Not Print)

16. DATE SIGNED

17. VA FORM 21-22-1 SENT TO:

USE CER FILE DU FILE SINSURANCE FILE CH. 30 DEA FILE LG FILE DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC

18. DATE SIGNED

19. DATE SENT CDATE SENT CONTROL (Date)

19. DATE SENT CDATE SENT CONTROL (Date)

10. DATE SENT CONTROL (Date)

10. DATE SIGNED

11. DATE SIGNED

12. DATE SENT CONTROL (Date)

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