| Department of Veterans Affair | VA DATE STAMP DO NOT WRITE IN THIS SPACE | | | | | | | | | |
|--|---|--------------------|--------------------------------------|----------------------|---------------------|----------------|--|--|--|--|
| REQUEST FOR EMPLOYMENT INFO | | | | | | | | | | |
| 1. NAME AND ADDRESS OF EMPLOYER OF VETERAN (Complete) | | | 2. ADDRESS (Complete) | | | | | | | |
| | | SETUDN | | | | | | | | |
| | | RETURN TO | | | | | | | | |
| | l | | | | | | | | | |
| 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 can either complete the form online o | | | | n ink, neatly and le | egibly to help pro | cess the form. | | | | |
| 3. VETERAN/BENEFICIARY'S NAME (First, Middle Initial, | Last) | | | | | | | | | |
| 4. SOCIAL SECURITY NUMBER | ILE NUMBE | ER (If applicable) | 6. DATE OF BIRTH | | | | | | | |
| | Month - | | | | Day - | Year | | | | |
| | | | ORMATION (To be completed | | | | | | | |
| 7. BEGINNING DATE OF EMPLOYMENT | | | EMPLOYMENT | 9. TYPE OF WORK | K PERFORMED | | | | | |
| Month Day Year — — | Month | _ Da | ay Year - | | | | | | | |
| 10. AMOUNT EARNED DURING 12 MONTHS PRECEDING EMPLOYMENT (BEFORE DEDUCTIONS) \$ | G LAST DATE OF E | MPLOYMENT | | | | | | | | |
| 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 REAS (IF RETIRED ON DISABILITY, PLEASE SPECIFY) | N OF EMPLOYMENT: | 14B. DATE LAS | ST WORKED Day | Year | | | | | | |
| 15A. DATE OF LAST PAYMENT 15 | 5B. GROSS A | AMOUNT PAYMENT | 16A. WAS LUMP SUM PAYMENT MADE? | 16B. DATE PAI | ID | | | | | |
| Month Day Year | UF LAST | PATIVICINI | YES NO | Month | Day — | Year | | | | |
| | | | GROSS AMOUNT PAID \$ | | | | | | | |
| 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 TH | IAT PREVEN | IT THEM FF | ROM PERFORMING THEIR MILIT | TARY DUTIES? | | | | | | |

| | | | | | | , | | | |
|--|----------------------|--------------------------------|------------------|----------------------|--|--------------------|--|--|--|
| 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 | | | | | | | | | |
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| 20. GROSS MONTHLY AMOUNT OF BENEFIT | | | | | | | | | |
| \$ | | | | | | | | | |
| 21A. DATE BENEFIT BEGAN | 21B DATE FIRE | ST DAVMENT ISS | NIED | 21C DATE BEN | 1C. DATE BENEFIT WILL STOP (If known) | | | | |
| ZIA. DATE BENEFIT BEGAN | ZID. DATETIK | 21B. DATE FIRST PAYMENT ISSUED | | | 210. DATE BENEFIT WILL STOP (IJ KNOWN) | | | | |
| | | | | | | | | | |
| Month Day Year | Month | Day | Year | Month | Day | Year | | | |
| <u>_</u> | _ | _ | | _ | _ | | | | |
| <u> </u> | _ | _ | | _ | _ | | | | |
| 22. REMARKS | | | | | | | | | |
| ZZ. TYZIWI WYO | | | | | | | | | |
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| I CERTIFY THAT the statements made in | this form are true a | nd complete to | the best of my k | mowledge and belice | ef. | | | | |
| OOA CIONATURE OF EMPLOYER OR CURERVIOL | OD (Bi1) | | | 23B D/ | ATE SIGNED (MM | I/DD/VVVV) | | | |
| 23A. SIGNATURE OF EMPLOYER OR SUPERVISO | JR (Kequirea) | | | 230. 07 | ATE SIGNED (MIM | (DD/1111) | | | |
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| PENALTY: The law provides severe penalt | ies which include f | ine or imprison | ment or both fo | or the willful cubmi | ssion of any stat | tement or evidence | | | |
| | | | | | | ement of evidence | | | |
| of a meterial fact, knowing it to be false, or f | or traudulent accep | nance of any pa | yment to which | you are not entitled | 1. | | | | |
| | | | | | | | | | |

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 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.

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