OMB Approved No. 2900-0881
Respondent Burden: 10 Minutes
Expiration Date: 07/31/2027

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

LAY/WITNESS STATEMENT

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 3. Use this form to submit a statement as a veteran/claimant or someone writing on your behalf to support a claim. If you or someone else writing on your behalf are providing additional statement(s) to support your claim(s) please submit this form with your application. For more information, you can contact us through Ask VA: https://ask.va.gov/ or call us toll-free at 1-800-827-1000 (TTY:711). VA forms are available at www.va.gov/vaforms. After completing the form, mail to: **Department of Veterans Affairs, Evidence Intake Center, P.O. Box 4444, Janesville, WI 53547-4444.**

SECTION I: VETERAN'S 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.

1. VETERAN'S NAME *(First, Middle Initial, Last)*

2. SOCIAL SECURITY NUMBER

3. VA FILE NUMBER *(If applicable)*

4. DATE OF BIRTH *(MM/DD/YYYY)*
Month Day Year

5. VA INSURANCE FILE NUMBER *(If applicable)*

6. CURRENT MAILING ADDRESS *(If applicable) (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code

7. TELEPHONE NUMBER *(Include Area Code)*

Enter International Phone Number *(If applicable)*

8. E-MAIL ADDRESS ☒ I agree to receive electronic correspondence from VA in regards to my claim.

SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION
(Complete this section ONLY IF the claimant is NOT the veteran)

9. CLAIMANT'S NAME *(First, Middle Initial, Last)*

10. SOCIAL SECURITY NUMBER

11. VA FILE NUMBER *(If applicable)*

12. DATE OF BIRTH *(MM/DD/YYYY)*
Month Day Year

13. VA INSURANCE FILE NUMBER *(If applicable)*

14. CURRENT MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code

15. TELEPHONE NUMBER *(Include Area Code)*

Enter International Phone Number *(If applicable)*

16. E-MAIL ADDRESS ☐ I agree to receive electronic correspondence from VA in regards to my claim.

SOCIAL SECURITY NUMBER ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION III: STATEMENT

(Use this section to submit your statement, or a statement from someone else writing on your behalf)

NOTE: Please indicate the claimed issue that you are addressing. If you would like to submit an additional statement on your own behalf or if you have more than one witness writing on your behalf, use a separate form (VA Form 21-10210) for each statement.

17. STATEMENT ***(Note:*** *Describe what you yourself know or have observed about the facts or circumstances relevant to this claim before VA)*

[Witness: write this in your own words. Replace the bracketed prompts and delete anything that does not apply.]

I, [your full name], have known [claimant's name] since [year] as their [spouse, friend, coworker, supervisor, or fellow service member]. The statement below is based only on what I have personally seen.

WHAT I HAVE OBSERVED ABOUT [CONDITION]:
[Describe the changes you have noticed, with specific examples and approximate dates. For example: physical limitations, pain behaviors, trouble with daily tasks, missed work, sleep problems, mood or personality changes, memory problems, or social withdrawal.]

BEFORE AND AFTER:
[If you knew the claimant before service or before the condition began, describe how they have changed.]

SPECIFIC EXAMPLES:
[Give one or two concrete situations you personally witnessed, with roughly when they happened.]

Everything in this statement is true and based on my own firsthand observation.

SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION III: STATEMENT *(Continued)*

(Use this section to submit your statement, or a statement from someone else writing on your behalf)

NOTE: Please indicate the claimed issue that you are addressing. If you would like to submit an additional statement on your own behalf or if you have more than one witness writing on your behalf, use a separate form (VA Form 21-10210) for each statement.

17. STATEMENT ***(Note:** Describe what you yourself know or have observed about the facts or circumstances relevant to this claim before VA)*

SECTION IV: WITNESS CONTACT INFORMATION

(Complete Section IV and V if the statement in Section III is from someone else writing on your behalf)

18. WITNESS NAME *(First, Middle Initial, Last)*

19. RELATIONSHIP TO VETERAN/CLAIMANT *(Check all that apply)*

☐ SERVED WITH VETERAN/CLAIMANT ☐ FAMILY/FRIEND OF VETERAN/CLAIMANT ☐ COWORKER/SUPERVISOR OF VETERAN/CLAIMANT

☐ OTHER *(Specify)*

20. TELEPHONE NUMBER *(Include Area Code)*

___ – ___ – ____

Enter International Phone Number *(If applicable)*

21. E-MAIL ADDRESS

SECTION V: CERTIFICATION OF STATEMENT AND SIGNATURE

I CERTIFY THAT I have completed this statement and that its information is true and correct to the best of my knowledge and belief.

22A. VETERAN/CLAIMANT/WITNESS SIGNATURE ***(REQUIRED)***

22B. DATE SIGNED *(MM/DD/YYYY)*

Month ___ – Day ___ – Year ____

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact knowing it to be false, or for fraudulent receipt of any document 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.

RESPONDENT BURDEN: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-0881, and it expires 07/31/2027. Public reporting burden for this collection of information is estimated to average 10 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing the burden, to VA Reports Clearance Officer at VACOPaperworkReduAct@va.gov. Please refer to OMB Control No. 2900-0881 in any correspondence. Do not send your completed VA Form 21-10210 to this email address.