OMB Control No. 2900-0075
Respondent Burden: 15 minutes
Expiration Date: 07/31/2027

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

STATEMENT IN SUPPORT OF CLAIM

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 2. Use this form to submit a statement to support a claim. 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/BENEFICIARY'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, and insert one letter per box to help expedite processing of the form.

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

2. VETERAN'S SOCIAL SECURITY NUMBER — ___ – ___ – ____

3. VA FILE NUMBER (If applicable)

4. VETERAN'S DATE OF BIRTH (MM/DD/YYYY) — __ – __ – ____

5. VETERAN'S SERVICE NUMBER (If applicable)

6. TELEPHONE NUMBER (Include Area Code) — ___ – ___ – ____

Enter International Phone Number (If applicable) _____

7. E-MAIL ADDRESS (Optional)

8. 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 — ____ – ____

SECTION II: REMARKS

(The following statement is made in connection with a claim for benefits in the case of the above-named veteran/beneficiary)

SUBJECT: PERSONAL STATEMENT IN SUPPORT OF CLAIM FOR [CONDITIONION]
This statement describes how [condition] began and how it affects me. Replace the bracketed prompts below with your own details, and delete anything that does not apply.

WHEN IT BEGAN: [approximate date, and where you were, e.g., during a 2021 field exercise].

HOW IT HAPPENED: [the injury, event, or exposure in service that caused or aggravated it].

SYMPTOMS: [what you feel, e.g., pain, numbness, stiffness, headaches, trouble sleeping].

HOW OFTEN / HOW SEVERE: [e.g., daily, or 2-3 times a week; typical pain /10, flare-up__/10]

A TYPICAL DAY VS. A FLARE-UP: [what you can and cannot do on a normal day, and what changes during a flare up and how long it lasts].

EFFECT ON WORK: [tasks it limits, duties you avoid, days missed, accommodations you need].

EFFECT ON DAILY LIFE: [sleep, exercise, hobbies, driving, chores, relationships, and mood].

WHAT HELPS OR MAKES IT WORSE: [medications, rest, positions, or activities]

I certify that the statement above is true and correct to the best of my knowledge.

VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION II: REMARKS *(Continued)*

(The following statement is made in connection with a claim for benefits in the case of the above-named veteran/beneficiary)

SECTION III: DECLARATION OF INTENT

I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.

9. SIGNATURE OF VETERAN/BENEFICIARY **(Required)**	10. DATE SIGNED (MM/DD/YYYY)
	☐☐ – ☐☐ – ☐☐☐☐

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.

PRIVACY ACT INFORMATION: The 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 required to obtain or retain benefits. 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. The 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 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: 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 2900-0075, and it expires 07/31/2027. Public reporting burden for this collection of information is estimated to average 15 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. 2900-0075 in any correspondence. Do not send your completed VA Form 21-4138 to this email address.