NEW YORK STATE OF OPPORTUNITY. **Department of Civil Service**

Albany, NY 12239

STAFFING SERVICES DIVISION
Disability Record Authorization

S-7 (4/15 L)

Name and address of New York State Agency:
Print Employee's Name:

According to our records, you have claimed status as a disabled war-time veteran. Please complete Section 1 below AND send this form to your Regional Office, U.S. Department of Veterans' Affairs for completion of Section 2.

SECTION 1

TO BE COMPLETED BY VETERAN

1. VA Claim Number:	2. Dates of Active Service: From: To:	3. Service Number:
4. Address of U.S. Department of Veterans' Affairs where your disability claim is maintained:		

I hereby authorize the U.S. Department of Veterans' Affairs to furnish the State of New York with the data requested in Section 2 below, pertaining to my disability status. I release the U.S. Department of Veterans' Affairs from all liability in complying with this request. I understand that all information furnished will be treated as confidential.

X _____ _____ _____

Employee's Signature **Date** **Social Security Number**

PERSONAL PRIVACY PROTECTION LAW NOTIFICATION

The information which you are providing on this application is being requested pursuant to Section 50.3 of the New York State Civil Service Law for the principal purpose of determining the eligibility of applicants to participate in the examination(s) for which they have applied. This information will be used in accordance with Section 96(1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e), and (f). Failure to provide this information may result in disapproval of the application. This information will be maintained by the New York State agency listed above. For future information, relating only to the Personal Privacy Protection Law, call (518) 457-9375.

SECTION 2

TO BE COMPLETED BY THE U.S. DEPARTMENT OF VETERANS' AFFAIRS
Please return original to the New York State Agency at the address listed above.
DO NOT RETURN THIS FORM TO THE DEPARTMENT OF CIVIL SERVICE

1. ☐ Yes ☐ No	Does the above named Veteran have a war-incurred disability, incurred during one of the following "Time of War" periods? In the **Armed Forces**: or in the **U.S. Public Health Service**: • (WWII) 12/7/41 to 12/31/46 **.** 1/29/45 to 9/2/45 • (Korea) 6/27/50 to 1/31/55 **.** 6/26/50 to 7/3/52 • (Viet Nam) 2/28/61 to 5/7/75 • (Lebanon) 6/1/83 to 12/1/87 • (Grenada) 10/23/83 to 11/21/83 • (Panama) 12/20/89 to 1/31/90 • (Persian Gulf) 8/2/90 – the date upon which such hostilities end
2. ☐ Yes ☐ No	Is this veteran's service-connected disability rated at 10% or more?
3. ☐ Yes ☐ No	Does the U.S. Department of Veterans' Affairs state affirmatively that a **PERMANENT STABILIZED** condition of disability exists to an extent of 10% or more?
4. ☐ Yes ☐ No	If the answer to question #4 is "No," has the veteran received a medical examination by the V.A. Medical Officer in connection with such disability within the last year? Date of last medical examination: ___/____/____ (MM/DD/YY) Date of next scheduled examination: ___/____/____ (MM/DD/YY)
5. Remarks:	

X _____ _____

Signature of Adjudication Officer **Date**