



**Department of  
Civil Service**  
Albany, NY 12239

**TESTING SERVICES DIVISION**  
Authorization for Disability Record

T-252 (06/2025)

Name (print): \_\_\_\_\_

You recently applied for NYS Civil Service examination(s) and claimed additional credits as a disabled veteran. Please complete **Part 1** below AND send this form to your Regional Office of the U.S. Department of Veterans Affairs for completion of **Part 2**. The Department of Civil Service will use this information to verify your current claim. The information will be maintained by the Department of Civil Service for one year.

Please type or print in ink.

**Part 1**

1. VA Claim Number:	2. Dates of Active Service: FROM: _____ TO: _____	3. Social Security Number:
4. Address of U.S. Department of Veterans Affairs where your disability claim is on file:		

I hereby authorize the U.S. Department of Veterans Affairs to furnish the New York State Department of Civil Service with the data requested in **Part 2** below pertaining to my disability status. I understand that all information furnished will be used solely for the purpose of verifying my eligibility for additional disabled veterans credits on civil service examinations.

X

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**PERSONAL PRIVACY PROTECTION LAW NOTIFICATION**

This information is being requested pursuant to Section 85(3) of the New York State Civil Law for the principal purpose of determining the eligibility of individuals for veterans credits. 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 claims for veterans credits being denied. This information will be maintained by the Director, Division of Testing Services, Department of Civil Service, Albany, NY 12239. For further information relating only to the Personal Privacy Protection Law, call (518) 457-9375. For information on your claim for veterans credits, send an email inquiry to: [ESRPU@cs.ny.gov](mailto:ESRPU@cs.ny.gov).

**Part 2 TO BE COMPLETED BY THE U.S. DEPARTMENT OF VETERANS AFFAIRS**

1. <input type="checkbox"/> YES <input type="checkbox"/> NO	Does the above named veteran have a service-connected disability?
2. <input type="checkbox"/> YES <input type="checkbox"/> NO	Is this veteran's service-connected disability rated at 10% or more?
2a. Date of VA Disability Determination	_____/_____/_____ (MM/DD/YY)
3. <input type="checkbox"/> YES <input type="checkbox"/> 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. <input type="checkbox"/> YES <input type="checkbox"/> NO	If the answer to question #3 is "NO," has the veteran received a medical examination by the VA Medical Officer in connection with such disability within the last year? Date of last medical examination: ____/____/____ (MM/DD/YY) Date of next scheduled exam: ____/____/____ (MM/DD/YY)
5. Remarks:	

X

\_\_\_\_\_  
Signature of Adjudication Officer

\_\_\_\_\_  
Date

**U.S. Department of Veterans Affairs -- please return this form to: The NYS Department of Civil Service, Albany, NY 12239, Attention: ESRPU -- Floor 16, or the form can be faxed to (518) 474-1605.**