

VA Northern Indiana Health Care System Registration Attachment

NAME OF VETERAN _____ SSN: _____

PLEASE PROVIDE THE INFORMATION REQUESTED BELOW

1. Are you a multiple birth? YES NO
2. Place of Birth (City and State): _____
3. Father's Name: _____
4. Mother's Name: _____
5. Mother' Maiden Name: _____
6. Hair Color: _____
7. Eye Color: _____
8. Education: _____
9. Identifying Marks: _____
10. Race: _____
11. Are you an Organ Doner? YES NO
12. Do you have an Advanced Directive or Living Will YES NO
(If yes please send a copy with application)
13. Were you in Combat? YES NO
14. If yes, please fill out information below:
 - a. Where: _____
 - b. Dates:
From: Month _____ Day: _____ Year: _____
To: Month _____ Day: _____ Year: _____

HEALTH CARE LOCATION:

Preference #1 _____
Preference #2 _____