VETERANS OF FOREIGN WARS.

DEPARTMENT of NEW JERSEY

VA Compensation Intake Form

Post Service Officer Name:	**Date:**
Post #	**District #**
Phone #	**Email:**

Leave Blank:			
Leave Blank:			
Veteran's Name:			
Street:			
City:	**County:**	**State:** NJ	**Zip:**
Phone:	**Are you a VFW member?** ☐ **No** ☐ **Yes** **Post #**		
Email:			
Branch of Service:			
Service Date Start:		**Entry Location**	
Service Date End:		**Discharge Location:**	
Conflict:			
Did you ever file a claim before?		**Representation By?**	
Current Rating?			

Briefly Describe Condition / Issue:

- ☐ **Hearing Loss / Tinnitus**
- ☐ **Vietnam - Agent Orange Exposure**
- ☐ **PTSD**
- ☐ **Respiratory**
- ☐ **Back Condition**
- ☐ **Gastrointestinal**
- ☐ **Orthopedic**

Send this form to the NJ VFW Veteran Service Officer Team

Fax: 609-393-3031

Email: claims@njvfw.com