

Necessary Medical Certificate Information

(Needs to be filled out completely and as accurately as possible)

Full Name: _____ Telephone: () _____

Residence: _____ City: _____

State: _____ County: _____ Country: _____ Postal Code: _____

Date of Birth: _____ Birthplace (city/town): _____ State: _____

Social Security # ____ - ____ - _____ Marital Status: Never Married Married Widowed Divorced

Spouse's Name: _____ Maiden: _____ Anniversary Date: _____

Father's (Full Name): _____ Birthplace (city/town): _____

Mother's (First & Maiden Name): _____ Birthplace (city/town): _____

Race (White, Black, American Indian, etc.): _____ Is person of Hispanic origin? Yes No

If YES, Please specify (Puerto Rican, Dominican, Cuban, etc.): _____

Education Level (# of years) (0-12) Elementary/Secondary College _____ Years (1-4 or 5+)

Employment Status: Presently Employed Not Employed Retired (Year ____)

Usual Occupation: _____ Type of Business: _____

Employer: _____ Mfg Whlse Retail No. of Years _____

Informant's Name: _____ Telephone: () _____

Informant's Street Address: _____

City: _____ State: _____ Postal Code: _____ Relationship: _____

Veteran: Yes No Specify War: _____ Branch of Service: _____

Service Dates: ____ / ____ / ____ to ____ / ____ / ____ Service No. _____ Rank: _____

Organization/Outfit: _____ Claim No. C-: _____