

HALL OF HEROES VERIFICATION FORM

Department of Veterans Affairs (VA) Medical Center, Tomah

1. I am interested is being considered as a possible veteran honored at the Veterans Hospital of Tomah's Hall of Heroes display.
2. I authorize required verification of my military records using several available such as County, State, Federal and Military records, including use of the Freedom of Information Act.
3. I authorize verification of citations and decorations need to be verified to ensure fairness to all applicants and families of veterans.
4. The Hall of Heroes is a public display. I am aware the news media may publicize appropriate pictures and stories in local, state and possibly national media outlets.
5. I receive my health care at the Tomah VA or one of its Community Based Outpatient Clinics (located in La Crosse, Loyal, Wausau and Wisconsin Rapids).

I agree to these guidelines and allow verification of my personal military records.

SIGNATURE: _____

(Please Print)

NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____

ZIP CODE: _____

TELEPHONE: __ (____) _____

FAMILY CONTACT IF NOMINEE IS DECEASED: _____

SIGNATURE TO AUTHORIZE RECORDS CHECK: _____

WITNESS OF AUTHORIZING SIGNATURE: _____

DATE: _____