

**REQUEST FOR COPY OF
MILITARY DISCHARGE FORM**

_____ **MEDINA** _____ **COUNTY**

Number of copies requested _____

PLEASE PRINT

VETERAN'S INFORMATION

1. Full Name of Person on Record	First Name	Middle Name		Last Name
2. Date of Discharge	Month	Day	Year	3. Gender
4. Date of Birth	Month	Day	Year	City/County/State
5. Social Security Number (if known)				

6. Requestor's name _____

7. Telephone #: (_____) _____ (MON-FRI 8:00A.M.-5:00P.M.)

8. Mailing Address: _____
STREET ADDRESS
CITY
STATE
ZIP

9. Relationship to person named in item 1: _____

9. Purpose for obtaining this record: _____

10. Identifying information for discharge record: ID#: _____

11. If copy is to be mailed to some other person, please complete:

Name _____ Street Address _____
 City _____ State _____ Zip Code _____

Your Signature

Date of Application

OFFICE USE ONLY	
Vol./Page _____	Certificate # _____
Date Issued _____	By _____