



APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

1. LAST NAME - FIRST NAME - MIDDLE NAME OF VETERAN	2. VA FILE NUMBER <i>(Include prefix)</i>
3. NAME OF SERVICE ORGANIZATION RECOGNIZED BY DEPARTMENT OF VETERANS AFFAIRS <i>(See list on reverse side before selecting organization)</i>	4. SOCIAL SECURITY NUMBER
	5. INSURANCE NUMBER(S) <i>(Include letter prefix)</i>
	6A. SERVICE NUMBER(S)
	6B. BRANCH OF SERVICE
INSTRUCTIONS - TYPE OR PRINT ALL ENTRIES	
7. NAME OF CLAIMANT <i>(If other than veteran)</i>	8. RELATIONSHIP <i>(If other than veteran)</i>
9. ADDRESS OF CLAIMANT <i>(No. and street or rural route, city or P.O., State and ZIP Code)</i>	10. DATE OF THIS APPOINTMENT

NOTE: Complete Items 11A and 11B only if claim filed for disability insurance benefits.

11A. TYPE OF DISABILITY INSURANCE BENEFITS FILED FOR <input type="checkbox"/> NSLI <input type="checkbox"/> USGLI <input type="checkbox"/> NSLI AND USGLI	11B. LOCATION OF INSURANCE RECORDS <input type="checkbox"/> PHILADELPHIA <input type="checkbox"/> ST. PAUL
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I hereby appoint the above-named service organization as my representative to present my claim for benefits from the Department of Veterans Affairs based on the service of the above-named veteran. I ratify all that the above-named representative shall lawfully do or cause to be done based on this appointment.

The accredited representative (Check one) is authorized, is not authorized to disclose information necessary in the development of my claim to the local organization named below.

THIS POWER OF ATTORNEY DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC

12. NAME AND ADDRESS OF CHAPTER, POST OR UNIT

VA USE ONLY	VA FORM 21-22-1 SENT TO <input type="checkbox"/> RSE FILE <input type="checkbox"/> DEA FILE <input type="checkbox"/> INSURANCE FILE <input type="checkbox"/> LG FILE	DATE SENT	ACKNOWLEDGED <i>(Date)</i>	REVOKED <i>(Reason and date)</i>
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AUTHORIZATION FOR ACCESS TO RECORDS OR INFORMATION PROTECTED BY 38 U.S.C. 7332

Unless specifically prohibited by me by checking the box below, I hereby authorize access to information or records relating to the diagnosis, treatment, or other therapy for the condition(s) of drug abuse, alcohol abuse, infection with the Human Immunodeficiency Virus (HIV), or Sickle Cell Anemia, that may be contained or maintained in VA claimant records pertaining to me, to the representative named on this appointment form. Redisclosure of the aforementioned information or records by my representative other than to VA, the service organization involved, or the Court of Veterans Appeals, is not authorized without my further written consent. This authorization will remain in effect until specifically revoked by me by filing a written revocation or by appointing a successor power of attorney.

I DO NOT authorize the above-named representative to have access to information in my records relating to drug abuse, alcohol abuse, infection with the Human Immunodeficiency Virus (HIV), or Sickle Cell Anemia.

It is understood that no fee or compensation of whatsoever nature will be charged me for service rendered pursuant to this power of attorney and that this power of attorney may be canceled by me, or by the service organization named, on written notice to the Department of Veterans Affairs.

13. SIGNATURE OF CLAIMANT

PRIVACY ACT INFORMATION: The information on this form is requested under Section 5902 of Title 38 U.S.C. which provides for the recognition of representatives of certain organizations in the preparation, presentation and prosecution of claims under laws administered by the Department of Veterans Affairs; such representatives, upon appointment of claimant, may act for him or her and become entitled to information under provisions of 38 U.S.C. 5701(b). The information will be used to identify your records. Responses may be disclosed outside the Department of Veterans Affairs only if the disclosure is authorized under the Privacy Act, including the routine uses identified in VA system of records, 58VA21/22/28, Compensation, Pension, Education and Rehabilitation Records-VA, published in the Federal Register. Disclosure of requested information is voluntary; however, failure to furnish the information would impose administrative difficulties which may result in a delay in identifying your records and/or in a delay in the appointment of the named organization as your representative.

RESPONDENT BURDEN: Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the VA Clearance Officer (723), 810 Vermont Ave., NW, Washington, DC 20420; and to the Office of Management and Budget, Paperwork Reduction Project (2900-0321), Washington, DC 20503. Do NOT send requests for benefits to these addresses.

NOTE: As long as this appointment is in effect the organization named herein will be recognized as the sole agent for presentation of your claim before the Department of Veterans Affairs in connection with your claim or any portion thereof.