		OMB Number: 2900-0759 Respondent Burden: 20 minute
Department of Veterans Affairs		ID NEWS RELEASE STIONNAIRE
NATIONAL VETER	RANS SUMMER SF	PORTS CLINIC
PRIVACY ACT: VA is asking you to provide the information of may disclose the information that you put on this form as permittee the Privacy Act systems of records notices identified as 121V voluntary.	d by law. VA may make a '	routine use" disclosure of the information as outlined in
RESPONDENT BURDEN: The Paperwork Reduction Act of 19 clearance requirements of Section 3507 of the Paperwork Reductio to, a collection of information unless it displays a valid OMB num application will average 20 minutes. This includes the time it will t	on Act of 1995. We may not ber. We anticipate that the t	conduct or sponsor, and you are not required to respond ime expended by all individuals who must complete this
All participants must complete questions 1-15, whether or 1 VA Public Affairs at 202-560-7305.	not you wish to have a ne	ws release. If you have any questions, please call
NAME (Last, First, MI)	DATE OF BIRTH	E-MAIL ADDRESS
1. PLEASE CONFIRM YOUR BRANCH OF SERVICE AIR FORCE ARMY COAST GUARD MA OTHER (Please specify)	ARINE CORPS NAVY	NATIONAL GUARD
2. IF YOU ARE A PEACETIME VETERAN, WHERE AND WHEN D	ID YOU SERVE?	_
3. DID YOU SERVE IN COMBAT IN ANY OF THE FOLLOWING C WWII KOREA VIETNAM THE GULF WA OTHER (Please specify)		☐ IRAQ
	YOU DO IN THE SERVICE?	6. ARE YOU CURRENTLY ON ACTIVE DUTY WITH ANY BRANCH OF THE MILITARY?
7. HOW WERE YOU INJURED?		
8. WERE YOU EVER HELD AS A POW? (If yes, where) YES	NO	
9. ARE YOU A VIETNAM ERA (NON-COMBAT) VETERAN?	ES NO	
10. UNDER WHICH GENERAL CONDITION DOES YOUR DIAGN	OSIS FALL?	
PARAPLEGIC		STROKE
QUADRIPLEGIC RIGHT LEG AK O	R BK	OTHER NEUROLOGICAL INJURY OR DISEASE
MULTIPLE SCLEROSIS LEFT LEG AK O	R BK	HIP/KNEE REPLACEMENT
BRAIN INJURY OTHER AMPUTATION		SEVERE ARTHRITIS
VISUALLY IMPAIRED		BURN INJURY
LEGALLY BLIND TOTALLY BLIND		
OTHER DIAGNOSIS (Describe in simple language, not medical to	erms)	
11. OF WHICH VETERANS SERVICE ORGANIZATIONS ARE YO	U A MEMBER? PVA	DAV VFW AMERICAN LEGION
AMVETS MOPH OTHER		
12. WHAT IS YOUR PRIMARY VA MEDICAL CENTER (OR MILITA	ARY HOSPITAL) (City, State)	

14. DO YOU WANT US TO PREPARE A NEWS RELEASE ABOUT YOUR PARTICIPATION IN THIS EVENT?

☐YES ☐ NO

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13. HOW MANY PAST YEARS HAVE YOU PARTICIPATED IN THE NATIONAL VETERANS SUMMER SPORTS CLINIC?

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MEDIA AND NEWS RELEASE QUESTIONNAIRE - Page 2	
15. IF YOU MARKED "YES" TO A NEWS RELEASE IN QUESTION 14, PLEASE PROVIDE THE FOLLOWING INFORMATION.	
REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION: I REQUEST AND AUTHORIZE THE DEPARTMENT OF VETERANS AFFAIRS TO RELEASE THE HEALTH INFORMATION CONTAINED ON THIS FORM FOR VA MEDIA PURPOSES. (See questions 4, 7, 10 and 12.)	
I GIVE MY PERMISSION FOR MY PHONE NUMBER TO BE INCLUDED IN MY NEWS RELEASE POSTED ON THE CLINIC'S WEBSITE	
I DO NOT WANT MY PHONE NUMBER LISTED ON MY NEWS RELEASE	
16. YOUR QUOTE: HOW DO YOU FEEL ABOUT THIS EVENT, WHY IS IT BENEFICIAL, AND WHAT WOULD YOU TELL OTHER VETERANS ABOUT IT? (Quotes are used for newsletter stories, participant profiles, speeches, and other public relations activities.)	
SIGNATURE (You must sign here so we can comply with your wishes) DATE SIGNED	