OMB Control No. 2900-0065
Respondent Burden: 15 minutes

Department of Veterans Affairs

REQUEST FOR EMPLOYMENT INFORMATION IN CONNECTION WITH CLAIM FOR DISABILITY BENEFITS

SECTION I - IDENTIFICATION INFORMATION *(To be completed by VA)*

1. NAME AND ADDRESS OF EMPLOYER OF VETERAN *(Complete)*	RETURN TO	2. ADDRESS *(Complete)*

INSTRUCTIONS: The veteran named in Item 3 has filed a claim for veterans disability benefits and has stated that he/she was recently employed by you. In order to arrive at a fair decision in this case, we need the information requested below. Please complete Sections II and III and return to this office at the above address. Please be sure to sign and date this form in Items 21A and 21B. FOR FREE HELP IN COMPLETING THIS FORM, CALL VA TOLL-FREE: 1-800-827-1000 (TDD 1-800-829-4833).

3. FIRST NAME - MIDDLE INITIAL - LAST NAME OF VETERAN	4. SOCIAL SECURITY NO.	5. VA FILE NO.

SECTION II - EMPLOYMENT INFORMATION *(To be completed by employer)*

6. BEGINNING DATE OF EMPLOYMENT	7. ENDING DATE OF EMPLOYMENT	8. AMOUNT EARNED DURING 12 MONTHS PRECEDING LAST DATE OF EMPLOYMENT (BEFORE DEDUCTIONS)	9. TIME LOST DURING 12 MONTHS PRECEDING LAST DATE OF EMPLOYMENT (DUE TO DISABILITY)
		$	

10. TYPE OF WORK PERFORMED	11. NUMBER OF HOURS WORKED	
	A. DAILY	B. WEEKLY

12. CONCESSIONS (IF ANY) MADE TO EMPLOYEE BY REASON OF AGE OR DISABILITY

13A. IF VETERAN IS NOT WORKING, STATE REASON FOR TERMINATION OF EMPLOYMENT. IF RETIRED ON DISABILITY, PLEASE SPECIFY	13B. DATE LAST WORKED	14A. DATE OF LAST PAYMENT 14B. GROSS AMOUNT OF LAST PAYMENT $

15A. WAS LUMP SUM PAYMENT MADE?	15B. GROSS AMOUNT PAID	15C. DATE PAID
☐ YES ☐ NO *(If "Yes," complete Items 15B and 15C)*	$	

SECTION III - INFORMATION ON BENEFIT ENTITLEMENT AND/OR PAYMENTS *(To be completed by employer)*

16. IS VETERAN RECEIVING OR ENTITLED TO RECEIVE, AS A RESULT OF HIS/HER EMPLOYMENT WITH YOU, SICK, RETIREMENT OR OTHER BENEFITS? ☐ YES ☐ NO *(If "Yes," complete Items 17 through 20)*	17. TYPE OF BENEFIT

18. GROSS MONTHLY AMOUNT OF BENEFIT	19A. DATE BENEFIT BEGAN	19B. DATE FIRST PAYMENT ISSUED	20. DATE BENEFIT WILL STOP *(If known)*

21A. SIGNATURE OF EMPLOYER OR SUPERVISOR	21B. DATE

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to determine eligibility for disability benefits based on unemployability (38 U.S.C. 1521). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at http:www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.