Department of Veterans Affairs

INFORMATION REGARDING POSSIBLE CLAIM AGAINST THIRD PARTY

TO	ADDRESS OF VA FACILITY **District Counsel (02)**	FROM	NAME AND ADDRESS OF VA FACILITY

VETERAN'S NAME *(Last, First, Middle Initial)*

TELEPHONE

VETERAN'S ADDRESS *(Number, Street, City, State, Zip Code)*

SOCIAL SECURITY NUMBER

DATE OF THIS REPORT

NAME OF PERSON FURNISHING THIS INFORMATION, *If other than veteran (Last, First, Middle Initial)*

RECORDS DEPOSITION SERVICE, INC.

TELEPHONE

ADDRESS OF PERSON FURNISHING THIS INFORMATION *(if other than veteran)*

PO BOX 505, SOUTHFIELD, MI, 48086-5054
P: 248-357-3330 F: 248-357-3337

NATURE OF INJURY OR DISEASE

REIMBURSABLE INSURANCE *(INSURANCE COMPANY + ADDRESS, POLICY NUMBER: TYPE OF COVERAGE: GROUP OR INDIVIDUAL)*

IF CLAIM OR CAUSE OF ACTION IS AGAINST A THIRD PARTY, GIVE NAME AND ADDRESS OF SUCH PARTY

☐ TORT-FEASOR
☐ WORKER'S COMPENSATION
☐ CRIMES OF PERSONAL VIOLENCE
☐ "NO FAULT" INSURANCE

HAS VETERAN SUBMITTED CLAIM ORALLY OR IN WRITTING
☐ YES ☐ NO

IF SUBMITTED TO THAN THIRD PARTY NAMED ABOVE, TO WHOM AND WHEN WAS IT SUBMITTED

NAME, TELEPHONE NUMBER AND ADDRESSES OF WITNESSES

GIVE DATE, TIME, EXACT LOCATION AND DESCRIPTION OF INCIDENT WHICH RESULTED IN INJURY

DATE OF INJURY:
LOCATION:
INJURIES SUSTAINED:

WHAT AUTHORITIES, IF ANY, CONDUCTED INVESTIGATION OF INCIDENT

HAS VETERAN CONTACTED ATTORNEY
☐ YES ☐ NO

NAME AND ADDRESS OF ATTORNEY REPRESENTING VETERAN *(if applicable)*

REMARKS

VA FORM JUNE 2007 **10-1023**