



Application to Transfer Membership

Paralyzed Veterans of America
Membership & Volunteer Program
1875 Eye Street, NW, Suite 1100 * Washington, DC * 20006
888-838-7782 * Direct Membership Line

TRANSFERRING MEMBER'S INFORMATION

First Name: _____ MI _____ Last Name: _____

Member Identification Number: _____ Social Security Number _____

Service connected injury or disease

Non-Service connected injury or disease

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Other Phone: _____

Email: _____

CHAPTER TRANSFER INFORMATION

Please transfer my membership.

From Chapter: _____

To Chapter: _____

Member's Signature: _____ Date: ____ / ____ / ____

GAINING CHAPTER USE ONLY

Chapter Name: _____

Membership Officer's Name: _____

Membership Officer's Signature: _____ Date: ____ / ____ / ____

NATIONAL OFFICE USE ONLY	
DATE RECEIVED	Processed by _____
	Process Date ____ / ____ / ____

Reset Form