

FACES OF HONOR Application

Print and Complete the Application below and e-mail this form to Info@AAFPRS.org or FAX form to 703-299-8284 along with your Authorization for Release Form.

1. Name
2. Mailing Address
3. City / State / Zip Code
4. Home Phone
5. Other Phone
6. E-mail Address
7. Please describe your war related injuries (**Injuries on the face, head or neck only**)

8. Which war or conflict did you serve and the dates:

9. Please provide the following: Check the boxes to the ones that are applicable and attached:

- Military Identification for Active Duty Members or Active Reserve Members
- Form DD 214 if discharged honorably from Active Duty
- Form DD 2527 (Statement of Personal Injury) if available.
- Purple Heart Citation where applicable.
- Copies of medical treatment record for related injury if available.
- Referral letter from referring physician if applicable and available. .

10. How did you learn about FACES OF HONOR? Please check the source:

- Friend
- Internet
- Newspaper
- Magazine
- Radio
- Agency
- TV

11. Other _____

I verify that the statements on this application and attachments are true. I authorize release of this information to the AAFPRS and the surgeons providing the medical care needed to repair the damage caused by a war related injury.

Signature: _____ Date _____

In addition to this form, please complete the FACES OF HONOR Authorization for Release and Use of Information Form Form