SHEBOYGAN AREA VETERANS TREATMENT COURT REFERRAL

Veterans Name: ______________________________________ SSN:________________________________

Address:___________________________________ Birthdate: __________________________

___________________________________ Phone Number: ______________________

Driver's License State/number: ____________________________ License Status: ___________________

Military Service Dates: ______________to________________ Character of Service: ________________

Where did you serve: __________________________________ Specialty:__________________________

Significant Duty: ____

Marital / Family Status: ____

Current Living Situation: ____

Employment: ____How Long:_______________

Attorney's Name: _______________________________________ Attorney's Phone:__________________

Current Charges: ____

Circuit Court:___________________________________

Condition / Treatment Needs: ____

VA Healthcare: YES NO if yes where:____

Fax to 920-459-3055 or E-mail [Sheboygan Area Veterans Treatment Court]