



New York Division of Military and Naval Affairs
330 Old Niskayuna Road
Latham New York 12110-3514

Received Date
DMNA Use Only

Email Address

Phone Number

Social Security Number

Please return this application to DMNA in an envelope marked "Personal and Confidential 9/11 Claim"

You must file this form with the New York Division of Military and Naval Affairs on or before September 11, 2026. If you are permanently incapacitated or become permanently incapacitated in the future, you will also need to file the Application for World Trade Center Accidental Disability Presumption (DMNA 911-B) to receive the benefit.

INFORMATION ABOUT YOU
1. Name: (First, Middle Initial, Last)
2. Date of Birth:
3. Address: (Including Street, City, State and Zip Code)
4. Telephone Numbers: HOME () WORK () CELL ()
5. Job Title on 9/11/2001:
6. Employer/Organization 9/11/2001:
7. Current Job Title:
8. Current Employer:

Table with 3 columns: Locations, Dates, Nature of the Work/Service Performed. Rows include World Trade Center Site, Fresh Kills Landfill, New York City Morgue, Temporary Morgue on Pier, etc.

If you worked at any sites not listed above, list the site with the address below:

Table with 3 columns: Locations, Dates, Nature of the Work/Service Performed. Empty rows for additional site information.

Description of Other Duties performed during the WTC rescue and recovery or clean up operations:

[Empty box for description of other duties]

MEDICAL RECORDS RELEASE AUTHORIZATION

I, _____, hereby authorize the release of all relevant medical psychiatric, psychological, hospital and health insurance records, including specially protected or listed records such as those relating to drug abuse, alcoholism, genetic testing, psychiatric care and/or confidential HIV/AIDS related information.

All pertinent records are authorized to be released to the New York Division of Military and Naval Affairs (DMNA) and will be used to determine a WTC disability and/or death claim.

I understand that I have a right to revoke this authorization at anytime. I understand that if I revoke this authorization, I must do so in writing and it may impact my ability to qualify for disability or accidental death benefits provided under NYS CLS MIL § 217.

By signing below I acknowledge that I have read and accept all of the above and hereby authorize any hospital, medical group, or other organization to disclose all information to the New York Division of Military and Naval Affairs.

Signature: _____ Date: _____

Please sign your name in full below:

I certify that the information on my application is true and complete to the best of my knowledge. I further certify that I am aware that any false statement I knowingly make or permit to be made on this or any record of DMNA constitutes a crime punishable by potential incarceration and other sanctions.

Signature: _____ Date: _____

ACKNOWLEDGEMENT TO BE COMPLETED BY A NOTARY PUBLIC

State of _____ County of _____ On the _____ day of _____ in the year _____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

NOTARY PUBLIC (Please sign and affix stamp)

***Social Security Disclosure Requirement**

In accordance with the Federal Privacy Act of 1974, you are hereby advised that disclosure of your Social Security account number is voluntary. Disclosure will be used in the processing and verification of the data supplied to determine eligibility for benefits. However, failure to submit requested data may delay or prevent further processing of this application.

Personal Privacy Protection Law

The Division of Military and Naval Affairs is required by law to maintain records to determine eligibility for benefits. Failure to provide information may interfere with the timely payment of benefits. The Division may be required to provide certain information to participating employers.