



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

**Military ID Number (if available)**

**Received Date**

DMNA Use Only

**Social Security Number** [last 4 digits]

**XXX-XX-**

**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. To be eligible for this presumption, the applicant must have participated in World Trade Center rescue, recovery or clean up operations for any period of time within the first 48 hours after the first airplane crashed, or a minimum of 40 hours between September 11, 2001 and September 12, 2002.

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:

Locations:	Dates:	Nature of the Work/Service Performed:
World Trade Center Site		
Fresh Kills Landfill		
New York City Morgue		
Temporary Morgue on Pier Locations on the West Side of Manhattan		
Barges between the West Side of Manhattan and the Fresh Kills Landfill		

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

Locations:	Dates:	Nature of the Work/Service Performed:

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

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**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.

DMNA 911-A

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