



**AMERICAN
VETERANS
ARCHAEOLOGICAL
RECOVERY**

SUBMITTING THE APPLICATION

Please complete this application and email materials to: info@americanveteransarchaeology.org

Alternatively, please send application materials to:

**American Veterans Archaeological Recovery
PO Box 440 Carlisle, PA 17013**

REQUIRED DOCUMENTATION

Applications without the required documentation of eligibility will NOT be processed. Please cover social security numbers and other sensitive information on eligibility documents. Your application and documents will be kept securely by American Veterans Archaeological Recovery and will not be shared with third parties. If you wish for your information to be deleted, please request this using the contact details above.

a) Please provide a copy of the following documents, as applicable, which must accompany this application as evidence of your eligibility:

DD 214 / DD 215 / WD AGO 53-55 / General Orders / DD 1300 / VA Award Letter of Disability

- b) If you are willing to drive on the dig, please send a copy of your driver's license (front and back). We rent vehicles to drive back and forth to the dig sites and will rotate turns driving. A copy of your license is required for insurance purposes.
- c) If you sustained an injury, please submit written verification of your injury, how the injury was sustained, or a copy of your Purple Heart.
- d) If you are willing to be included on AVAR promotional materials (e.g. our website, Facebook or flyers), please send a minimum of one photo of yourself (maximum of three). Photos may include you in the military/in uniform, you with your family/friends/pets, or a photo of your choice. By sending these photos, you consent to AVAR including these photos on promotional materials.

PERSONAL INFORMATION

Name:		Date of Birth:	
Address:			
City:	State:	Zip:	Country:
Phone:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Email address:			
Marital status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Service: <input type="checkbox"/> Army <input type="checkbox"/> Marine Corps <input type="checkbox"/> Navy <input type="checkbox"/> Air Force <input type="checkbox"/> Coast Guard			
Component: <input type="checkbox"/> Active <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard <input type="checkbox"/> Retired <input type="checkbox"/> Separated			
Highest Rank Held:			

EMERGENCY CONTACT

Name:		Relationship:
Phone:		
Email:		
Do you consent for us to contact this person in case of emergency? <input type="checkbox"/> Yes <input type="checkbox"/> No		

DIG PREFERENCE

If you are placed on a waiting list and a dig becomes available, would you like to be contacted for a potential space even at short-notice? Yes No If yes, please indicate the best way to contact you:

PERSONAL HEALTH HISTORY

Please provide as much information as possible in this section. Your health information will help staff prepare the digs appropriately so that you have the best experience. This information will be kept confidential and only shared with medical personnel in case of emergencies.

Are you medically discharged for wounds or injuries sustained in combat operations? Yes No

Did your injuries or wounds occur during OIF/OEF? Yes No

Do you have a registered assistive service animal that would be accompanying you? Yes No

Please note that if we are traveling overseas, any and all laws involving animals traveling to that country will have to be followed. Not all countries follow the same assisted service animal laws as the United States of America.

Type of Injury / Condition (check all that apply)

- | | | |
|----------------------------------|---|---|
| <input type="checkbox"/> Amputee | <input type="checkbox"/> Depression | <input type="checkbox"/> Spinal Cord Injury (SCI) |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Substance Use Disorder |
| <input type="checkbox"/> Blind | <input type="checkbox"/> Post-Traumatic Stress Disorder | <input type="checkbox"/> Traumatic Brain Injury (TBI) |
| <input type="checkbox"/> Burn | <input type="checkbox"/> Spinal Cord Injury (SCI) | <input type="checkbox"/> Other (please specify below) |

Other:

Please provide a brief description of your injury/mental health condition and the impact on your daily activities:

Are you currently taking any medication for physical or mental health conditions? Yes No

If yes, please describe:

Do you use a wheelchair: Yes No

Do you require any other special services or assistance? Yes No

If yes, please describe:

CONNECTING WITH AVAR

Have you applied for an AVAR program in the past? Yes No

How did you hear about AVAR?

Signature:

Date: