

**Patriot Flight, Inc ~ A hub of the National "Honor Flight Network" ~ Veteran Application**  
*www.PatriotFlightInc.com*

Veteran's Last Name: \_\_\_\_\_

*Patriot Flight Inc* recognizes WWII veterans for your sacrifices and achievements by flying you to Washington, DC to see YOUR memorial at no cost. In order for *Patriot Flight* to achieve this goal, guardians fly with the veterans on every flight providing assistance and helping veterans have a safe, memorable and rewarding experience. *Guardians can only be one generation.* For what you and your comrades have given to us, please consider this a small token of appreciation from us at *Patriot Flight, Inc.*

*WWII Veterans will have served at some time between December 7, 1941 and December 31, 1946.*

Questions, contact Danielle Havel (518) 783-1754 or Ron Lewis (518) 542-9834.

*Fields with an \* are mandatory.*

*Veterans First Name, Last Name and Middle Initial MUST BE AS IT APPEARS ON DRIVER'S LICENSE (REQUIRED)*

Please fill out and mail this *entire* application to:

Patriot Flight Inc. ~ 740 Hoosick Road ~ Box 4260 ~ Troy, NY 12180

**Veteran's Information:**

First Name \* \_\_\_\_\_

Middle Initial \* \_\_\_\_\_

Last Name \* \_\_\_\_\_

Address \* \_\_\_\_\_

Apartment \_\_\_\_\_

City \* \_\_\_\_\_

State \* \_\_\_\_\_

Zip \* \_\_\_\_\_

Phone (day) \* \_\_\_\_\_

Phone (evening) \* \_\_\_\_\_

Email Address \_\_\_\_\_

Date of Birth (MM/DD/YYYY) \* \_\_\_\_\_

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Veteran's Last Name: \_\_\_\_\_

Age \* \_\_\_\_\_

Weight \* \_\_\_\_\_

Shirt Size \* \_\_\_\_\_

Rank \* \_\_\_\_\_

Branch of Service \* \_\_\_\_\_

Hometown at Time of Service \* \_\_\_\_\_

Dates Served (from and to) \* \_\_\_\_\_

Activity During WW II \*  
(no abbreviations, be specific) \_\_\_\_\_

Duties During WW II \* \_\_\_\_\_

Citations / Awards \* \_\_\_\_\_

**Veterans Medical Information**

Medical information provided will not disqualify you. It permits us to assess the support needed during the trip. *Information is for Patriot Flight and Medical Personnel only.* If you have a health issue, we may require a Doctor's written permission for participating in this event.

Do you use mobility equipment (circle one)    YES    NO \_\_\_\_\_

If yes, please circle device                      CANE    WHEELCHAIR    WALKER    SCOOTER \_\_\_\_\_

Medications (name, dosage and how often you take it) \_\_\_\_\_

*Medication*    *Taken How Often* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Veteran's Last Name: \_\_\_\_\_

*Medication (cont)*

*Taken How Often (cont)*

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Do you have any drug allergies? If yes, please list.

Do you have a history of seizures?                      YES    NO

If yes, when was your last seizure and what type of seizure was it (i.e. grand mal, petit mal, etc)

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**Alternate Contact (i.e. Son, Daughter, etc)**

First Name \*

Last Name \*

Address \*

Apartment

City \*

State \*

Zip \*

Phone (day) \*

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Veteran's Last Name: \_\_\_\_\_

Phone (evening) \* \_\_\_\_\_

Email Address \_\_\_\_\_

Relationship to Veteran \* \_\_\_\_\_

***Emergency Contact (REQUIRED)***

First Name \* \_\_\_\_\_

Last Name \* \_\_\_\_\_

Address \* \_\_\_\_\_

Apartment \_\_\_\_\_

City \* \_\_\_\_\_

State \* \_\_\_\_\_

Zip \* \_\_\_\_\_

Phone (day) \* \_\_\_\_\_

Phone (evening) \* \_\_\_\_\_

Email Address \_\_\_\_\_

Relationship \* \_\_\_\_\_