The Service Dog Fund

Service Dog Application

P: (833) 499-2408

E: info@servicedogfund.org

PROPOSED RECIPIENT_____

RESIDENCE ADDRESS_____

CITY_____ STATE_____ ZIP_____

PHONE #_____ EMAIL_____

DATE OF BIRTH_____ AGE_____ GENDER_____

MARITAL STATUS_____ SPOUSES NAME IF APPLICABLE_____

GUARDIANS NAME IF APPLICABLE_____

EDUCATION LEVEL_____

EMPLOYER_____ OCCUPATION_____

ATTENDING PHYSICIAN_____

STREET ADDRESS_____

CITY_____ STATE_____ ZIP_____ PHONE#_____

APPLICANT'S NAME (IF OTHER THAN RECIPIENT)_____

RELATIONSHIP TO PROPOSED RECIPIENT_____

BRIEFLY DESCRIBE
DISABILITY/IMPAIRMENT_____
_____
_____

WHEN DID THE DISABILITY BEGIN_____

WHAT WAS THE CAUSE_____

DESCRIBE ANY MEDICAL EQUIPMENT YOU ARE CURRENTLY USING
_____
_____

DESCRIBE ATTENDANT CARE REQUIRED, IF ANY
_____
_____

HEIGHT _____ WEIGHT _____

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IN PRIORITY ORDER, STATE THE VARIOUS TASKS A DOG IS TO PERFORM 1.

_____ 1. _____ 2.
_____ 3. _____ 4.
_____ 5. _____ 6.
_____ 7. _____ 8.

DESCRIBE ANY OTHER EXPECTATIONS YOU HAVE OF THE SERVICE DOG

_____
_____

BRIEFLY DESCRIBE YOUR HOME LIFE, SOCIAL LIFE, AND HOBBIES

_____
_____
_____

DESCRIBE TYPE OF HOUSING YOU RESIDE IN

_____

LIST ANY OTHER PERSON LIVING IN YOUR HOUSEHOLD

FULL NAME	AGE	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST ANY PETS OR ANIMALS LIVING IN YOUR HOUSEHOLD

TYPE OF ANIMAL	PURPOSE	AGE	WEIGHT
_____	_____	_____	_____
_____	_____	_____	_____

IF YOU EVER HAD A SERVICE DOG, PLEASE ANSWER THE FOLLOWING DATE ACQUIRED _____
DURATION OF STAY _____ AGE _____ BREED _____

OBTAINED FROM _____

TASKS PERFORMED _____

IF NO LONGER WITH YOU, STATE REASON _____
_____

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PLEASE PROVIDE THREE PERSONAL REFERENCES – STATE NAME, ADDRESS, TELEPHONE NUMBER, AND RELATIONSHIP TO YOU

1. _____
_____

2. _____
_____

3. _____
_____

HAVE YOU APPLIED FOR A SERVICE DOG FROM ANOTHER SOURCE? YES NO

IF YES - FROM WHOM _____

DATE OF APPLICATION _____ ESTIMATED COST $_____

ANTICIPATED PLACEMENT DATE _____

DATE _____ _____

Signature of Proposed Recipient

DATE _____ _____

Signature of Applicant

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ATTENDING PHYSICIAN STATEMENT

Please sign the Authorization Section and forward pages four and five to your physician for completion and return to you. Should you have more than one current medical provider, please use photocopies of pages four and five . After completion, include these pages with all other pages of this application for return to American Service Dog Association.

PHYSICIAN'S NAME _____

STREET ADDRESS _____ _____

CITY _____ STATE _____ ZIP _____

TELEPHONE _____ _____ - _____

PATIENT'S NAME _____

DATE OF BIRTH _____ SOCIAL SECURITY #

_____

1. History

Length of association with patient _____ Date of last visit _____

Nature of treatment _____

Names of other treating physicians _____

_____

2. Diagnosis & Duration of Impairments _____

_____

_____

_____

_____

_____

3. Description of Limitations _____

_____

_____

_____

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4. Prognosis & Effects on performing daily activities _____

_____

_____

_____

5. Do you believe the patient is competent to make decisions regarding regular daily activities?

YES NO If NO, please explain _____

_____

_____

6. Do you know of any reason why patient should not be assisted by a service dog?

YES NO If YES, please explain _____

_____

_____

7. Please list current medications prescribed _____

_____

_____

_____

Date _____ _____

Signature of Physician

Print Physician's Name _____