

The Service Dog Fund

Service Dog Application

Sara-marie Robinson- Executive Director

P: (602)487-7158 E: info@servicedogfund.com

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
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST ANY PETS OR ANIMALS LIVING IN YOUR HOUSEHOLD

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

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

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 _____