

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 _____

The Service Dog Fund
Service Dog Application

Sara-marie Robinson- Executive Director
P: (602)487-7158 E: info@servicedogfund.com

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 _____

The Service Dog Fund
Service Dog Application

Sara-marie Robinson- Executive Director
P: (602)487-7158 E: info@servicedogfund.com

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 _____