Paws In Hand Canine Consulting

SERVICE DOG APPLICATION

(Please Note: If applying for a service dog, applicants are required to submit a physician statement verifying their disability or diagnosis)

Date_____

Name of Applicant_____

Address_____ Date of Birth_____/_____/_____

_____ Height_____

_____ Weight _____

Phone (home)_____ Phone (cell) _____

Email _____

Is the applicant a minor? YES NO

Parent/ Guardian Name(s)_____

_____

Address_____

Phone(home)_____ Phone (cell)_____

Other persons living in the home_____

Other pets living in home:

_____

_____

Do you OWN / RENT your home? (Circle one)

PERSONAL INFORMATION

Primary Diagnosis/ Disability: _____

_____

Secondary Diagnoses/ Disabilities? _____

_____

Is your condition progressive? _____

_____

Do you use any equipment for mobility? _____

_____

Do you have personal attendants who assist you from outside of your home? How often? _____

_____

How long have you been diagnosed with your disability?_____

_____

Do you use a manual or electric wheelchair? _____

Which is your dominant hand or "strong" side?_____

Have you worked with a service dog in the past? YES/ NO If yes, please explain _____

_____

Describe your housing: (Apartment, house, dormitory, rural, city)

_____

Describe your work setting:

_____

Do you attend school? _____

Describe your daily routine: _____

_____

_____

_____

What forms of transportation do you use? _____

_____

Describe your hobbies and interests: _____

_____

What is the climate like where you live? _____

_____

Do you like to travel? _____

Have you ever had a pet dog? _____

Are you a smoker? _____

Are your friends/ family supportive of the decision to get a service dog?

_____

DOG INFORMATION

What tasks would you like a dog to perform for you?

_____

_____

_____

Do you have a breed preference? _____

Gender preference? _____

If there is a preference of breed, please explain: _____

_____

_____

_____

Please provide any other information that may be useful in selection of a dog for your situation: _____

_____

_____

_____

Do you have access to a fenced yard?_____

_____

Paws In Hand Canine Consulting
Physician Statement

(This form is to be completed by a physician or licensed mental health professional)

I, _____ (Physician or Licensed Mental

Health Practitioner), hereby certify that

_____ (patient) has been diagnosed

with the condition(s) as described below.

_____

_____

_____

_____

_____

Name of Physician _____

Date_____

Physician Signature_____

License _____

City/ State of Practice_____

Submit all applications to:

Paws-in-hand@hotmail.com

or

Paws In Hand Canine Consulting
Attn: Briana Bartlett
678 Peggy Lane
Gunter, TX 75058