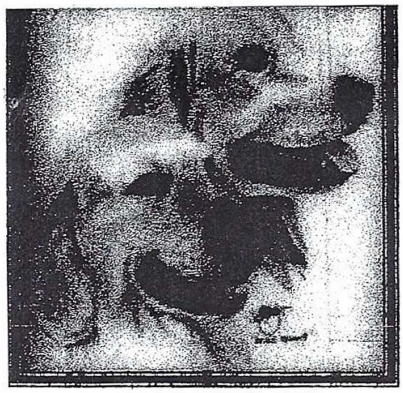

A. S. D. E. C.

Assistance Service Dog Educational Center
P.O. Box 367 / 32785 Road 212
Woodlake, CA 93286
Phone: (559) 564-PAWS
(7297)

Enclosed please find the application packet you requested. Only those applications which are ***returned complete (all information included)*** *will be processed, so please read the following instructions carefully. If you have any questions, please call us for clarification.*

A completed application includes the following:

1. **A $25 application fee.**
2. *The completed* ***Program Application*** *form.*
3. *The* **Medical History** *Form completed by your physician or primary care specialist.*
4. *A* **personal letter of reference** *from a friend, teacher, or someone other than a family member.*
5. *A* **one-page letter** *stating your reasons for wanting a service dog and how you feel the dog would benefit you.*

Staff, upon receipt, will review your completed application. Those applications we feel qualify for our program based on the application process will be contacted to schedule an interview.

If you are selected for placement, there is a fee, based on the type of service dog, as well as a $500.00 fee for the two-week training course, which is held at our Assistance Service Dog Educational Center campus. The $500.00 fee is due upon your arrival on the first day of class. Payment of the dog will be due upon selection and receipt of dog.

Thank you for your interest in our program.

Sincerely,

Donna Whittaker
Enclosures

Assistance Service Dog Educational Center

Program Application

First Name:_____ Last Name:_____

Address:_____ Apt. Number:_____

Cily:_____ .State, Zip:_____

Home Phone ( )_____ Fax: ( )_____

Nearest Relative:_____

Address:_____ Apt. Number:_____

City:_____ State, Zip:_____

Home Phone:( )_____ Work Phone: ( )_____

What is your primary disability?_____

What caused your disability?_____

Please list any secondary disabilities, if any:_____

At what age were you disabled?_____ ls your disability prngressive? I !Yes I I No

Date of birth:_____ Approximate weight:_____ Approx. Height:____

Sex: 11 Male 11 Female

CHECK ALL THAT APPLY:

What are the effects of your disability?

□ Deafness D Speech Impairment D Reduced Stamina D Hearing Loss □ Coordination Problems
□ Limited Mobility D Memory Loss D Spasticity D Slowed Development □ Vision Impairment
o Muscular Weakness

□ Other:_____

Do you have any problems with.....

o Allergies □ Chronic Pain □ Heightened Emotions □ Depression o Seizures
D Skin Sensitivity D Balance D Brittle Bones □ Heal/Cold Sensitivity

Do you use an aid or assistive device?
□ Prosthesis o Leg Brace D Wheelchair (Electric) D Wheelchair (Manual) o Wrist Brace
D Hearing Aid D Crutch/Cane D Walker

D Other:_____

Assistance Service Dog Educational Center
Applicant Medical History Form

This form is to be completed by your physician and sent together with your other application materials to the Assistance Service Dog Educational Center.

Dr. _____,

Please release the requested information regarding my condition to the above identified organization. This information will help determine my abilities in regards to the placement of an assistance dog.

Applicant's Name (please print): _____

Applicant's Signature: _____ Date: _____

Doctor's Name: _____

Type of practice: _____

Address _____

City _____ **County** _____ **State** _____ **Zip** _____

Phone _____ **Fax** _____

Patient Information:

What is this patient's primary disability? _____
What was the cause of the disability? _____
Are there significant secondary disabilities?.....[ ] Yes [ ] No
If so, please describe: _____
At what age was (s)he disabled? _____ **Is this disability progressive?**.... [ ] Yes [ ] No
Is there an incapacity due to or affected by alcoholism or drug abuse.....[ ] Yes [ ] No

Check all that apply:

What are the effects of your disability? (Circle all that apply)

Deafness Speech impairment Reduced Stamina Hearing Loss
Coordination problems Limited mobility Memory loss Spasticity
Slowed development Vision impairment Muscular weakness
Other: _____

Does patient have any problems with...(circle all that apply)

Allergies Chronic pain Heightened emotions Depression Seizures
Skin sensitivity Balance Brittle bones Heat/Cold sensitivity

Does patient use an aid or assistive device? (Circle all that apply)

Prosthesis Leg brace Wheelchair (electric) Wheelchair (manual)
Wrist brace Hearing aid Crutch/cane Walker Other: _____

Current number of hours of attendant care per week:_____

Does patient...(Circle all that apply)

Drive Ride buses Fly Driven by others Travel distances on foot/wheels

Other:_____

ADL = Activities of Daily Living

Is this patient:	Please Circle Below		
A. Able to exercise judgment and make decisions necessary for ADL?	Yes	Minimally	No
B. Able to sustain an attention span?	Yes	Minimally	No
C. Manifesting inappropriate behavior Beyond his/her control?	Yes	Minimally	No
D. Able to control physical and motor Movement sufficient to sustain ADL?	Yes	Minimally	No
E. Capable of perception and memory to the degree necessary to sustain ADL?	Yes	Minimally	No
F. Able to follow directions and learn To the degree necessary to sustain ADL?	Yes	Minimally	No
G. Under medication which impairs Physical or mental functioning?	Yes	Minimally	No
H. Capable of decisions concerning self and others needs and safety?	Yes	Minimally	No

Can you recommend this individual for an assistance dog?.....[ ] Yes [ ] No

Do you feel the assistance dog program might benefit from a consultation with you?
.....[ ] Yes [ ] No

Comments:_____

_____

_____

Physician Signature:_____ Date_____

What kind of assistance dog are you looking for?

☐ Guide ☐ Service ☐ Hearing ☐ Social/Therapy ☐ Seizure Alert

☐ Other: _____

What is your marital status?

☐ Single ☐ Married ☐ Separated ☐ Divorced Other: _____

With whom do you live? Check all that apply!

☐ Alone ☐ With parent(s) ☐ With spouse or significant other ☐ With Attendant

☐ With roommates ☐ Other: _____

Where do you live?

☐ In a house ☐ In an apartment ☐ In a dorm ☐ Other: _____

Check on this line if you ☐ live with children ☐ have children who visit regularly.

How many children? _____ What are their ages? _____

Check on this line if your current living situation has | | a fenced yard or | | an enclosed area.

Are you able to travel to the program office for your interview? | | Yes | | No

If no, please explain: _____

_____ _____

Applicant Signature Date

If the applicant is a minor, or under guardianship or conservatorship or a ward of the court, the parent or duly authorized representative is required to sign below pursuant to state and federal law.

Name

(First): _____ (Last): _____

Relationship to applicant: _____

Address: _____

City: _____ State, Zip: _____

Home Phone: ( ) _____ Fax: ( ) _____

_____ _____

Parent or Guardian Signature Date

FOR OFFICE USE ONLY

Date Received: _____ Received By: _____

Application Complete [ ] Yes [ ] No Interview Meets program requirements: [ ] Yes [ ] No

Scheduled: _____ Pre-interview form sent: _____

Method of Interview: [ ] Phone or [ ] Video [ ] In Person [ ] Other: _____