



**Applicant Medical Form**

This form is to be completed by your physician and sent together with your application material to: Paws Giving Independence, POBox 9572 Peoria IL 61162 or [dkosner@givingindependence.org](mailto:dkosner@givingindependence.org)

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Information Release:

Dr. \_\_\_\_\_, Please release the requested medical information regarding my condition to the above identified organization. The information will be used to help determine if I may benefit from a service/assistance dog.

Applicants Name (printed): \_\_\_\_\_

Applicants Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor Name: \_\_\_\_\_

Type of Practice: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Phone \_\_\_\_\_

**Patient Information:**

Patient primary disability: \_\_\_\_\_

List secondary disabilities: \_\_\_\_\_

How long has the patient been under your care? \_\_\_\_\_

Please Circle All That Apply

The applicant (has)...

- |                                       |                             |                        |
|---------------------------------------|-----------------------------|------------------------|
| Walks at a community speed            | Walks slowly                | Walks unsteady         |
| Is non ambulatory                     | Uses a cane                 | Uses a walker          |
| Uses a manual wheelchair              | Uses a power wheelchair     | Hearing loss           |
| Spends majority of day in bed         | Memory loss                 | Autism                 |
| Vision Impairments                    | Seizures                    | Depression             |
| Anxiety                               | PTSD                        | Developmental Delay    |
| Difficulty with transitions/locations | Difficulty picking up items | Difficulty with stairs |
| Other: _____                          |                             |                        |

Does the applicant:

- |  |                          |
|--|--------------------------|
| 1) Independently make judgments/decisions for ADLS?            | Yes - Minimally –No-Unkn |
| 2) Independently make decisions concerning self/others safety? | Yes - Minimally –No-Unkn |
| 3) Pose any threat or danger to an animal?                     | Yes - Minimally –No-Unkn |
| 4) Have a good support system at home?                         | Yes - Minimally –No-Unkn |
| 5) Receive ongoing treatment for their condition?              | Yes - Minimally –No-Unkn |
| 6) Have a diagnosis of PTSD?                                   | Yes- -NO                 |

What 3 tasks could a service dog do to make this applicant more independent?

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

Do you recommend this individual be considered to receive a service/companion dog?

( ) YES ( ) NO

Comments:

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Doctor Signature: \_\_\_\_\_ Date \_\_\_\_\_