Assistance Service Dog Educational Center

Program Application

First Name:_____Last Name:_____

Address:_____Apt. Number:_____

City:_____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?_____Is your disability progressive? [ ]Yes [ ] No

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

Sex: [ ] Male [ ] Female

CHECK ALL THAT APPLY:

What are the effects of your disability?

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

☐ Other:_____

Do you have any problems with.....

☐ Allergies ☐ Chronic Pain ☐ Heightened Emotions ☐ Depression ☐ Seizures
☐ Skin Sensitivity ☐ Balance ☐ Brittle Bones ☐ Heat/Cold Sensitivity

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

☐ Other:_____