



**Service  
Dogs**  
*your way of living*

Thank you for your interest in our UDS Service dogs program. Below you will find an application and medical forms for you to complete and return to me at your earliest convenience. After your application has been reviewed, the interviewing committee will contact you for an appointment.

The popularity of service dogs is increasing and currently our waiting list could be as long as 3years. We currently use Golden Retrievers, Labrador Retrievers and Boxers in our program. We do not give our clients a choice in the breed of service dog that they receive, though we do try to work with our clients with specific allergy requirements.

Our program offers one-on-one client training. Our clients receive individualized training designed specifically for their individual needs. We do require that our clients attend some training sessions at our training facility in Lancaster, PA.

The estimated value of a service dog is \$20,000. UDS Service Dogs requires that each person who receives a trained service dog pay \$5,000. Our fee is based on the individualized training we give to each client and the amount of monies already invested in training each service dog. Payment is requested at the time of placement however payment arrangements can be made if discussed in advance with the Program Manager. We will work with you on ideas for fundraisers to assist in obtaining a service dog

Please take into consideration the ongoing expenses of having a service dog before returning the application along with a \$25 application processing fee. This is a commitment that will require ongoing dedication in order for you and your service dog to achieve success.

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_

Place of employment \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_

What is your primary disability? \_\_\_\_\_

What is the cause of your disability? \_\_\_\_\_

Are there significant secondary disabilities? \_\_\_\_ Yes \_\_\_\_ No

Please describe \_\_\_\_\_

At what age were you disabled? \_\_\_\_\_ Is your disability progressive? \_\_\_\_ Yes \_\_\_\_ No

Date of birth \_\_\_\_\_ Weight \_\_\_\_ Height \_\_\_\_ Sex \_\_\_\_M \_\_\_\_F

**Circle all that apply:**

What are the effects of your disability?

- |                       |                    |                   |
|-----------------------|--------------------|-------------------|
| Speech impairment     | Reduced stamina    | Hearing loss      |
| Memory loss           | Vision impairment  | Spasticity        |
| Coordination problems | Deafness           | Muscular weakness |
| Limited mobility      | Slowed development |                   |

Do you have any of the following problems?

- |                     |                  |                       |
|---------------------|------------------|-----------------------|
| Allergies           | Chronic pain     | Depression            |
| Seizures            | Balance          | Brittle Bones         |
| Heightened emotions | Skin sensitivity | Heat/Cold sensitivity |

Do you use an assistive device?

- |                       |                     |             |
|-----------------------|---------------------|-------------|
| Prosthesis            | Leg brace           | Walker      |
| Wrist brace           | Hearing aid         | Crutch/cane |
| Wheelchair (electric) | Wheelchair (manual) |             |

Can you:

- |                                 |                   |                    |                   |              |
|---------------------------------|-------------------|--------------------|-------------------|--------------|
| A. Pick up items off the floor? | <i>Always</i>     | <i>Often</i>       | <i>Sometimes</i>  | <i>Never</i> |
| B. Push elevator buttons?       | <i>Always</i>     | <i>Often</i>       | <i>Sometimes</i>  | <i>Never</i> |
| C. Turn lights on and off?      | <i>Always</i>     | <i>Often</i>       | <i>Sometimes</i>  | <i>Never</i> |
| D. Push a manual wheelchair?    | <i>Always</i>     | <i>Often</i>       | <i>Sometimes</i>  | <i>Never</i> |
| E. Flex your wrist?             | <i>Left wrist</i> | <i>Right wrist</i> | <i>Neither</i>    |              |
| F. Make a fist?                 | <i>Left hand</i>  | <i>Right hand</i>  | <i>Not at all</i> |              |

Do you:

Drive Travel distances on foot/wheels	Ride buses	Fly in airplanes Driven by others
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Are you:

Single	Married
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Do you live:

Alone Spouse/significant other	With Parents Roommates	Attendant
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Do you live with or have children, or do children visit regularly? \_\_\_\_\_ Yes \_\_\_\_\_ No

Number of children \_\_\_\_\_ Ages \_\_\_\_\_

Do you:

A. Use a:	<i>Manual chair</i>	<i>Electric chair</i>	<i>Scooter</i>	<i>Walker/Crutches</i>
B. Transfer by:	<i>Standing</i>	<i>Pivoting</i>	<i>Slide board</i>	<i>With help</i>
C. Is your speech:	<i>Clear-rapid</i>	<i>Clear-slow</i>	<i>Slurred</i>	<i>Difficult to understand</i>
D. Communicate best by:	<i>Voice</i>	<i>Letter board</i>	<i>Interpreter</i>	<i>Other</i>
E. Walk:	<i>Short distances</i>	<i>Only with support</i>	<i>On level ground</i>	<i>No</i>
F. Lift your arms:	<i>Above your head</i>	<i>To your shoulders</i>	<i>Only slightly</i>	
G. Exercise:	<i>Regularly</i>	<i>Often</i>	<i>Sometimes</i>	<i>Infrequently</i> <i>Never</i>

Is your...

A. Voice:	<i>Loud</i>	<i>Average</i>	<i>Soft</i>	
B. Lung capacity:	<i>Normal</i>	<i>Somewhat limited</i>	<i>Very limited</i>	
C. Hearing:	<i>Normal</i>	<i>Somewhat limited</i>	<i>Very limited</i>	<i>Deaf</i>
D. Balance:	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>Poor</i>
E. Endurance:	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>Poor</i>
F. Mobility:	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>Poor</i>
G. Physical strength:	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>Poor</i>
H. Speed of reaction:	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>Poor</i>
I. Vision (with correction):	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>Poor</i>

**Circle all that apply:**

Are you:

A. Extra sensitive to heat	<i>Always</i>	<i>Often</i>	<i>Sometimes</i>	<i>Never</i>
B. Extra sensitive to cold	<i>Always</i>	<i>Often</i>	<i>Sometimes</i>	<i>Never</i>
C. Extra sensitive to pain	<i>Always</i>	<i>Often</i>	<i>Sometimes</i>	<i>Never</i>
D. Socially active	<i>Always</i>	<i>Often</i>	<i>Sometimes</i>	<i>Never</i>

Does your current living situation have:

Animals in the household: Dogs	Cats	Other	
A fenced yard	Enclosed outside area		Park or yard nearby
Neighbors in close proximity	Busy streets nearby		
Neighborhood dogs running loose			

Do you:

Work/volunteer outside the home	Work/volunteer from/at home	Attend school
Shop – groceries, clothes, etc	Engage in recreation outside the home	Formally exercise

Do you belong to any clubs, groups, or organizations listed below?

Lions	Veterans	GFWC
Rotary	Kiwanis	Soroptimists

What tasks/jobs are you interested in having a service dog do for you? Why? \_\_\_\_\_

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Please describe personal/physical care management practices that you have which could affect the service dog placement. \_\_\_\_\_

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Please describe your home life, social activities, hobbies, and lifestyle in general. \_\_\_\_\_

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Please describe how you will handle the following areas of dog care:

- A. Feeding \_\_\_\_\_
- B. Grooming \_\_\_\_\_
- C. Toileting \_\_\_\_\_
- D. Vet care \_\_\_\_\_
- E. Financial costs \_\_\_\_\_
- F. If you are hospitalized \_\_\_\_\_
- G. Flea problems \_\_\_\_\_
- H. Family, friend involvement \_\_\_\_\_
- I. Access issues \_\_\_\_\_
- J. Dog behavior problems \_\_\_\_\_

Are you the kind of person who:

Enjoys people contact?	<i>Never</i>	<i>Rarely</i>	<i>Sometimes</i>	<i>Often</i>	<i>Always</i>
Is a risk taker?	<i>Never</i>	<i>Rarely</i>	<i>Sometimes</i>	<i>Often</i>	<i>Always</i>
Easily expresses emotions?	<i>Never</i>	<i>Rarely</i>	<i>Sometimes</i>	<i>Often</i>	<i>Always</i>
Likes to be in charge?	<i>Never</i>	<i>Rarely</i>	<i>Sometimes</i>	<i>Often</i>	<i>Always</i>
Is easily bored with people?	<i>Never</i>	<i>Rarely</i>	<i>Sometimes</i>	<i>Often</i>	<i>Always</i>
Is determined to accomplish goals?	<i>Never</i>	<i>Rarely</i>	<i>Sometimes</i>	<i>Often</i>	<i>Always</i>

Rate yourself in the following areas:

Assertive	<i>Never</i>	<i>Rarely</i>	<i>Sometimes</i>	<i>Often</i>	<i>Always</i>
Self-confident	<i>Never</i>	<i>Rarely</i>	<i>Sometimes</i>	<i>Often</i>	<i>Always</i>
Ability to respond rationally to crisis	<i>Never</i>	<i>Rarely</i>	<i>Sometimes</i>	<i>Often</i>	<i>Always</i>
Ability to accept criticism/correction	<i>Never</i>	<i>Rarely</i>	<i>Sometimes</i>	<i>Often</i>	<i>Always</i>
Willing to learn new concept	<i>Never</i>	<i>Rarely</i>	<i>Sometimes</i>	<i>Often</i>	<i>Always</i>
Ability to laugh at self	<i>Never</i>	<i>Rarely</i>	<i>Sometimes</i>	<i>Often</i>	<i>Always</i>
Personal shyness	<i>Never</i>	<i>Rarely</i>	<i>Sometimes</i>	<i>Often</i>	<i>Always</i>

Are you able to travel for your interview? \_\_\_\_\_ Yes      \_\_\_\_\_ No

If no, please explain. \_\_\_\_\_

Do you currently have a pet? \_\_\_\_\_ Yes      \_\_\_\_\_ No

If yes, list the type of pet, age and whether this is an inside or outside pet. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Applicant Signature** \_\_\_\_\_

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

Name (please print) \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

**Parent or Legal Guardian Signature** \_\_\_\_\_

FOR OFFICE USE ONLY

Date received \_\_\_\_\_ By \_\_\_\_\_

Application complete? \_\_\_\_\_

Application fee enclosed? \_\_\_\_\_ Check/Money Order/Cash \_\_\_\_\_

Date of interview \_\_\_\_\_ Interviewer \_\_\_\_\_

Accepted/Rejected \_\_\_\_\_ Reason for rejection \_\_\_\_\_

# APPLICANT MEDICAL HISTORY FORM

This form is to be completed by your physician and sent together with your other application materials to New Life Assistance Dogs.

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 patient's disability? (*Check all that apply*)

\_\_\_\_ Deafness

\_\_\_\_ Hearing loss

\_\_\_\_ Memory loss

\_\_\_\_ Spasticiat

\_\_\_\_ Speech impairment

\_\_\_\_ Coordination problems

\_\_\_\_ Vision impairment

\_\_\_\_ Muscular weakness

\_\_\_\_ Reduced stamina

\_\_\_\_ Limited mobility

\_\_\_\_ Slowed development

Other: \_\_\_\_\_

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

- |                                     |  |  |
|-------------------------------------|--|--|
| <input type="checkbox"/> Allergies  | <input type="checkbox"/> Chronic pain  | <input type="checkbox"/> Heightened emotions   |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Seizures      | <input type="checkbox"/> Skin sensitivity      |
| <input type="checkbox"/> Balance    | <input type="checkbox"/> Brittle bones | <input type="checkbox"/> Heat/cold sensitivity |

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

- |                                      |   |   |
|--------------------------------------|---|---|
| <input type="checkbox"/> Prosthesis  | <input type="checkbox"/> Wheelchair(manual) | <input type="checkbox"/> Wheelchair(electric) |
| <input type="checkbox"/> Leg brace   | <input type="checkbox"/> Wrist brace        | <input type="checkbox"/> Hearing aid          |
| <input type="checkbox"/> Crutch/cane | <input type="checkbox"/> Walker             | Other: _____                                  |

**Activities of Daily Living**

Is this patient:

*Please Circle Below*

- |   |     |           |    |
|---|-----|-----------|----|
| A. Able to exercise judgement and make decisions necessary for daily living?            | 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 daily living?      | Yes | Minimally | No |
| E. Capable of perception and memory to the degree necessary to sustain daily living?    | Yes | Minimally | No |
| F. Able to follow directions and learn to the degree necessary to sustain daily living? | 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 \_\_\_\_\_

