



4 Paws for Ability
207 Dayton Ave
Xenia, OH 45385

4 PAWS FOR VETERANS - APPLICATION

Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: Hm: _____ Work: _____ Cell: _____
Email: _____
Birthdate: _____
Are you a Veteran? Y N War or Operation: _____
Are you Active Duty? Y N
Is your disability combat related? Y N

If Yes, Explain:

Emergency Contact name and number: _____
Alternate contact name and number: _____

Primary Physician: _____ Phone: _____
Therapist: _____ Phone: _____
Therapist: _____ Phone: _____
Other: _____ Phone: _____
May we contact them? Y N

Primary Diagnosis: _____
Other diagnoses or issues: _____

How do your disabilities affect your ability to function?

Do you have restrictions or precautions as a result of your disability?

What type of medical treatment are you receiving?

Medications: What are you taking and why?

What types of adaptive equipment do you use?

If you are no longer in the military are you employed? Y N

Employer: _____ Phone: _____
Contact: _____ Email: _____

What do you do?

Who lives in your home?		
Name	Age	Relationship

Pets in the home?

Species (cat, dog, other) Name Age M / F Spayed?

Where do the pets live?

Veterinarian: _____ Phone: _____

Are the pets up to date with all required veterinary care? Yes No

If not, Why?

Do you have a fenced yard: Yes No

What do you want the service dog to do for you?

Can you handle the dog without help? Yes No

What help would you need?

Can you physically care for the dog (feeding, potty breaks, etc) Yes No

Can you afford grooming or do it yourself? Yes No

Will you need help with dog food? Yes No

Will you need help with Veterinary Care? Yes No

If there is anything else you would like us to know please include a letter with your application.

References must be from people who are not related to you. Therapists are a good source for references.

In signing I understand I will have to provide proof of veterinary care annually and failure to provide veterinary care will result in the dog returning to 4 Paws For Ability.

Signature: _____ Date: _____

Please return by mail, email or fax:

Mail - 207 Dayton Ave. Xenia, Ohio 45385

Email - karen@4pawsforability.org

Fax - (937) 376-2720

Contact info: karen@4pawsforability.org, (937) 374-0385, or www.4pawsforability.org

4 Paws for Ability, Inc. a nonprofit agency
TAKING THE 'dis' OUT OF disABILITY



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4 PAWS FOR VETERANS - MEDICAL FORM

Applicants name: _____

What are the applicants disabilities and how do they affect him/her?

Does this applicant's physical disability affect their mental or cognitive condition?
For example: memory, retention, concentration, or understanding. If so, please explain
in as much detail as possible.

TAKING THE 'dis' OUT OF disABILITY



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4 PAWS FOR VETERANS - REFERENCE

Name: _____ Date: _____

Address: _____

Phone: Hm _____ Work _____ Cell _____

Email: _____

Relationship to applicant: _____

How long have you known the applicant? _____

How does the applicant's disability affect their functional abilities?

Tell us about the applicant? Do you think they would benefit from the use of a service dog? Do you think they have the ability to handle the dog? Caring for a dog is a lot of work. Do you feel the applicant has the ability to care for the dog? If not, do they have a support system in place that would be available on a daily basis to assist in the care of the dog?

If the applicant has pets or if you have observed the applicant with other animals, how did they interact? If they have pets, are they well cared for? Do they live inside or outside?

Additional comments?

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