



**Capable Canines of Wisconsin, Inc.**

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## Application for Service Dog

### Personal Information

Name of applicant: \_\_\_\_\_  
First Last Middle

Address: \_\_\_\_\_  
Street (Apt) City State Zip

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Email: \_\_\_\_\_  
Month Day Year

Home phone: (\_\_\_\_) \_\_\_\_\_ Mobile: (\_\_\_\_) \_\_\_\_\_

Emergency contact: \_\_\_\_\_  
Name Relationship Phone

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Education (highest level completed): \_\_\_\_\_

Plans for future (education/employment/living arrangements): \_\_\_\_\_

\_\_\_\_\_

Where did you hear about Capable Canines of Wisconsin? \_\_\_\_\_

### Lifestyle

Residence:  Apartment  Duplex  House  Condo  Mobile home  Parents

Is there a yard?  Yes  No

Is it fenced?  Yes  No

Own/rent?  Homeowner  Renter

If renting, landlord name: \_\_\_\_\_ Landlord phone: (\_\_\_\_) \_\_\_\_\_

Please list all individuals living with you in the household:

Name: Age: Relationship:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Animal Experience

Have you ever owned a dog?  Yes  No If yes, please describe your experience: \_\_\_\_\_

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

Please list all animals you have owned within the past 5 years:

Name:	Type of animal:	Years in home:	Still living with you?	Reason for death or leaving:
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Current or intended veterinarian: \_\_\_\_\_

Vet's phone: (\_\_\_\_\_) \_\_\_\_\_ Vet's address: \_\_\_\_\_  
Street City State Zip

Have you visited any other veterinarians in the past 5 years?  Yes  No

Have you ever applied for or worked with another service dog organization?  Yes  No

If yes, which organization(s)? \_\_\_\_\_

## Service Dog Needs

Would the service dog accompany you to work or school?  Work  School

School: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

With 1 being most important and 5 being least important, please rank 5 of the following tasks you would like a service dog to perform:

- |                                       |  |
|---------------------------------------|--|
| _____ Pick up dropped items           | _____ Press life alert button  |
| _____ Pull out of chair, bed, etc.    | _____ Help balance while walking or standing                         |
| _____ Seizure response                | _____ Deep tissue pressure   |
| _____ Diabetic response               | _____ Alert adult if child leaves boundaries                         |
| _____ Turn on/off light switches      | _____ Open doors   |
| _____ Reading buddy                   | _____ Alert to certain noises (fire alarm, alarm clock, phone, etc.) |
| _____ Tether to child while in public |  |
| _____ Other (please specify): _____   |  |
- \_\_\_\_\_  
\_\_\_\_\_

## Medical Information

Disability: \_\_\_\_\_ Onset: \_\_\_\_\_

Current height: \_\_\_\_\_ Current weight: \_\_\_\_\_

Which of the following do you use? (Check all that apply)

Braces  Cane  Crutches  Walker  Electric wheelchair  Manual wheelchair  Hearing aids  Oxygen tank

Other (please list): \_\_\_\_\_

Please list allergies and explain reaction(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Primary doctor: \_\_\_\_\_

Doctor's phone: (\_\_\_\_\_) \_\_\_\_\_

Clinic address: \_\_\_\_\_

Street

City

State

Zip

Do you have an attendant?  Yes  No

Attendant's hours:  Full time  Part time

Attendant's name: \_\_\_\_\_

Attendant's phone: (\_\_\_\_\_) \_\_\_\_\_

Do you have a physical therapist?  Yes  No

Physical therapist's name: \_\_\_\_\_

Physical therapist's phone: (\_\_\_\_\_) \_\_\_\_\_

Clinic address: \_\_\_\_\_

Street

City

State

Zip

## Disclaimer and Signature

I certify the answers I have provided are true and complete to the best of my knowledge. I understand that false or misleading information in my application or in other communications with Capable Canines of Wisconsin may result in the revocation of the service dog.

I give Capable Canines of Wisconsin, Inc. permission to contact the medical health care providers, landlord(s), and veterinarians I have listed to learn more about my disability and to further identify my personal needs. I understand that this information will be treated with confidentiality.

I understand that the application fee is nonrefundable and in no way guarantees approval of this application.

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