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Please check applicable boxes and provide details if necessary:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> High/Low blood pressure      | <input type="checkbox"/> Rheumatic fever       | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Heart disease                | <input type="checkbox"/> Impaired hearing      | <input type="checkbox"/> Hernia              |
| <input type="checkbox"/> Hemophilia                   | <input type="checkbox"/> Impaired sight        | <input type="checkbox"/> Polio               |
| <input type="checkbox"/> Migraines                    | <input type="checkbox"/> Memory loss           | <input type="checkbox"/> Spasticity          |
| <input type="checkbox"/> Dizziness/Fainting/Blackouts | <input type="checkbox"/> Reduced stamina       | <input type="checkbox"/> Depression          |
| <input type="checkbox"/> Allergies & likely reactions | <input type="checkbox"/> Chronic pain          | <input type="checkbox"/> Imbalance           |
| <input type="checkbox"/> Epilepsy                     | <input type="checkbox"/> Brittle bones         | <input type="checkbox"/> Infantile paralysis |
| <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Nervous disorders   |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Convulsive seizures   | <input type="checkbox"/> Limited mobility    |
| <input type="checkbox"/> Muscular weakness            | <input type="checkbox"/> Coordination problems | <input type="checkbox"/> Skin sensitivity    |
|   |  | <input type="checkbox"/> Speech impediment   |

Details:

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Is there any other information that you feel is pertinent, that may affect the applicant's ability to care for a service dog?

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Physician Name: \_\_\_\_\_ Date: \_\_\_\_\_

(Please print name)

Physician Address: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Phone #: \_\_\_\_\_

**\*NOTE: PLEASE RETAIN A COPY OF THIS COMPLETED FORM FOR YOUR FILES**