Wisconsin Academy for Graduate Service Dogs

1337 Greenway Cross,#157
Madison WI 53713

Professional Reference Form

Applicant Instructions: Please provide the information requested on the first page of this form. The Professional Reference Form should then be completed by your Occupational Therapist, Physical Therapist, Rehabilitation Counselor, Psychologist or Case Worker. The completed form should be returned to WAGS.

Applicant Name (print): _____

Address: _____

_____

Phone: _____

Healthcare Provider,

Please release to the Wisconsin Academy for Graduate Service Dogs (WAGS) any requested information regarding my condition. The information you provide will be used to evaluate and assess my application for a WAGS Service Dog. WAGS will keep this information strictly confidential and will not share it with anyone but the professional staff of the agency that is involved in evaluating my application request or in providing services for me.

_____ _____
Applicant Signature Date

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

_____ _____
Guardian Name (print) Date

_____
Guardian Signature

Wisconsin Academy for Graduate Service Dogs
1337 Greenway Cross, #157
Madison WI 53713
608-250-9247

Professional Reference Form

To the Healthcare Provider: Please complete this form and return it to the Wisconsin Academy for Graduate Service Dogs (WAGS). This form is needed to complete your patient's application for a WAGS Service Dog. The information provided will help WAGS determine the applicant's suitability for a service dog, and to plan a training program that takes into consideration the applicant's medical conditions. All medical information about the applicant will be kept strictly confidential.

Provider Information

Name: _____

Title: _____

Address: _____

_____

Phone: _____

Applicant Information

11. Applicant's Name: _____
12. What is the applicant's primary disability?

_____

13. What is the prognosis of the disability?

_____

14. Please list any secondary disabilities:

_____

15. Does the applicant's disability affect their cognitive abilities or functioning in any capacity? Yes / No *If yes, please describe:*

_____

16. Do you have any concerns about the applicant's ability to physically tolerate the training required to work with a service dog? Yes / No *If yes, please describe:*

_____

17. Do you have any concerns about the applicant's ability to cognitively participate in the training? Yes / No *If yes, please describe:*

_____

18. Do you have any concerns about the applicant's ability to care for a service dog? Yes / No *If yes, please describe:*

_____

19. Why do you feel the applicant would benefit from having a service dog?

_____

20. Are there any additional comments you wish to make that might help us in evaluating your patient's application for a service dog? _

_____

Your Signature _____ Date _____

** Thank you **