ASSISTANCE DOG CERTIFICATION APPLICATION

Part One
APPLICATION INFORMATION

Be certain to include all of the following materials in your application packet:

- ☐ Completed application part one and two
- ☐ Recent photograph of yourself
- ☐ Autobiography (please use separate sheet)
- ☐ $50.00 application fee (non-refundable)

If any of the above items are not included in your packet, CST will not be able to process your application. Please remember to make certain that all the required documents are received by CST.

COST:

Application: Include a $50 non-refundable Application fee with your completed application.

Evaluation Fee: $75 non-refundable. Your dog will be evaluated by our training staff. Dogs will only be accepted for our outside certification program if our trainers find the dog to be of suitable temperament and training of a Service Dog. Certain breeds are excluded; Rottweilers, Pitt Bulls and other bully/protection breeds. (puppies in training will be re-evaluated at 6 and 18 months.)

Training/Certification Fee: $2500 This will provide six (6) private training sessions with a CST trainer and unlimited access to group classes. When determined by our training staff, you and your dog will take our Public Access Test. Upon passing you will be issued a CST identification card, collar, leash & vest for your dog. Subsequent and Annual test will be charged at $100 per test and any required replacement equipment will be charged at the current rate. If the dog is deemed unsuitable at any time in the future, certification will be revoked and all equipment must be returned.

Please send all applications to: **Canine Support Teams, Inc.**
P.O. Box 891767
Temecula, CA 92589-1767

FOR OFFICE USE ONLY

DATE RECEIVED _____/_____/_____ RECEIVED BY: _____

ITEMS MISSING: _____

Canine Support Teams
P.O. Box 891767
Temecula CA 92589-1767
Phone: (951) 301-3625 ● Fax: (951) 301-3605
cstmain@aol.com
www.caninesupportteams.org

ASSISTANCE DOG CERTIFICATION APPLICATION

PERSONAL INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Birth Date: ____/____/___ Phone: (____) _____ Cell (_____) _____

Place of Employment: _____

Work Address: _____ Work Phone: (_____) _____

Cell Phone: (____) _____ Email Address: _____

City: _____ State: _____ Zip: _____

Nearest Relative: _____ Relationship: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: (_____) _____

How did you hear about Canine Support Teams? _____

_____

What is your disability? _____

_____

How long have you been disabled? _____

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PERSONAL INFORMATION (Check all that apply)

Print Name: _____

☐ Married ☐ Single ☐ Children: #_____ Ages: _____

☐ Divorced ☐ Separated ☐ Widowed

I live in a: ☐ House ☐ Apartment ☐ Other: _____

I live with: ☐ Parents ☐ Spouse ☐ Group

☐ Alone ☐ Number of residents in home: _____

My home has a: ☐ Fenced yard ☐ Enclosed Area

My other pets include: ☐ Dogs # _____ ☐ Cats #_____ ☐ Birds #_____

Breeds & Gender _____

You must be able to travel to CST. Can you? ☐ Yes ☐ No

If no, please give a reason: _____

Do you currently receive government benefits? ☐ Yes ☐ No

☐ SSI: $_____ ☐ SSDI: $_____ ☐ Other: $ _____

Monthly income (other than government benefits) $_____

Do you ☐ Rent or ☐ Own your home? Amount of Rent/Mortgage per month $_____

1) Check all that apply:

☐ Work at home ☐ work outside home ☐ attend school

Please describe work/school environment: _____

_____

_____

2) Describe your activity level (low, moderate, high) and explain: _____

_____

3) Please describe your home life, social life, hobbies, and your lifestyle as a whole:

_____

_____

_____

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PERSONAL INFORMATION (Continued)

Print Name: _____

4) Please describe your house and yard: _____

_____

_____

5) Please list, in order of importance, the tasks you would like your dog to perform for you:

_____

_____

_____

6) Please describe all means of transportation that you use: _____

_____

_____

7) What kinds of adaptive equipment do you routinely use?

_____

_____

8) Please describe your knowledge of dog care:

_____

_____

9) Please describe your knowledge of dog behavior:

_____

_____

10) What characteristics do you like in a dog?

_____

11) What characteristics do you dislike in a dog?

_____

12) In what ways do you feel you will need to change your lifestyle to meet the physical and psychological needs of your Service Dog?

_____

_____

_____

_____

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PERSONAL INFORMATION (Continued)

Print Name: _____

Please rate yourself in the following area. Number 1 represents the lowest rating, 3 represents average, and 5 represents the highest. Circle the number which best defines you:

1)	Assertive ability with other people when facing differences of opinion:	1	2	3	4	5
2)	Self-confidence when facing new or uncertain circumstances or problems:	1	2	3	4	5
3)	Ability to react calmly to crisis:	1	2	3	4	5
4)	Expression of fear:	1	2	3	4	5
5)	Expression of sorrow:	1	2	3	4	5
6)	Expression of love:	1	2	3	4	5
7)	Expression of hope:	1	2	3	4	5
8)	Expression of anger:	1	2	3	4	5
9)	Expression of joy:	1	2	3	4	5
10)	Ability, when challenged, to stand your ground:	1	2	3	4	5
11)	Willingness to learn new concepts, even if contrary to current beliefs:	1	2	3	4	5
12)	Ability to carry and assume responsibility:	1	2	3	4	5
13)	Ability to control emotions:	1	2	3	4	5
14)	Emotional sensitivity:	1	2	3	4	5
15)	Willingness to accept criticism:	1	2	3	4	5
16)	Ability to laugh at yourself	1	2	3	4	5
17)	Sensitivity to embarrassment:	1	2	3	4	5
18)	Personal shyness:	1	2	3	4	5
19)	Ability to empathize:	1	2	3	4	5
20)	Personal exuberance:	1	2	3	4	5

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PERSONAL INFORMATION (Continued)

Print Name: _____

21) Please give any further information about yourself that might be helpful in making an assessment:
_____

_____

_____

CANINE SUPPORT TEAMS, INC. ANTI-DISCRIMINATION CLAUSE

It is the policy of CST to extend equal consideration and treatment to all persons regardless of race, color, national origin, religion, creed, gender, sexual orientation, martial status, age, or physical or mental disabilities or medical conditions.

CST reserves the right to deny services to an applicant if it can be determined that the individual's special circumstances or requirements could result in the unsafe handling of the dog or may cause undue hardship, personal injury to the handler or endanger the safety of the general public.

_____ _____

APPLICANT SIGNATURE **DATE**

IF APPLICANT IS A MINOR, 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.

Print Name: _____

Relationship, Title, or Agency: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number (_____) _____ OR (_____) _____

_____ _____

SIGNATURE **DATE**

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ASSISTANCE DOG CERTIFICATION APPLICATION
PART TWO

APPLICANT MEDICAL HISTORY RELEASE FORM

Print Name: _____

I authorize the release of any requested information regarding my health to Canine Support Teams. The information given will not be used for any other purpose than to evaluate and assess my condition as it relates to making successful canine placement. CST will keep this information confidential and will not share it with anyone but the professional staff involved in helping provide services for me.

_____ _____
Applicant's Signature Date

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

Sign name: _____ Print name: _____

Relationship, Title or Agency: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (_____) _____ Date: _____

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Providers of Assistance Dogs

ASSISTANCE DOG CERTIFICATION APPLICATION

Part two

Professional Reference Report

THIS FORM IS TO BE COMPLETED BY YOUR PHYSICIAN

Print Patient's Name: _____

Doctor's Name: _____

Doctor's Address: _____

City: _____ State: _____ Zip: _____

Date of last visit: _____

How long have you been associated with this patient? _____

Please give prognosis and list the effects of your client's disability relating to the individual's ability to engage in activities of daily living (ADL). These include the ability to attend personal care needs such as feeding, toileting, dressing, and managing finances, maintaining home and attaining needed outside services.

Mental/ Emotional Evaluation of Client:

1. Does your client have the ability to exercise judgment and make decisions necessary for ADL? ☐ Yes ☐ No

2. Does your client possess the ability of memory and perception necessary for ADL? ☐ Yes ☐ No ☐ Minimally

3. Does your client have the ability to sustain a reasonable attention span? ☐ Yes ☐ No

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4. Is your client taking any medications in which it impairs normal functioning?

☐ Yes ☐ No

If yes, what?

_____

_____

_____

_____

_____

_____

5. Does your client demonstrate inappropriate behavior that is beyond his/her control? ☐ Yes ☐ No ☐ Minimally

If yes, please explain:

_____

_____

_____

6. Does your client possess the ability to learn and follow directions to the degree necessary to sustain ADL? ☐ Yes ☐ No ☐ Minimally

7. Is your client able to make decisions concerning his/herself as well as others needs and safety? ☐ Yes ☐ No ☐ Minimally

8. Is your client's disability due to or affected by alcoholism, drug use or abuse?

☐ Yes ☐ No

If yes, please complete the following:

a) Has your client ever been accepted into a treatment facility?

☐ Yes ☐ No

If yes, when: _____

b) Has your client ever refused treatment or a referral to a treatment center?

☐ Yes ☐ No

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c) Is your client capable of making rational decisions?

☐ Yes ☐ No

d) Does your client present a danger to him/herself or others?

☐ Yes ☐ No

9. Do you recommend this client for an assistance dog?

☐ Yes ☐ No

10. May we contact you for more information or clarification?

☐ Yes ☐ No

11. Additional Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Professional Date

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Providers of Assistance Dogs

MEDICAL HISTORY REPORT

Current Physical Status:

1. Visual Impairment: ☐ Yes ☐ No

   If yes, please describe:

   _____

   _____

   _____

Uncorrected Vision: Right: _____ Left: _____

Corrected Vision: Right: _____ Left: _____

2. Hearing Impairment: ☐ Yes ☐ No

   If yes, please describe:

   _____

   _____

   _____

   Right: _____ Left: _____

3. Speech Impairment: ☐ Yes ☐ No

   If yes, please describe:

   _____

   _____

   _____

4. Cardiac System Involvement: ☐ Yes ☐ No

   If yes, please describe in detail. Include such information as use of pacemaker, monitor, arrhythmias, murmurs, history of cardiac arrest or congestive heart failure, circulation deficiencies, etc:

   _____

   _____

   _____

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5. Renal system involvement: ☐ Yes ☐ No

If yes, please describe in detail, including whether or not patient requires dialysis, type of dialysis, and frequency:

_____
_____
_____

6. Respiratory system involvement: ☐ Yes ☐ No

If yes, please describe in detail, including history of respiratory arrest or insufficiency:

_____
_____
_____
_____
_____

7. Seizures: ☐ Yes ☐ No

If yes, please describe, including cause (if known) type, frequency of occurrence, duration and integral since last seizure:

_____
_____
_____
_____

8. Learning Disabilities: ☐ Yes ☐ No

If yes, please describe:

_____
_____
_____
_____

9. Mental and Emotional status.

Does patient exhibit any of the following?

Awareness of surroundings: ☐ Yes ☐ No

Appropriate orientation: ☐ Yes ☐ No

Appropriate attention span: ☐ Yes ☐ No

Ability to relate positively with others: ☐ Yes ☐ No

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Providers of Assistance Dogs

Ability to communicate ideas clearly: ☐ Yes ☐ No

Ability to follow, absorb and incorporate sequenced instructions: ☐ Yes ☐ No

Ability to form insights, judgments and to plan course of action: ☐ Yes ☐ No

If there are any "No" answers to Question 9 above, please explain.

_____

_____

10. Mental and Emotional Status.

Memory Impairment: ☐ Yes ☐ No

Prior history of institutionalization: ☐ Yes ☐ No

History of substance abuse: ☐ Yes ☐ No

If there are any "Yes" answers to Question 12 above, please explain:

_____

_____

11. Medications:

Please list all medications currently prescribed, dosage, conditions requiring medications and anticipated response to the medication. Please, also indicate possible side effects:

_____

_____

_____

_____

PHYSICIAN'S STATEMENT:

It is my opinion that this patient is physically, mentally, and emotionally able to participate in Team Training for an assistance dog. I believe that such a placement would contribute to his/her independence.

_____ _____

Physician's Signature Date

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