

NAME



NAME: _____

ASSISTANCE DOG OUTSIDE CERTIFICATION APPLICATION

Part One APPLICATION INFORMATION

Be certain to include all 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) (*waived for Veterans*)
- Copy of DD-214 (**for Veterans only**)

Any of the above items that are missing from your packet will delay processing of your application. Please remember to make certain that all the required documents are submitted to CST.

COST:

Application: Include a **\$50** non-refundable Application fee with your completed application. (*waived for Veterans*)

Evaluation Fee: **\$75** non-refundable. (*waived for Veterans*) 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** (*waived for Veterans*) 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: _____

NAME



NAME:

ASSISTANCE DOG OUTSIDE 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(are) your disability(ies)? _____

How long have you had this(these) disability(ies)? _____

NAME



NAME:

About your dog:

Name: _____ Age: _____

Breed (please include all breeds if a mix): _____

At what age did you get your dog? _____

Has your dog had any formal training? (Petco/PetSmart classes, private training, etc.) _____

NAME



NAME: _____

PERSONAL INFORMATION (Check all that apply)

Married Single Children: # _____ Ages: _____
 Divorced Separated Widowed
 I live in a: House Apartment Other: _____
 I live with: Parents Spouse Roommate(s)
 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:



NAME: _____

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?



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 |



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, marital 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



ASSISTANCE DOG OUTSIDE CERTIFICATION

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: _____



ASSISTANCE DOG OUTSIDE CERTIFICATION

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



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



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:



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 interval 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:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Appropriate orientation:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Appropriate attention span:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ability to relate positively with others:	<input type="checkbox"/> Yes	<input type="checkbox"/> No



- 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