NAME:

ASSISTANCE DOG OUTSIDE CERTIFICATION APPLICATION

Part One
APPLICATION INFORMATION

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

- ☐ Application parts one and two
- ☐ Recent photograph of yourself
- ☐ Autobiography (please use separate sheet)
- ☐ $100.00 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: ***(Fees waived for Veterans)***

Application: Include a **$100** non-refundable Application fee with your completed application.

Evaluation Fee: **$125** 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. There is no guarantee a dog accepted upon evaluation will successfully complete each level of training and meet ADI Standards upon completion. There are no refunds for any training received should your dog not meet service dog standards at any stage. Certain breeds may be excluded. (Puppies in training will be re-evaluated at 6 and 18 mo.)

Training/Certification Fee: **$5500 due prior to 1st training session.** (Dogs discharged prior to 1 month will receive a refund of 90%, 2mo:80%, 3mo: 70%, 4mo: 60%, and 5mo: 50%. There are no refunds for dogs training with CST for 6 months or more.

This will provide a minimum of 240 hours of required training sessions with a CST trainer and unlimited access to group classes. You must also provide documentation of 480 hours minimum independent training. Upon completion, you and your dog will attend a 2-week Team Training event to complete certification. You and your dog must pass a Public Access Test. Upon passing you will be issued a CST identification card, collar, leash & vest for your dog. Subsequent and Annual tests will be charged at $100 per test and any required replacement equipment will be charged at the current rate. **At ANY TIME throughout the process or after certification testing, CST can decide to discharge any dog because of temperament, health, or training issues and all CST equipment must be returned.**

Please send all applications to: Canine Support Teams, Inc., P.O. 75, Murrieta, CA 92564

FOR OFFICE USE ONLY **DATE RECEIVED__________** **RECEIVED BY: ________**

Canine Support Teams, Inc
PO Box 75, Murrieta, CA 92564
951-301-3625
cstmain@caninesupportteams.org
www.caninesupportteams.org

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 your disability? ____

____

How long have you been disabled? ____

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NAME:

About your dog:

Name:		DOB:		Color:	
Breed(s):			Is your dog Spayed/Neutered?		
Microchip #:		Lic. #:		Date acquired dog:	
Rabies Cert. & Exp. Date:		UTD on all vaccines?			
Has your dog had any formal training? If yes, describe:					

Veterinarian Information

Name: ______________________________ License Number: ____________________

Address: ____

Street Address **Ste/Unit #**

____

City **State** **Zip Code**

____

Phone **Email**

All dogs to be considered for the program must be current on all vaccinations. The dog must also be spayed/neutered prior to Certification.

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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:

____

____

____

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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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Please rate yourself in the following area. Number 1 represents the lowest rating, 3 representsaverage, 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

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

____

____

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PROGRAM REQUIREMENTS

1. The dog must meet all ADI (Assistance Dog International) standards
2. The dog must be trained to perform at least 3 tasks to mitigate the client's disability
3. The client must demonstrate knowledge, understanding and application of acceptable training techniques
4. The client must demonstrate knowledge, understanding and application of canine health and care
5. The client must commit to maintaining training and continue to add new skills as required
6. The client must demonstrate knowledge and understanding of local access laws and appropriate public behavior with a service dog
7. The client must commit to a minimum of 240 hours in person training at our facility and in a variety of settings and document a minimum of 480 hours of independent training to successfully complete the initial portion and enter a Team Training for certification. This generally takes 6-12 months and must be completed within 18 months.
8. Client must agree to carry CST ID card and use approved CST vest and equipment
9. The client must participate in all follow up requirements, including but not limited to annual Public Access Tests, veterinary health reports, and home visits (Dog must meet all ADI Standards and be equally well behaved in the home.

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: ____

_________________________________ _________________________
SIGNATURE **DATE**

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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 except 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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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 patient'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 Patient:

1. Is your patient able to exercise judgment and make decisions necessary for ADL?
   ☐ Yes ☐ No
2. Does your patient possess the ability of memory and perception necessary for ADL?
   ☐ Yes ☐ No ☐ Minimally
3. Is your patient able to sustain a reasonable attention span?
   ☐ Yes ☐ No
4. Does your patient take medications which impair normal functioning?
   ☐ Yes ☐ No

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If yes, what?

____

____

____

____

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

If yes, please explain:

____

____

____

6. Is your patient able to learn and follow directions to the degree necessary to sustain ADL? ☐ Yes ☐ No ☐ Minimally

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

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

☐ Yes ☐ No

If yes, please complete the following:

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

☐ Yes ☐ No

If yes, when: ____

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

☐ Yes ☐ No

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c) Is your patient capable of making rational decisions?

☐ Yes ☐ No

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

☐ Yes ☐ No

9. Do you recommend this patient 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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MEDICAL HISTORY REPORT

<u>Current Physical Status:</u>

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 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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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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