



K9S 4 MOBILITY

11805 Campstool Rd

Cheyenne, WY 82007

[info@k9s4mobility.org](mailto:info@k9s4mobility.org)

### ASSISTANCE DOG APPLICATION INFORMATION

Name \_\_\_\_\_ DOB \_\_\_\_\_ M or F \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_ Home phone \_\_\_\_\_ Other phone \_\_\_\_\_

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

*This information will be used only to determine if the applicant can benefit from the use of an Assistance Dogs as provided by K9s 4 Mobility. This application will remain confidential by K9s 4 Mobility. Applicants will be considered regardless of race, sex or religion.*

#### MEDICAL HISTORY

Physical disability \_\_\_\_\_

Medical diagnosis \_\_\_\_\_

Date and/or age at diagnosis \_\_\_\_\_

Mobility Devices used \_\_\_\_\_

Other disabilities \_\_\_\_\_

Current medications including doses and their use (can use separate paper if necessary) \_\_\_\_\_

Physicians information (please attach business card) \_\_\_\_\_

Length of time with Physician \_\_\_\_\_ Last visit to Physician \_\_\_\_\_

MEDICAL INFORMATION (to be completed by the physician or physician's staff)

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood pressure \_\_\_\_\_ Pulse \_\_\_\_\_ Temp \_\_\_\_\_

Is the applicant's appearance healthy? YES NO

Is the applicant on any medications which might impair their ability to make good decisions? YES NO

Is the applicant likely to exhibit behavior that is dangerous to themselves or others? YES NO

Has the applicant followed doctor recommendations and treatments as advised? YES NO

ROM Left arm \_\_\_\_\_ ROM right arm \_\_\_\_\_

Is the applicant able to give a firm handshake with the left hand? YES NO right hand? YES NO

Is the applicant able to stand and balance without assistance? YES NO how long? \_\_\_\_\_

Is the applicant able to stand and balance with minimal assistance? YES NO how long? \_\_\_\_\_

Is the applicant able to stand and balance with maximum assistance? YES NO how long? \_\_\_\_\_

Does the applicant require oxygen? FULL TIME PART TIME PRN

Does the applicant have attendant care? FULL TIME PART TIME PRN NONE

Does the applicant schedule their own appointments? YES NO

Does the applicant keep scheduled appointments? YES NO Arrive on time? YES NO

Vision test: NORMAL CORRECTED WITH LENSES VISUAL IMPAIRMENT LEGALLY BLIND

Hearing test: NORMAL CORRECTED WITH AIDES HEARING IMPAIRMENT LEGALLY DEAF

Does the applicant have seizures? YES NO How often? \_\_\_\_\_

Are the seizures controlled with medication? YES NO Describe the type and length of seizures: \_\_\_\_\_

Physicians Signature: \_\_\_\_\_ Date: \_\_\_\_\_

DAILY ROUTINE

What time do you typically awake in the morning? \_\_\_\_\_

What time do you typically get out of bed in the morning? \_\_\_\_\_

Please list what activities you typically will perform on a normal day: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you typically take a nap during the day? YES NO Time/length? \_\_\_\_\_

What time do you typically go to bed at night? \_\_\_\_\_

Places you typically visit: GROCERY STORE SHOPPING CENTER DR. OFFICE CHURCH MOVIE  
FRIENDS HOUSE RESTERAUNT CONCERT SPORTING EVENT SCHOOL ACTIVITY PARK  
LAKE/CAMPING AIRPORT

Traveling includes: CAR/VAN PUBLIC BUS PLANE TRAIN BOAT

Do you typically travel alone? YES NO

Do you drive a vehicle? YES NO TRUCK CAR VAN W/LIFT VAN W/RAMP

Activities you perform unassisted: SHOWER RESTROOM BRUSH HAIR/TEETH COOK SHOPPING  
MAKE BED DISHES CLEANING ANSWERING THE DOOR ANSWERING THE PHONE EAT  
DRINK GET DRESSED/UNDRESSED TAKE MEDICATIONS

Do you have attendant care? YES NO FULL TIME PART TIME PRN

Is the attendant care a family member? YES NO

ENVIRMONMENT

Living arrangements: HOUSE APARTMENT TRAILOR OWN RENT

Accessibility: ROLL IN SHOWER RAMP LIFT ELEVATOR HOSPITAL BED

Please list all other persons in the home and if children their ages: \_\_\_\_\_

\_\_\_\_\_

Please all other animals in the home and their age and breed: \_\_\_\_\_

Describe the outside areas where the dog can exercise: FENCED YARD                      INVISIBLE FENCE                      DOG PARK  
NEIGHBORS YARD                      TIE OUT                      NONE

Are you okay with dog hair being on you and your furniture?    YES    NO

Are you prepared to brush your dog daily?                      YES    NO

Are you prepared to bathe your dog when needed?            YES    NO

Please describe where you will place the dog's crate where they can take a break: \_\_\_\_\_

#### FINANCIAL RESPONSIBILITIES

Please estimate how much it will cost to feed the dog for a year: \_\_\_\_\_

Please estimate how much vet care for the dog will cost for a year: \_\_\_\_\_

Will you be able to provide all the necessary preventative care (heartworm and flea/tick) for the dog?    YES    NO

Veterinarian's information (please include a business card): \_\_\_\_\_

Length of time known: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Please include a letter from your Veterinarian stating:

Animals you have had in the past under their care and treatments they received

Recommending and supporting the applicant to obtain an Assistance Dog.

Commitment to providing services to the applicant and caring for the Assistance Dog.

Willingness to communicate with K9s 4 Mobility in the future to discuss the Assistance Dog.

*This application must be completed in full to be considered for an Assistance Dogs from K9s 4 Mobility. Please mail to K9s 4 Mobility, 11805 Campstool Rd, Cheyenne, WY 82007 or the*

*documents can be scanned and emailed to [mwoerner@k9s4mobility.org](mailto:mwoerner@k9s4mobility.org). Once the completed application is received, please allow 14 days to be contacted.*