

CANADIAN VETERAN SERVICE DOG UNIT (CVSDU)



MEDICAL FORM

APPLICANT INFORMATION (to be completed by applicant)

FIRST NAME _____ LAST NAME _____

DATE OF BIRTH _____

DAY / MONTH / YEAR

ADDRESS: _____

CITY _____ PROVINCE _____ POSTAL CODE _____

PRIMARY PHONE NUMBER _____

I give my consent for my Medical Provider to complete this medical form to assist with my application for a Service Dog with the Canadian Veteran Service Dog Unit.

APPLICANT'S SIGNATURE

DATE

MEDICAL INFORMATION (to be completed by Medical Provider)

Why does your patient / client require a Service Dog?

How will your patient/client benefit from having a Service Dog?

Do you have any concerns about your patient/client having a Service Dog? Are there any barriers or challenges that the CVSDU needs to aware of?

Please comment on your patient's / client's ability to attend training sessions including public access training with a Service Dog.

MEDICAL PROVIDER INFORMATION

FIRST NAME _____ LAST NAME _____

ADDRESS: _____

CITY _____ PROVINCE _____ POSTAL CODE _____

PHONE NUMBER _____

May we contact you directly if further information is required from the intake coordinator?

MEDICAL PROVIDER'S SIGNATURE

DATE