Southern Oregon Service Dog Training
Physician's Statement

This form to be completed and mailed by your physician.

I, _____, give permission for my physician
Patient's Printed Name
Physician's Name: _____

Physician's Address: _____

Physician's City, State, Zip: _____

to release the information requested by this form.

_____ _____
Patient's Signature Date

Dear Physician:
The patient listed above desires to have Service Dog trained by Southern Oregon Service Dog Training.
The A.D.A. allows Service Animals to accompany disabled persons into any business that serves the public.
In order to verify that your patient has a qualifying disability, we would appreciate your answering the following questions:

1) Is the person listed above currently a patient of yours? ___ Yes ___No

2) Is this person disabled? ___ Yes ___No

3) What is the category of the disability? ___ Physical ___ Mental ___ Emotional

4) What is the expected duration of the disability? ___ Months ___ Years

5) Is your patient currently taking medication for this disability? ___ Yes ___ No
If yes, does/will the medication impair their ability to handle or control a Service Dog?

No / Yes. If Yes, how so? _____

_____

6) Is your patient in therapy for this disability? ___ Yes ___ No

7) Is there any additional information that will assist us to meet the needs of this persons disability? ___ Yes ___ No If yes, please explain below

_____

_____

_____

Thank you for your time in completing this form.

Physician's Printed Name: _____

Address: _____

Signature: _____ Date: _____

Please mail this form to:

Southern Oregon Service Dog Training
Post Office Box #000
Roseburg, OR 97470-0000