



DOGS FOR INVISIBLE DISABILITIES

33821 Brewster Rd
Lebanon, Oregon 97355
541-974-0327

Email: info@dogsforinvisible disabilities.com
<http://www.dogsforinvisible disabilities.com>

Physician's Statement

This form must be completed by your physician and returned with your enrollment application.

I, _____, give permission for the below named physician to release the
(Patient's Name) information requested in this form.

Signature

Date

Dear Physician:

The patient listed above wants to train a dog with Dogs for Invisible Disabilities. The Americans with Disabilities Act allows Service Animals to accompany people with qualified disabilities into privately owned business that serve the public. In order to verify that your patient has a qualifying disability, we would appreciate your answering the following questions:

Is the person listed above currently a patient of yours? _____ Date of last Tetanus shot: _____

Is this person disabled? Yes ___ No ___ What category is the disability? Physical Mental

Emotional

Is this patient taking medication related to this disability? Yes ___ No ___

Is this person involved in therapy related to this disability? Yes ___ No ___

Is there any additional information you would like to provide that will assist us to better meet the needs of this person? _____

Our classes are open to the public. Please feel free to call us to find the location of our next class (541-974-0327). Thank you for your time.

Physician Name: _____ Date: _____

Physician Signature: _____ Phone: _____

Address: _____