

Return to:
TOP DOG, Inc.
350 S Williams Blvd Suite 150
Tucson, AZ 85711
520-323-6677
Fax(520) 323-3512
info@topdogusa.org



For Office Use Only
Sent: _____
Returned: _____

CLIENT APPLICATION

Name: _____

Date of Birth: _____

Address: _____

City/State/Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Occupation _____

OR Occupation before retirement: _____

Household Members:

Spouse _____

Children _____

Other: _____

Pets _____

DOG INFO:

Name: _____

Breed: _____

Age: _____



Are you a permanent resident of Tucson? _____
How long? _____

Diagnosis: Type of disability _____
How long? _____

Other medical problems: _____

What type of medical treatment, including medications, are you receiving?

Physician(s) _____

Therapist (OT, PT, Speech, ect) _____

Type of restrictions/ precatations: _____

What type of adaptive equipment/aids(walker, wheelchair, splints,ect.) do you use?

Do you Drive? Y/N _____

If not, how to plan to attend class? _____

How did you hear about TOP DOG? _____

Why are you interested in applying to TOP DOG? _____

OWNING A DOG IS NOT A PREREQUISITE – If you don't already have a dog, **TOP DOG will assist in finding an appropriate dog for you.** If you already have a dog that you would like to take through the program, please fill out the following section as completely as possible. One requirement is that you have at least a small attached yard for your dog.

Dog's Name: _____

Breed: _____ Size: _____

Additional Information: _____

Tattoo/Microchip/License # _____

Date Neutered/Spayed (TOP DOG will **NOT** accept a dog that has not been spayed or neutered) _____

Date of birth or age _____ Sex _____

Veterinarian Name: _____

Address: _____

Previous training (if any) _____

What type of "misbehavior" does your dog engage in? _____

When your dog misbehaves, what do you do? _____

I understand and am willing to make the following commitments to the best of my knowledge and ability:

- | | |
|--|---------------|
| 1) Attend weekly classes for up to 2 years | Initial _____ |
| 2) Meet with my training assistant between classes | _____ |
| 3) Practice daily with my dog | _____ |
| 4) Keep the lines of communication open | _____ |

Signature _____ Date _____



TOP DOG Emergency Information

PERSONAL INFORMATION

Name: _____ Date: _____

Physical Disability: _____

Who should TOP DOG notify in case of emergency?

1) Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

2) Name: _____

3) Relationship: _____

Home Phone: _____ Work Phone: _____

Physician's Name: _____ Phone: _____

Hospital Preference: _____

List Regular Medications: _____

List any allergies to medications, etc: _____

Are there any acute symptoms (seizures, diabetic shock, fainting, etc.) that may occur during class? If so, please list them and how we can best assist you should this occur.



DOG INFORMATION

Dog's Name: _____ Breed: _____

License: _____ Micro Chip # / Tattoo #: _____

Regular Medications: _____

Veterinarian / Clinic: _____

Phone: _____

Where would you like the dog to be cared for in case of emergency?

Emergency Hospital: _____

Phone: _____

Address: _____

Special Diet: _____

Feeding Schedule: _____

PLEASE LIST ANY ADDITIONAL INFORMATION BELOW:

CLIENT HEALTH FORM

PLEASE ASK YOUR PHYSICIAN TO COMPLETE & RETURN TO:

TOP DOG, Inc.
350 S Williams Blvd Suite 150
Tucson, AZ 85711
520-323-6677
www.topdogusa.org

TOP DOG is non-profit organization that teaches people with physical disabilities to train their own service dogs.

Our clients and certified teams include, but are not limited to, people with Juvenile Rheumatoid Arthritis, Cerebral Palsy, Muscular Dystrophy, Multiple Sclerosis, Arthritis, Spinal cord injuries and other bone joint and muscle deficiencies.

We are not qualified to train dogs for clients who need assistance for sight and hearing impairments, or for people who primary disability is emotional or stress related (e.g. post-traumatic syndrome) , or is of a nature that seriously affects memory retention, concentration or understanding.

We would appreciate your answers to these questions:

_____ Has applied to become a TOP DOG client.

1. The Client has the permanent physical disability or conditions described below: _____

2. Is this a progressive condition? _____ May we contact you in the future if we are concerned about the degree of progression? _____
3. The client is taking the following medications(if there are any pertinent side-effects, please list the medication(s) _____

4. Are there any symptoms or special considerations we should be aware of in this patient's case?

You may make additional comments on the reverse side of this form. *We can not finish processing the client's application without this completed. Physical's Health Form.*

Physician's Signature

Office Phone

Office Address

TOP DOG, Inc.
350 S Williams Blvd Suite 150
Tucson, AZ 85711
520-323-6677



Veterinarian's Name: _____

Clinic Name: _____

Address: _____ **City:** _____ **Zip:** _____

Client's Name: _____

Dog's Name: _____ **Dog's Age** _____

Date of spay/neuter: _____

How long have you been seeing this dog? _____

Dog's general health: _____

Have you treated this dog for any chronic problems? Yes: _____ **No:** _____

If Yes, would you please specify: _____

Have you examined this dog for hip/joint disorders? Yes: _____ **No:** _____

Would you recommend an x-ray? _____

Have you examined this dog's eyes for Pannus: _____ **PRA** _____ **Cataracts** _____

Date/Results _____

Does this dog have any discernible allergies? _____

Are vaccinations current? _____ **Date of last DHLPP** _____ **Corona** _____

Rabies _____

Have you encountered any behavioral problems examining this dog? _____

Additional comments _____

Signature of Veterinarian

Date