DOGS FOR INVISIBLE DISABILITIES

384 NW Conifer Blvd
Corvallis, OR 97330
541-974-0327
Email: info@dogsforinvisibledisabilities.com
https://www.dogsforinvisibledisabilities.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? ____

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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: ____