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**APPLICATION FOR GUIDE DOG MOBILITY TRAINING**

Mr.  Mrs.  Miss  Ms.

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Mailing Address \_\_\_\_\_

Phone (\_\_\_\_\_) (\_\_\_\_\_) (\_\_\_\_\_) \_\_\_\_\_  
Home Cell Work

Email \_\_\_\_\_

**I do hereby apply to OccuPaws for a guide dog and for special, in-home training in the use and care of said dog, with the understanding that I will not be required to pay or promise to pay any amount of money therefore. To assist OccuPaws in determining whether or not I can use and care for a guide dog, I submit the following information:**

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security Number \_\_\_\_\_

Gender:  Male  Female Race/Ethnic Origin \_\_\_\_\_

Name of spouse/life partner \_\_\_\_\_

Number and ages of children \_\_\_\_\_ , \_\_\_\_\_

With whom do you reside? \_\_\_\_\_  
i.e. self, parents, spouse, roommates

Name of person you reside with \_\_\_\_\_

Please describe your house or apartment \_\_\_\_\_

Please describe your neighborhood (i.e. downtown, rural, suburban) \_\_\_\_\_

How long have you lived at your present address?  <6 months  6-12 months  1-5 yrs.  5+ yrs.

Do you anticipate a move or lifestyle change within the next year?  Yes  No

If yes, please explain \_\_\_\_\_

Do you routinely travel independently?  Yes  No

Do you consider yourself a confident traveler?  Yes  No

Current method of travel  cane  sighted guide  guide dog  other

Please describe the areas you frequent \_\_\_\_\_

What obstacles/challenges do you encounter in the areas you frequent? \_\_\_\_\_

Do you encounter stray or loose dogs, aggressive dogs (restrained or behind fences), small animals (squirrels, rabbits, etc)?

Why do you desire a guide dog? \_\_\_\_\_

Have you ever attended a guide dog school?  Yes  No attach a separate page if necessary

Name of the school	When?	Did you graduate?	Reason for retirement/return
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you now or have you ever had dogs as pets? \_\_\_\_\_

What are the ages, sizes, breeds and personalities of the other dogs you currently have? \_\_\_\_\_

Please list any other pets \_\_\_\_\_

i.e. cat, rabbit, bird, hamster, guinea pig, ferret, etc.

## Educational Background

Highest level of education  Elementary  High School  Some College  College Graduate  Post Graduate

Please list any special degrees or training \_\_\_\_\_

What community organizations or activities relating to blindness are you involved with, if any? \_\_\_\_\_

## Veterans

Are you a veteran?  Yes  No If yes, which branch of service? \_\_\_\_\_

## Occupation

Are you employed?  Yes  No

Occupation: Before blindness \_\_\_\_\_

After blindness \_\_\_\_\_

Employer \_\_\_\_\_  
Name

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Supervisors name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

What are the accommodations for the dog at work? \_\_\_\_\_

If not employed, what is your present means of support? \_\_\_\_\_

Income Level: 5,000 – 10,000 a year \_\_\_\_\_ 30,000 – 40,000 a year \_\_\_\_\_

10,000 – 20,000 a year \_\_\_\_\_ 40,000 – or above a year \_\_\_\_\_

20,000 – 30,000 a year \_\_\_\_\_

Can you support the cost of a guide dog's food and health care? \_\_\_\_\_

## Emergency Contact

Please list the name, address and telephone numbers of two family members to contact in case of an emergency.

Name \_\_\_\_\_ Relationship to applicant \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Name \_\_\_\_\_ Relationship to applicant \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

## General Health

Height \_\_\_\_\_ Weight \_\_\_\_\_

Are you legally blind?  Yes  No In what year did you become legally blind? \_\_\_\_\_

What is your cause of blindness? \_\_\_\_\_

Please describe your residual vision \_\_\_\_\_

Do you have a hearing impairment?  Yes  No Do you wear hearing aides?  Yes  No

Do you have any physical limitations or special needs? \_\_\_\_\_

Do you have or have you ever had seizures?  Yes  No Date of last seizure \_\_\_\_\_

Do you have diabetes?  Yes  No **If so, please have your physician complete the diabetic report.**

Are you insulin dependent?  Yes  No

What diet do you follow? \_\_\_\_\_  Strict  Casual

Please list your dietary needs \_\_\_\_\_

Please list any surgeries \_\_\_\_\_

Do you now or have you ever had a substance abuse problem?  Yes  No

If yes, please explain \_\_\_\_\_

Please describe your rehabilitation program (list program attended, location and dates) \_\_\_\_\_

Comments: \_\_\_\_\_

**Do you suffer from any of the following? (check all that apply)**

- |                                                        |                                              |
|--------------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> coordination                  | <input type="checkbox"/> balance problems    |
| <input type="checkbox"/> spasticity                    | <input type="checkbox"/> limited mobility    |
| <input type="checkbox"/> reduced stamina               | <input type="checkbox"/> muscular weakness   |
| <input type="checkbox"/> brittle bones                 | <input type="checkbox"/> paralysis           |
| <input type="checkbox"/> chronic pain                  | <input type="checkbox"/> frequent headaches  |
| <input type="checkbox"/> speech impairment             | <input type="checkbox"/> memory loss         |
| <input type="checkbox"/> depression                    | <input type="checkbox"/> heightened emotions |
| <input type="checkbox"/> heat/cold sensitivity         | <input type="checkbox"/> skin sensitivity    |
| <input type="checkbox"/> deafness                      | <input type="checkbox"/> hearing loss        |
| <input type="checkbox"/> allergies (please list) _____ |                                              |

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other \_\_\_\_\_

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**Do you use any of the following? (check all that apply)**

- |                                          |                                        |                                            |
|------------------------------------------|----------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Assistance Dog  | <input type="checkbox"/> Sighted guide | <input type="checkbox"/> White cane        |
| <input type="checkbox"/> Low vision aids | <input type="checkbox"/> Hearing aid   | <input type="checkbox"/> Leg brace         |
| <input type="checkbox"/> Wrist brace     | <input type="checkbox"/> Prosthesis    | <input type="checkbox"/> Crutch            |
| <input type="checkbox"/> Support cane    | <input type="checkbox"/> Walker        | <input type="checkbox"/> Manual wheelchair |
| <input type="checkbox"/> Other _____     |                                        |                                            |

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**Comments:** \_\_\_\_\_

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## Personal and Professional References

**Incomplete information will greatly delay the processing of your application**

Please list the names and contact information of three personal references.

**1)** \_\_\_\_\_ ( ) \_\_\_\_\_ ( )  
Name (Relationship to applicant) Home Phone Work Phone

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Email Address

**2)** \_\_\_\_\_ ( ) \_\_\_\_\_ ( )  
Name (Relationship to applicant) Home Phone Work Phone

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Email Address

**3)** \_\_\_\_\_ ( ) \_\_\_\_\_ ( )  
Name (Relationship to applicant) Home Phone Work Phone

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Email Address

Please list the name and contact information of your **Orientation and Mobility Instructor**

\_\_\_\_\_  
Name ( )  
Phone Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Email Address

Please list the name and contact information of your **Blind Services or Rehabilitation Counselor**

\_\_\_\_\_  
Name ( )  
Phone Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip Code

What was the date of your last Orientation and Mobility instruction? \_\_\_\_\_

Have you ever had any blindfold training?  Yes  No      Would you consider it?  Yes  No

Did you attend an Orientation and Mobility program that offers Independent Living skills training?  Yes  No

Was it an in-residence program?  Yes  No    If yes, please give location \_\_\_\_\_

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**REASON FOR CHOOSING** OccuPaws? \_\_\_\_\_

How did you learn about OccuPaws Guide Dog Association?

OGDA Graduate \_\_\_\_\_

Graduate's Name

Lion's Club \_\_\_\_\_

Name and Location of Club

Convention or Conference \_\_\_\_\_

Please List

O & M Instructor \_\_\_\_\_

Name of Instructor

Other \_\_\_\_\_

Please Explain

**Name of person who assisted in completing this form**

\_\_\_\_\_  
Name (      ) Phone Number

\_\_\_\_\_  
Address City      State      Zip Code

**I certify that the above information is true and correct.**

\_\_\_\_\_  
Applicant's Signature Date

\_\_\_\_\_  
Assistant's Signature Date

Please note: By signing and submitting this application your name will be added to the OGDA mailing list, please indicate to us if you DO NOT want to be added to this list; OGDA will not sell or share your mailing information with any third parties. All medical information contained in this document is confidential and will only be shared with those that you have given us authorization to share this information with as stated on the Information Release Form.

**Please Enclose a Photograph**



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## INFORMATION RELEASE FORM

I, \_\_\_\_\_, hereby give my consent and authorization to release information from the physicians, agencies and guide dog schools listed in my application, for the purposes of determining eligibility for a guide dog training program, to assist in providing appropriate medical attention, and for any other legal purpose deemed necessary by The OccuPaws Guide Dog Association.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name

A copy of this form will be sent to each physician, agency, and guide dog school.



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## PHYSICIAN'S REPORT

**Applicant:** This form must be completed by your primary physician upon an examination.

**Physician:** Your patient has applied for a guide dog to enhance his/her mobility and independence. When completing this form, please keep in mind that the applicant will undergo rigorous training, both physical and mental. They will spend 14 to 21 days training and will be expected to walk a minimum of ½ hour twice daily in all types of terrain, with their guide dog, regardless of weather conditions. Your information will help us provide your patient with the training and instruction most suited to their needs. The Ophthalmologist's report and verification of blindness is a separate form. Thank you for your assistance.

Applicant's Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone: (\_\_\_\_) \_\_\_\_\_ Medical/Clinic ID number: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_ Respiration: \_\_\_\_\_  
 How long have you attended the applicant? First visit \_\_\_\_\_ ; # of years \_\_\_\_\_ Date of last tetanus immunization: \_\_\_\_\_

**Is applicant legally blind?**  Yes  No **Cause of blindness:** \_\_\_\_\_

**Does the applicant have any of the following medical problems?** (please answer yes or no)

- |                            |                          |                           |                          |
|----------------------------|--------------------------|---------------------------|--------------------------|
| Arthritis _____            | Allergies _____          | Asthma _____              | Cancer _____             |
| Circulatory Problems _____ | Back Problems _____      | Amputations _____         | Addictions _____         |
| High Blood Pressure _____  | Seizures _____           | Heart Disorder _____      | Knee/Hip _____           |
| Psychiatric Problems _____ | Epilepsy _____           | Intestinal Problems _____ | Ulcers _____             |
| Headaches _____            | Foot Trouble _____       | Infectious Diseases _____ | Fainting _____           |
| Neuropathy _____           | Dexterity Problems _____ | Nervousness _____         | Speech Impairments _____ |

If yes, please explain \_\_\_\_\_

**Please list any surgeries** \_\_\_\_\_

**Does the applicant have a hearing problem?** \_\_\_\_\_ **Which ear?**  Left  Right  Both

Does applicant wear hearing aides? \_\_\_\_\_ Is hearing within normal range with aides? \_\_\_\_\_

**Does applicant have a learning disorder?** \_\_\_\_\_

**Does applicant have any impairments of the use of either leg/foot?** \_\_\_\_\_ **Hand/arm** \_\_\_\_\_

**Does applicant have any limitations? Please explain** \_\_\_\_\_

**Is applicant diabetic?** \_\_\_\_\_ **If yes please complete diabetic report.**

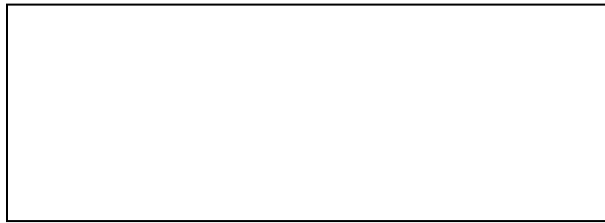
**\*Is applicant stable enough to undergo the rigors of training away from home for 28 days?** \_\_\_\_\_

**Date of exam on which report is based:** \_\_\_\_\_

\_\_\_\_\_  
**Physician's Signature**

Doctor's name: \_\_\_\_\_  
*Please print*

Telephone: (\_\_\_\_) \_\_\_\_\_



Hospital / Clinic Stamp



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## DIABETIC REPORT

**Physician and Applicant:** The OccuPaws Guide Dog Association does not have a nurse on staff. Applicant must be capable of administering his/her own injections and must be responsible for maintaining an appropriate lifestyle. Our protocol is to call 911, should the applicant need assistance.

Applicant's name: \_\_\_\_\_

Is Applicant:  Type I     Type II     Stable     Brittle

Last Insulin reaction: \_\_\_\_\_ please describe: \_\_\_\_\_  
 \_\_\_\_\_

Are Insulin reactions frequent? \_\_\_\_\_

Are Insulin reactions severe? \_\_\_\_\_

What can be offered in the event of a reaction? \_\_\_\_\_

Date of last hospitalization due to: Hypoglycemia \_\_\_\_\_ Hyperglycemia \_\_\_\_\_

Diet: \_\_\_\_\_

Oral Medication: \_\_\_\_\_ Daily Dosage \_\_\_\_\_

Insulin Name: \_\_\_\_\_ Daily Dosage \_\_\_\_\_

Does Applicant utilize an Insulin pump?  Yes     No

If yes please list any special instructions \_\_\_\_\_

Can Applicant self-administer Insulin? \_\_\_\_\_ Can Applicant adjust his/her own Insulin? \_\_\_\_\_

Please indicate any special instructions or suggestions \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**I understand the protocol of The OccuPaws Guide Dog Association and certify that the above information is true and correct.**

\_\_\_\_\_  
 Physician's Signature

\_\_\_\_\_  
 please print name

\_\_\_\_\_  
 date

\_\_\_\_\_  
 Applicant's Signature

\_\_\_\_\_  
 please print name

\_\_\_\_\_  
 date



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**MEDICATION AND HEALTH INSURANCE INFORMATION**

**Physician and Applicant:** Please list all medications, strength, dosage, and reason for use. Also, please indicate any side effects that may affect the applicant during their time in training. Applicant is responsible for administering his/her own medication.

**Applicant's name** \_\_\_\_\_ **Date** \_\_\_\_\_

Medication	Strength	Dosage	Reason	Side Effects

**Health Insurance Information**

Policy number: \_\_\_\_\_  
 Policyholder's name: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_  
 Telephone number: \_\_\_\_\_



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## OPHTHALMOLOGIST / OPTOMETRIST REPORT

**Applicant:** This form must be completed by your Ophthalmologist or Optometrist.

**Physician:** Your patient has applied for a guide dog to enhance his/her mobility and independence. Although our training sessions are conducted in the patients' home environment, we may travel to different locations within Southern Wisconsin. Your information will help us provide your patient with the training and instruction most suited to their needs. Thank you for your assistance.

Applicant's name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Details of Blindness:** Is Applicant legally blind?  Yes  No Date of last examination: \_\_\_\_\_

<b>Cause of vision loss:</b>	<b>Primary</b>	<b>Secondary</b>
OD	_____	_____
OS	_____	_____

Is Applicant's vision loss considered to be:  
 Progressive \_\_\_\_\_ Stable \_\_\_\_\_ Likely to improve \_\_\_\_\_ Uncertain \_\_\_\_\_

In what year did blindness occur? \_\_\_\_\_ How long have you attended this patient? \_\_\_\_\_

Visual Acuity

With correction:	OD _____	OS _____	OU _____
Uncorrected:	OD _____	OS _____	OU _____

Visual Fields

Central:	OD _____	OS _____	OU _____
Peripheral:	OD _____	OS _____	OU _____

Please describe residual vision:

No light perception	Some light perception	Gross movement	Count fingers	Read with lens
OD _____	_____	_____	_____	_____
OS _____	_____	_____	_____	_____

Please list any ocular medications: \_\_\_\_\_

Comments: \_\_\_\_\_

**Date of exam on which report is based:** \_\_\_\_\_

\_\_\_\_\_  
**Physician's Signature**

Doctor's name: \_\_\_\_\_  
*Please print*

Telephone: (\_\_\_\_) \_\_\_\_\_



Hospital / Clinic Stamp