Return to:
TOP DOG, Inc.
9420 E Golf Links Rd
Ste 108 PMB 355
Tucson, Arizona 85730-1317
(520) 323-6677
contact-us@topdogusa.org

For Office Use Only

Returned: _____

Call:_____
Notes:
_____
_____
_____
_____

STUDENT APPLICATION

Name:_____ SDS_____ SDM_____

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:_____ Microchip #_____

Age:_____ License #_____

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/ precations:_____

_____

What type of adaptive equipment/aids (walker, wheelchair, splints, and 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? _____

_____

_____

Please note: If you are accepted into the TOP DOG program, there is a onetime program fee which includes supplies and training.

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_____

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: _____

Address:_____

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 ANYADDITIONAL INFORMATION BELOW:

_____

_____

_____

_____

_____

CLIENT HEALTH FORM

PLEASE ASK YOUR PHYSICAN TO COMPLETE & RETURN TO:
TOP DOG Inc.
9420 E Golf Links Rd Ste #108-355
Tucson, Arizona 85730

We would appreciate your answers to these questions:

Name: _____has applied to become a TOP DOG client.

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.

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 cannot finish processing the client's application without this completed Client Health Form.*

_____
Physician's Signature

_____
Office Phone

_____

Office Address

PLEASE ASK YOUR VET TO COMPLETE & RETURN TO:
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9420 E Golf Links Rd Ste #108-355
Tucson, Arizona 85730-1317

Veterinarian's Name:_____

Clinic Name:_____Phone_____

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