OccuPaws Guide Dog Association

P.O. Box 45857 Madison, WI 53744
Phone: (608) 772-3787 Fax: (866) 854-3291
barb@occupaws.org
www.occupaws.org

APPLICATION FOR GUIDE DOG MOBILITY TRAINING

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Name _____ Date _____

Address _____

City State Zip _____ How Long _____

Prior Address _____ How Long _____

Phone (____) _____ (____) _____ (____) _____
Home Cell Work

Email _____

I do hereby apply to OccuPaws for a gui de dog and for special, in-home training in the use and care of said dog, with th e 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 _____

Gender: ☐ Male ☐ Female

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 _____

What would you estimate the annual cost of a guide dog's food and health care and can you afford it? _____

_____

_____

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)

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

_____

☐ other_____

_____

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

- ☐ Assistance Dog
- ☐ Sighted guide
- ☐ White cane
- ☐ Low vision aids
- ☐ Hearing aid
- ☐ Leg brace
- ☐ Wrist brace
- ☐ Prosthesis
- ☐ Crutch
- ☐ Support cane
- ☐ Walker
- ☐ Manual wheelchair
- ☐ Other _____

_____

Comments: _____

_____

_____

_____

_____

Personal and Professional References

Incomplete information will greatly delay the processing of your application

Please list the names and contact information of two personal references who are not immediate family members.

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

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 _____

_____

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. NOTE: OccuPaws may conduct a background search.

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Email: barb@occupaws.org

I, _____, give full permission to _____

to disclose my following medical information to
OccuPaws Guide Dog Association
PO Box 45857
Madison, WI 53744

Information to be disclosed (check all that apply):

XX Medical Records
XX Treatment Records
XX Diagnostic Records

This protected health information is being used or disclosed for the following purposes:
To determine eligibility for a guide dog training program, to assist in providing appropriate medical attention, and any other legal purpose deemed necessary by the OccuPaws Guide Dog Association.

This authorization expires when I no longer have or need the use of a guide dog.

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

Finally, you may revoke this authorization in writing at any time by sending written notification to your health care provider. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

You may inspect or copy the protected health information to be used or disclosed under this authorization.

_____
Signature of Participant or Personal Representative

_____
Date

_____
Printed Name of Participant or Personal Representative

_____
Description of Personal Representative's Authority

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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 Applicant's Signature

_____ _____

please print name please print name

_____ _____

date 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 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: _____

Cause of vision loss:	**Primary**	**Secondary**
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