



P.O. Box 45857 🐾 Madison, WI 53744
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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 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 _____

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)

- | | |
|--|--|
| <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) _____ | |

other _____

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 _____ | | |

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.

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: (____) _____



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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 10 to 14 days training and will be expected to walk a minimum of an 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 for 10-14 days? _____

Date of exam on which report is based: _____

Physician's Signature

Doctor's name: _____
Please print

Telephone: (____) _____



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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: _____

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: (____) _____



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