

**PAWS FOR VETERANS**

Paws for Veterans  
63 Ocean Blvd.  
Satellite Beach, FL 32937

Phone: (321) 425-4189  
Fax: (321) 425-4183  
Website: www.pawsforveterans.com



# APPLICATION

FULL LEGAL NAME: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

HOME/ALTERNATE PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ SEX: \_\_\_\_\_ AGE: \_\_\_\_\_

CHILDREN'S AGES AND SEX: \_\_\_\_\_

BRANCH: \_\_\_\_\_ IN WHICH WAR(S) DID YOU SERVE: \_\_\_\_\_

INJURIES: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

DIAGNOSING DOCTOR: \_\_\_\_\_

DOCTOR'S ADDRESS: \_\_\_\_\_

DOCTORS PHONE: \_\_\_\_\_

I AM CURRENTLY: ACTIVE DUTY / RETIRED / DISCHARGED (TYPE \_\_\_\_\_)

EMERGENCY CONTACT NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

FULL ADDRESS: \_\_\_\_\_

PERSONAL REFERENCE NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

FULL ADDRESS: \_\_\_\_\_

PERSONAL REFERENCE NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

FULL ADDRESS: \_\_\_\_\_

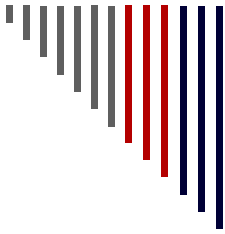
PROFESSIONAL REFERENCE NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

FULL ADDRESS: \_\_\_\_\_

PROFESSIONAL REFERENCE NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

FULL ADDRESS: \_\_\_\_\_





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HAVE YOU BEEN CONVICTED OF A NJP, COURT-MARTIAL, OR FELONY: YES OR NO  
IF SO, WHAT TYPE: \_\_\_\_\_

ANNUAL HOUSEHOLD INCOME: \_\_\_\_\_

ARE YOU PHYSICALLY, MENTALLY, EMOTIONALLY, AND FINANCIALLY ABLE TO CARE FOR A SERVICE DOG  
IF PROVIDED ONE: YES OR NO

HOW DID YOU HEAR ABOUT US: \_\_\_\_\_

WHAT MADE YOU DECIDE TO APPLY WITH PAWS FOR VETERANS: \_\_\_\_\_

I RESIDE IN: PRIVATE HOME OFF BASE / BASE HOUSING / BARRACKS  
APARTMENT / WOUNDED WARRIOR BARRACKS / OTHER \_\_\_\_\_

YARD: FENCED / UNFENCED PREVIOUSLY OWNED DOG(S): Y OR N

BREED(S): \_\_\_\_\_

CURRENTLY OWN DOG(S): Y OR N BREEDS: \_\_\_\_\_ AGE: \_\_\_\_\_ HOW MANY: \_\_\_\_\_

CURRENTLY OWN OTHER ANIMALS: Y OR N SPECIES/SEX: \_\_\_\_\_

MOST RECENT VETERINARIAN'S NAME, ADDRESS, PHONE NUMBER, AND NAMES OF ANIMALS:

PREFERED BREEDS (although we do not choose or match dogs based on breed but on temperament and personality)

1ST CHOICE: \_\_\_\_\_ 2ND CHOICE: \_\_\_\_\_

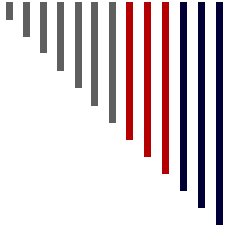
3RD CHOICE: \_\_\_\_\_ 4TH CHOICE: \_\_\_\_\_

MY HOUSEHOLD ACTIVITY LEVEL IS: HIGH / MEDIUM / LOW

IF ACCEPTED, I WILL NEED A DOG THAT CAN HELP WITH MOBILITY ASSISTANCE  
(GETTING UP AND DOWN AND BEING ABLE TO HOLD SOME OF MY WEIGHT IF I  
GET DIZZY, LIGHT HEADED, LOSE MY BALANCE, OR FALL: Y OR N

I NEED A DOG THAT CAN REMIND ME TO TAKE MEDICATIONS: Y OR N

I TAKE MEDICATIONS \_\_\_\_\_ TIMES A DAY AT THESE TIMES: \_\_\_\_\_



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## APPLICATION

**IN YOUR OWN WORDS PLEASE EXPLAIN WHY YOU NEED A SERVICE DOG/  
HOW OWNING A SERVICE DOG WILL IMPROVE YOUR LIFE:** \_\_\_\_\_

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**IN YOUR OWN WORDS PLEASE EXPLAIN WHAT YOU WANT YOUR SERVICE DOG TO  
BE ABLE TO DO FOR YOU:** \_\_\_\_\_

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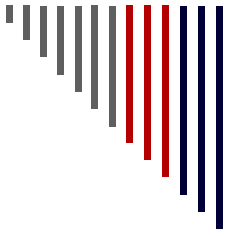
**BY SIGNING BELOW YOU ARE AGREEING TO:**  
**-ATTEND UP TO A 2 CONSECUTIVE WEEKS TRAINING COURSE AT OUR LOCATION IN FLORIDA  
IMMEDIATELY UPON RECEIVING YOUR SERVICE DOG**  
**-ATTEND A 1 WEEK COURSE 6 TO 12 MONTHS LATER FOR FOLLOW-UP, TESTING, AND GRADUATION**  
**-SUBMIT 1 YEAR OF MONTHLY VIDEO SUBMISSIONS AS WELL AS PHONE AND WEB CONFERENCING**  
**BY SIGNING BELOW YOU ATTEST THAT ALL THE INFORMATION ON PAGES 1 THROUGH 3 OF THIS  
APPLICATION IS TRUE AND CORRECT**

**I TESTIFY THAT I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS AND IF THE ABOVE MENTIONED REQUIREMENTS AND OUR  
TERMS AND CONDITIONS ARE NOT MET AND MAINTAINED, YOU AGREE TO SURRENDER YOUR SERVICE DOG TO PAWS FOR VETERANS,  
AND RETURN ALL SUPPLIES AND EQUIPMENT PROVIDED TO YOU AND REFUND PAWS FOR VETERANS ALL THE  
MONEY THAT PAWS FOR VETERANS INVESTED IN THE TRAINING OF YOU AND YOUR SERVICE DOG.**

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PRINTED NAME:** \_\_\_\_\_





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**CONTRACTUAL AGREEMENT**

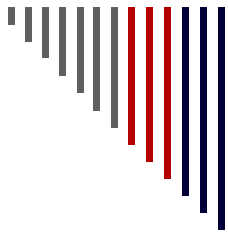
I AGREE TO MAINTAIN PROPER CARE AND HANDLING OF MY SERVICE DOG FOR THE ENTIRE LIFE OF MY SERVICE DOG, SUCH AS:

- ◇ I AGREE TO FEED HIM/HER A HIGH QUALITY DOG FOOD 2 TIMES DAILY
- ◇ I AGREE TO HAVE CLEAN FRESH WATER AVAILABLE AT ALL TIMES
- ◇ I AGREE TO KEEP HIS/HER SHOTS UP TO DATE YEARLY BY A PROFESSIONAL VETERINARIAN
- ◇ I AGREE TO TAKE MY DOG ON WALKS NO LESS THAN ½ MILE DAILY
- ◇ I AGREE TO PLAY WITH MY DOG AT LEAST ONCE EVERY DAY (FETCH, HIDE AND SEEK, ETC.)
- ◇ I AGREE TO BATHE MY DOG USING DOG SHAMPOO AND CLEAN WATER ONCE A MONTH
- ◇ I AGREE TO KEEP MY DOG ON A MONTHLY FLEA/TICK AND HEARTWORM PREVENTATIVE
- ◇ I AGREE TO TRIM MY DOG’S NAILS MONTHLY BY A GROOMER, VETERINARIAN, OR MYSELF
- ◇ I AGREE TO MONITOR MY DOG’S ANAL GLANDS AND TAKING HIM/HER TO A VETERINARIAN OR GROOMER TO HAVE THE ANAL GLANDS EXPRESSED AS NEEDED
- ◇ I AGREE TO CLEAN MY DOG’S EARS 2 TIMES A MONTH
- ◇ I AGREE TO TAKE MY DOG TO THE VETERINARIAN WITHIN 12 HOURS OF THE DOG DISPLAYING SIGNS OF ILLNESS OR LETHARGY
- ◇ I AGREE TO TAKE MY DOG TO A VETERINARIAN ANNUALLY FOR A HEALTH EXAM AND VACCINATIONS INCLUDING: RABIES, DISTEMPER, LEPTO, PARVO, AND **BORDETELLA**
- ◇ I AGREE TO MICROCHIP MY SERVICE DOG AND UPDATE THE ADDRESS OF THE MICROCHIP IF I RELOCATE
- ◇ I AGREE TO REGISTER/LICENSE MY SERVICE DOG WITH BASE ANIMAL CONTROL
- ◇ I AGREE TO LICENSE MY DOG WITH THE CITY OR COUNTY THAT I AM LIVING IN AND KEEP LICENSE CURRENT

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PRINTED NAME:** \_\_\_\_\_





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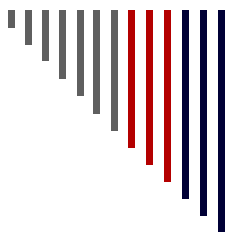
**CONTRACTUAL AGREEMENT**

- ◇ I AGREE TO MAINTAIN PET INSURANCE FOR MY SERVICE DOG THROUGH MY HOME OWNERS, RENTERS, OR A PRIVATE INSURANCE POLICY AND PROVIDE DOCUMENTATION SHOWING THE POLICY TO PAWS FOR VETERANS WITHIN 1 MONTH OF RECEIVING MY SERVICE DOG
- ◇ I AGREE TO NOT ALLOW ANYONE OTHER THAN MYSELF TO HANDLE MY SERVICE DOG OUTSIDE OF MY HOME
- ◇ I AGREE TO NEVER LEAVE MY DOG OUTSIDE OR INSIDE ON A TIE OUT, LEASH, DOG RUN, CHAIN, OR ANY OTHER METHOD UNATTENDED
- ◇ I AGREE TO KEEP MY DOG SECURE IN A CRATE OF PROPER SIZE FOR MY DOG'S SIZE IF I EVER NEED TO LEAVE THE HOME WITHOUT TAKING MY DOG WITH ME
- ◇ I AGREE TO BOARD MY DOG AT A PROFESSIONAL KENNEL, BOARDING FACILITY, OR VETERINARIAN IF I EVER NEED TO LEAVE MY DOG FOR MORE THAN 1 DAY AT A TIME
- ◇ I AGREE TO ONLY TAKE MY DOG TO DOG PARKS THAT CHECK ALL DOG'S VACCINATION RECORDS AND MONITOR FOR AGGRESSIVE DOG BEHAVIOR
- ◇ I AGREE TO SOCIALIZE MY DOG WITH OTHER DOGS, ANIMALS, CHILDREN, AND ADULTS A MINIMUM OF ONCE A WEEK
- ◇ I AGREE TO NOTIFY PAWS FOR VETS, INC. IN THE EVENT OF AN ILLNESS, BITE, INJURY, OR ACCIDENT WITHIN 2 HOURS OF THE EVENT
- ◇ I AGREE TO NEVER SURRENDER, GIVE AWAY, OR TAKE MY DOG TO A SHELTER OR ANYONE WITHOUT WRITTEN CONSENT FROM PAWS FOR VETS, INC.
- ◇ I AGREE THAT IF FOR ANY REASON I CAN NOT MAINTAIN PROPER CARE OR FOLLOW ALL OF THE ABOVE LISTED CONDITIONS FOR MY SERVICE DOG, I WILL CONTACT PAWS FOR VETS, INC. AND TURN MY DOG AND ALL DOG RELATED SUPPLIES OVER TO PAWS FOR VETS, INC.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PRINTED NAME:** \_\_\_\_\_





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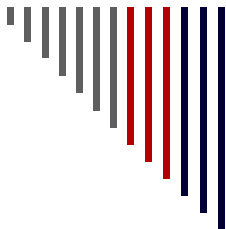
**CONTRACTUAL AGREEMENT**

- ◇ I AGREE THAT IF THERE WERE TO BE ANY INCIDENT INVOLVING ANIMAL CONTROL, BASE HOUSING, OR POLICE, I WILL NOTIFY PAWS FOR VETERANS WITHIN 1 HOUR OF SUCH INCIDENT
- ◇ I AGREE TO NOT ABANDON THE DOG AND REPORT LOSS, INJURY, OR ILLNESS TO PAWS FOR VETERANS IMMEDIATELY
- ◇ I AGREE TO SURRENDER VEST, ID CARDS, AND ANY OTHER SUPPLIES PROVIDED BY PAWS FOR VETERANS AND THEIR AFFILIATES IMMEDIATELY FOLLOWING INCIDENT ANY INCIDENT INVOLVING ANIMAL CONTROL, BASE HOUSING, OR POLICE
- ◇ I AGREE THAT UPON COMPLETION OF INVESTIGATION, IF I AM FOUND IN VIOLATION, I WILL SURRENDER DOG TO PAWS FOR VETERANS (OR AUTHORITIES IF NECESSARY) AND RELEVANT PARTIES WILL BE NOTIFIED
- ◇ I AGREE TO PERSONALLY ACCEPT ALL RESPONSIBILITY AND LIABILITY OF MY AND MY SERVICE DOGS ACTIONS
- ◇ I AGREE THAT AT NO TIME WILL I USE MY SERVICE DOG VEST ON ANY OTHER DOG OTHER THAN MY PAWS FOR VETERANS DESIGNATED AND APPROVED SERVICE DOG
- ◇ I AGREE THAT AT NO TIME WILL MY SERVICE DOG BE ALLOWED OFF LEASH WHILE OUTSIDE MY HOME UNLESS IN A COMPLETELY FENCED IN AND HUMAN SUPERVISED SETTING
- ◇ IF AT ANYTIME I DO NOT FOLLOW ALL RULES AND GUIDELINES, I AGREE TO SURRENDER SERVICE VEST, ID CARDS, SUPPLIES, AND SERVICE DOG TO PAWS FOR VETERANS (OR AUTHORITIES) AND BE REMOVED FROM THE PAWS FOR VETERANS PROGRAM
- ◇ I AGREE THAT IF I AM FOUND IN VIOLATION OF ANY OF THE ABOVE TERMS, I WILL FINANCIALLY REIMBURSE PAWS FOR VETERANS THE TOTAL COST OF MY SERVICE DOG, SUPPLIES, AND TRAVEL EXPENSES INCLUDING ANY ADDITIONAL EXPENSES THAT PAWS FOR VETERANS INCURS IN HAVING TO TAKE BACK POSSESSION OF MY SERVICE DOG INCLUDING, BUT NOT LIMITED TO TRAVEL, FINES, AND VETERINARY CARE

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PRINTED NAME:** \_\_\_\_\_





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**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

**Patient Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

The above named person must indicate when this authorization is to expire:

	When information is received	In one year
	In six months	<input checked="" type="checkbox"/> In three years
	On date	_____

**The person named above is or has been a patient of**

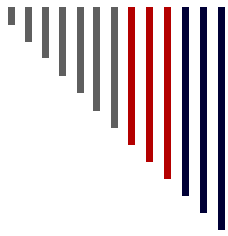
Name of Person, Provider, or Facility	_____
Address	_____
Phone	_____
Fax	_____

The person named above hereby authorizes PAWS FOR VETERANS/PAWS FOR VETS to

<input type="checkbox"/> Request health information from	<input type="checkbox"/> Send health information to
<input checked="" type="checkbox"/> Discuss health information with	<input checked="" type="checkbox"/> Discuss health information with

**The person named above authorizes information to be requested or released by representatives of**

Name Of Person, Provider, Or Facility	PAWS FOR VETERANS/PAWS FOR VETS
Address	63 Ocean Blvd. Satellite Beach, FL 32901
Email	info@pawsforveterans.com
Fax	321-425-4183



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**Scope**

All information regarding assessment, diagnosis, and treatment of patient's condition, concern, or disease (specify):

ALL MEDICAL CONDITIONS THAT REQUIRE USE OF SERVICE DOG

All information regarding care received by patient between the dates of \_\_\_\_\_ and \_\_\_\_\_

Starting Date

Ending Date

Other information (specify): \_\_\_\_\_

**Authorization**

Printed name of Patient or Authorized Representative

Signature of Patient  
or Authorized Representative

If not signed by the patient, indicate relationship of authorizing person to patient:

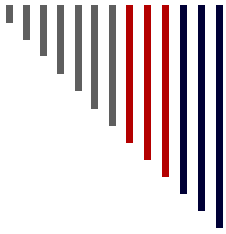
- Parent or guardian of minor child
- Guardian or conservator of conserved patient
- Beneficiary or personal Representative of a deceased individual

Certain information is covered by additional protection and requires specific authorization. To authorize release or discussion of the following type of information, the person named above must initial and date each item. If an item is not initialed and dated, the information, if such information exists, cannot be released or discussed.

Initial	Date		From	To
_____	_____	Alcohol or Drug Use/Abuse Treatment	_____	_____
_____	_____	Mental Health Treatment	_____	_____
_____	_____	HIV Status or Treatment	_____	_____

**“ALCOHOL OR DRUG USE/ABUSE TREATMENT” AND “MENTAL HEALTH TREATMENT” ABOVE MUST BE INITIALED, DATED, AND “FROM” ONE YEAR PRIOR TO TODAY’S DATE AND “TO” ONE YEAR FROM TODAY’S DATE**





## PAWS FOR VETERANS

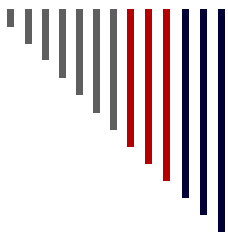
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Website: [www.pawsforveterans.com](http://www.pawsforveterans.com)



The above named person has the following rights:

- This authorization is effective for the above requested and authorized health care information only. You may ask for and receive a copy of this authorization form.
- This authorization will expire on the date you indicated above. Additionally, you may revoke this authorization at any time by submitting a written request to this clinic or caretaker. Your revocation will be honored except to the extent that is been acted upon in good faith while in force.
- You have the right to inspect the information you are authorizing to be re-released. This and other specific rights regarding the handling of your health information are outlined in our Privacy Practices document.
- The information you are authorizing to be released could be re-released or disclosed by the recipient. Such additional disclosures or releases may not be prohibited by law. We are not responsible for the actions of others who may be provided with information released as a result of this authorization.
- You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your health care provider in determining appropriate treatment. Your refusal to sign this authorization will not affect your eligibility for benefits



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## Consent and Waiver of Liability

This agreement releases **Paws for Vets, Inc., Paws for Veterans, Crystal Ayala, staff, volunteers, CFRC and all affiliates** from all liability relating to injuries or death that may occur **during any and all dog training, dog handling, trainer training, classroom instruction, events, and all situations relating to participating in a Paws for Vets, Inc. activity.** By signing this agreement, I agree to hold **Paws for Vets, Inc., Paws for Veterans, Crystal Ayala, staff, volunteers, CFRC and affiliates** entirely free from any and all liability, including but not limited to financial responsibility for injuries incurred, regardless of whether injuries are caused by negligence.

I also acknowledge the risks involved in **dog training, dog related events, and dog ownership.** These include but are not limited to hyperextended limbs, bruises, cuts, dog bites, sore muscles, broken bones, head injuries, torn muscles. I swear that I am participating voluntarily, and that all risks have been made clear to me. Additionally, I accept all responsibility of the dog that I am being provided as of the date at the bottom of this waiver.

By signing below, I forfeit all right to bring a suit against **Paws for Vets, Inc., Paws for Veterans, Crystal Ayala, their staff, volunteers, and affiliates** for any reason. I accept full and sole responsibility for myself, my family, my entire party and any and all actions of the dog provided to me from now until the time the dog dies. In return, I will receive instruction in dog training and handling. I will also obey safety precautions as listed in writing and as explained to me verbally. I will ask for clarification when needed.

In addition, I consent to being photographed and video recorded for further educational and company use such as, but not limited to, websites, Facebook pages, media, and television. All photographs and videos will be in good taste, as judged by Paws for Vets, Inc., edited as needed, and for the purpose of education and awareness regarding psychiatric service dogs, trainers, fundraising and Paws for Vets, Inc.

I, \_\_\_\_\_, fully understand and agree to the above terms and have read and fully understand Paws for Vets, Inc. terms and conditions.

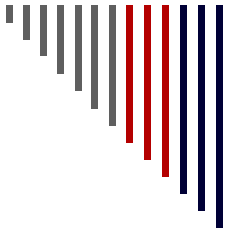
(Printed Full Name)

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(Participant Signature)

Date

Time



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**SAMPLE MENTAL HEALTH DOCTOR'S LETTER**

March 20, 20XX

RE: John Smith

To Whom It May Concern:

John Smith is under my care for treatment of his disability. Due to John's disability, he is in need of a medical service dog to improve his quality of life and help mitigate the symptoms related to his disability.

Sincerely,

*Dr. Jane Doctor*

Dr. Jane Doctor



FCIC/NCIC

Request

URGENT  
ROUTINE



Date Requested: \_\_\_\_\_

➡ First Name: \_\_\_\_\_

➡ Middle Initial: \_\_\_\_\_

➡ Last Name: \_\_\_\_\_

➡ Race: \_\_\_\_\_ Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

➡ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

➡ Driver's License Number: State \_\_\_\_\_ #: \_\_\_\_\_

Company Representation: PAWS FOR VETERANS

➡ Occupation: \_\_\_\_\_

Purpose of Visit: DOG TRAINING AND GRADUATION

Length of Visit: ONE WEEK

Person Requesting Approval: \_\_\_\_\_ Extension \_\_\_\_\_

APPROVED: \_\_\_\_\_ DENIED: \_\_\_\_\_

By: \_\_\_\_\_ Date: \_\_\_\_\_

Only complete the sections with the ➡



FCIC/NCIC

Request

URGENT  
ROUTINE



Date Requested: \_\_\_\_\_



First Name: \_\_\_\_\_



Middle Initial: \_\_\_\_\_



Last Name: \_\_\_\_\_



Race: \_\_\_\_\_ Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_



Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_



Driver's License Number: State \_\_\_\_\_ #: \_\_\_\_\_

Company Representation: PAWS FOR VETERANS



Occupation: \_\_\_\_\_

Purpose of Visit: DOG TRAINING AND GRADUATION

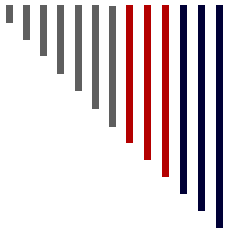
Length of Visit: ONE WEEK

Person Requesting Approval: \_\_\_\_\_ Extension \_\_\_\_\_

APPROVED: \_\_\_\_\_ DENIED: \_\_\_\_\_

By: \_\_\_\_\_ Date: \_\_\_\_\_

Only complete the sections with the 



**PAWS FOR VETERANS**

Paws for Veterans  
1900 S. Harbor City Blvd.  
Suite 106  
Melbourne, FL 32901

Website: [www.pawsforveterans.com](http://www.pawsforveterans.com)  
E-mail: [application@pawsforveterans.com](mailto:application@pawsforveterans.com)



# APPLICATION

## CHECKLIST

**BEFORE TURNING IN YOUR APPLICATION, INITIAL THE FOLLOWING TO MAKE SURE YOU HAVE COMPLETED ALL THE FORMS AND PROVIDED ALL THE NEEDED INFORMATION AND ITEMS INCLUDING:**

\_\_\_\_\_ 6 PAGE APPLICATION AND CONTRACUAL AGREEMENT FILLED OUT **COMPLETELY**; WITH NO BLANKS  
*PAGES 1 TO 6*

\_\_\_\_\_ MEDICAL RELEASE FORM COMPLETED BY YOUR DOCTOR'S OFFICE AND SIGNED BY YOU  
*PAGES 7 TO 9*

\_\_\_\_\_ CONSENT AND WAIVER OF LIABILITY  
*PAGE 10*

\_\_\_\_\_ COPY OF THE LETTER FROM YOUR DIAGNOSING MENTAL HEALTH DOCTOR  
*PAGE 11 is an example letter*

\_\_\_\_\_ COPY OF YOUR DRIVERS LICENSE

\_\_\_\_\_ COPY OF YOUR DD214 (showing discharge type) OR 60 DAY LETTER

\_\_\_\_\_ A BRIEF BIO EXPLAINING YOUR MILITARY SERVICE AND HOW A SERVICE DOG WOULD HELP YOU

\_\_\_\_\_ 4 PHOTOS: 2 PHOTOS OF YOU IN UNIFORM; 2 PHOTOS OF YOU WITH YOUR FAMILY

\_\_\_\_\_ PHOTOS OF YOUR RESIDENCE (FRONT, BACK, INTERIOR)

\_\_\_\_\_ COMPLETED FCIC/NCIC BACKGROUND CHECK FORM FOR YOU AND YOUR SPOUSE/PARTNER

