Retrieving Independence
1802 Williamson Court
Suite 101
Brentwood, TN 37027
615.934.0444
info@retrievingindependence.org

Dear Applicant,

Enclosed you will find the application package that you requested from Retrieving Independence. Please return your completed application either by email to info@retrievingindependence.org or by mail to the address listed above, Attn: Application Coordinator. If you need any further information or assistance, please call us at 615.934.0444.

A completed application must include all of the following:

- ☐ **The completed application form**
- ☐ **$50 application fee**
- ☐ **Medical History Form completed by your physician or primary care specialist**
- ☐ **A letter of personal reference from a friend, co-worker, teacher or anyone other than a family member**
- ☐ **A letter of reference from a therapist, social worker, teacher or other professional with whom you have contact**

When we receive your completed application package, the first step of the application process with be complete.

The second step is an interview, either in person or over the phone. The interview is crucial in helping us understand your needs, personality, and lifestyle which will greatly assist us in matching you with a dog. The last step is the hardest, waiting for your dog. Your wait can be anywhere from 6 months to 2 years, or longer, depending on your needs and our current waitlist.

Thank you for your understanding. Please do not hesitate to call with any questions or concerns at the contact information above.

Application Form - Retrieving Independence Service Dog

Name:

Date:

Address:

City: State: Zip:

Home Phone: Cell Phone:

Work Phone: Email:

Date of Birth: Sex:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other:

Name of Nearest Relative:

Relationship:

Phone Number: Email:

Address:

City: State: Zip:

What is your primary disability:

What caused your disability and at what age:

Please list any secondary disabilities, if applicable:

Is your disability progressive?

What is your approximate height? Weight?

Please check all that apply:

What are the effects of your disability?

- ☐ Deafness
- ☐ Hearing Loss
- ☐ Memory Loss
- ☐ Vision Impairment
- ☐ Other:
- ☐ Speech Impairment
- ☐ Coordination Problems
- ☐ Spasticity
- ☐ Muscular Weakness
- ☐ Reduced Stamina
- ☐ Limited Mobility
- ☐ Slowed Development

Do you have problems with….?

- ☐ Allergies
- ☐ Heightened Emotions
- ☐ Heat or Cold Sensitivity
- ☐ Chronic Pain
- ☐ Skin Sensitivity
- ☐ Seizures
- ☐ Balance
- ☐ Brittle Bones
- ☐ Depression

If you checked seizures, what type and how often are your seizures?

Also, what treatments or medications are you using or have you used to control your seizures?

Do you use any of the following aids or assisting devices?

- ☐ Prosthesis
- ☐ Manual Wheelchair
- ☐ Crutch/Cane
- ☐ Other:
- ☐ Leg Brace
- ☐ Wrist Brace
- ☐ Walker
- ☐ Electric Wheelchair
- ☐ Hearing Aid

Are you active in the military, a veteran, or a dependent of an active military or veteran? If yes, please explain:

Primary Care Physician, PT, OT and/or other health professionals important to your care:

Name: Phone Number:

Do you live in: ☐ House ☐ Apartment ☐ Other:

Is your yard: ☐ Fenced ☐ No Fence ☐ No yard

Please list all those living with you:

Name Relationship Age

Do you have an attendant? ☐ Yes ☐ No

If yes, are they ☐ Full time? ☐ Part time? ☐ Other:

Please describe your home and your neighborhood (i.e. quite, lots of visiting children, close to retail or commercial areas, suburban, rural, lots of traffic, etc.):

Does anyone in your household smoke? ☐ Yes ☐ No

Have you ever had a dog? ☐ Yes ☐ No

Please describe your experience with your dog:

Do any other animals live with your or visit you frequently? ☐ Yes ☐ No

If so, please describe (include breed, seem age, etc.) - who is responsible for the care of these animals?

Who will assist in the daily care and training of your dog, if appropriate?

Does anyone in your household have concerns about having a service/companion dog in their home? If so, please describe:

Are you (or anyone in your household) allergic to animals? ☐ Yes ☐ No

Are you (or anyone in your household) concerned about fleas or shedding? ☐ Yes ☐ No

Are you currently employed? ☐ Yes ☐ No

If so, do you want your dog to assist you while at work? In what way?

Are you currently in school? ☐ Yes ☐ No

If so, do you want your dog to assist you while in school? In what way?

Have you discussed with your principal and teachers about having a dog in school?
☐ Yes ☐ No

Are they supportive? ☐ Yes ☐ No

Pick five of the following words that would best describe the dog you would like to have:

☐ Confident	☐ Serious	☐ Playful	☐ Slow	☐ Sensible
☐ Willing	☐ Attentive	☐ Energetic	☐ Communicative	☐ Sweet
☐ Smart	☐ Stable	☐ Calm	☐ Protective	☐ Dependable
☐ Easy Going	☐ Devoted	☐ Happy	☐ Assertive	☐ Independent
☐ Responsible	☐ Friendly	☐ Loving	☐ Submissive	☐ Dependent
☐ Excitable	☐ Trusting	☐ Other:		

Pick five of the following words that would describe traits you would not like to have in a dog:

☐ Serious	☐ Slow	☐ Calm	☐ Indifferent	☐ Distracted
☐ Playful	☐ Jealous	☐ Fearful	☐ Manipulative	☐ Stubborn
☐ Protective	☐ Joking	☐ Excitable	☐ Assertive	☐ Dependent
☐ No-nonsense	☐ Foolish	☐ Resistant	☐ Other:	

Describe your means of transportation:

Are you able to attend a two week training camp in Nashville? ☐ Yes ☐ No

How do you feel a service dog could improve your life? With what specific tasks would you hope a dog could help you with?

Please tell us a little more about yourself - hobbies, activities, clubs, interests, etc.

Retrieving Independence
1802 Williamson Court
Suite 101
Brentwood, TN 37027
615.934.0444

Applicant Medical History Form

This form is to be completed by your physician and sent with all other application materials and application fee to Retrieving Independence.

Information Release:

Dr. ,

Please release the requested medical information regarding my condition to the above identified organization. This information will be used to help determine my abilities in regards to the placement of an assistance dog.

Applicant's Name:

Applicant's Signature: **Date:**

Doctor's Name:

Type of Practice:

Address:

City: County: State: Zip:

Phone Number: Fax Number:

What is the patient's primary disability?

What is the cause of the disability?

Are there significant secondary disabilities? ☐ Yes ☐ No

If yes, please describe:

At what age was the patient disabled:

Is this disability progressive? ☐ Yes ☐ No

Is there an incapacity due to drugs or alcohol abuse? ☐ Yes ☐ No

Please check all that apply:

The patient suffers from the following as a result of his or her disability:

☐ Deafness ☐ Speech Impairment ☐ Reduced Stamina

☐ Hearing Loss ☐ Coordination Problems ☐ Limited Mobility

☐ Memory Loss ☐ Delayed Development ☐ Spasticity

☐ Vision Impairment ☐ Muscular Weakness

☐ Other:

Does this patient have trouble with….?

☐ Allergies ☐ Chronic Pain ☐ Heightened Emotions ☐ Depression

☐ Seizures ☐ Balance ☐ Heat or Cold Sensitivity ☐ Brittle Bones

Does this patient use any of the following airs or assistance devices?

☐ Prosthesis ☐ Leg Brace ☐ Manual Wheelchair ☐ Walker

☐ Wrist Brace ☐ Hearing Aid ☐ Electric Wheelchair ☐ Crutch/Cane

☐ Other:

Does the patient….? ☐ Drive ☐ Travel by bus ☐ Travel by airplane

Current number of hours of attendant care per week:

Please answer the following questions about the patient to the best of your ability.
Check the appropriate answer box.
ADL = Activities of Daily Living

Is this patient:

Able to exercise judgment and make decisions necessary for ADL?

☐ Yes ☐ Minimally ☐ No

Able to sustain an attention span?

☐ Yes ☐ Minimally ☐ No

Manifesting inappropriate behavior beyond his or her control?

☐ Yes ☐ Minimally ☐ No

Able to control physical and motor movement sufficient to sustain ADL?

☐ Yes ☐ Minimally ☐ No

Capable of perception and memory to the degree necessary to sustain ADL?

☐ Yes ☐ Minimally ☐ No

Able to follow directions and learn to the degree necessary to sustain ADL?

☐ Yes ☐ Minimally ☐ No

Under medication which impairs physical or mental functioning?

☐ Yes ☐ Minimally ☐ No

Capable of decisions concerning self and others needs and safety?

☐ Yes ☐ Minimally ☐ No

Can you recommend this individual for an assistance dog? ☐ Yes ☐ No

Do you feel this program might benefit from a consultation with you? ☐ Yes ☐ No

Comments:

Physical Signature: **Date:**

Please send a $50 application fee - check made payable to Retrieving Independence, Inc.

Please make sure your application is complete before submitting. Incomplete applications cannot be considered. Do not forget the medical history form and two letters of reference.

Applicant Signature:

Date:

If the applicant is a minor, or under guardianship or conservatorship or a ward of the court, the parent or duly authorized representative is required to sign below pursuant to state and federal law.

Authorized representative signature:

Date:

Name: Relationship:

Address:

City: State: Zip:

Phone Number: Email:

Return this completed application to:

Attn: Application Coordinator
Retrieving Independence
1802 Williamson Court
Suite 101
Brentwood, TN 37027

or email to info@retrievingindependence.org

Please do not hesitate to contact us at 615.934.0444 or email at info@retrievingindependence.org if you have any questions or concerns about this application or service dogs in general.