USWDA Retired Military Working Dog
BlindSight Program

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Email: _____

Veterinarian Information:

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Email: _____

Retired MWD's Name: _____
Tattoo: _____ Dates of Service: _____

Breed: _____ DOB (If Known): _____ Weight: _____

I certify the above information is true and correct. Email this application along with a prescription from your Veterinarian confirming blindness.

Signature: _____ Date:_____

Email this application along with a prescription from your Veterinarian for the use of a wheelchair for your retired Military Working Dog to wardogcare@uswardogs.org.