USWDA Retired Military Working Dog
Specialized Medical Care Program

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Email: _____

Retired MWD's Name: _____

Tattoo: _____ Dates of Service: _____

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

Branch of Service: _____ Unit: _____

Deployment Locations: _____

Adoption Location: City_____ State:_____

Medical care needed:

_____

_____

I certify the above information is true and correct.

Signature: _____ Dates:_____

Email this application along with copies of your retired Military Working Dogs adoption papers to wardogcare@uswardogs.org.