



I, _____ give my consent for my medical provider to release the requested information on this form. Signature: _____ Date: _____

Applicant's Name: _____ DOB: _____ Gender: _____

Date of last visit: _____ How long have you been treating the patient? _____

Applicant's Primary Medical Diagnosis: _____

Other Conditions or Diagnoses: _____

Medication taken on a regular basis: _____

Please describe the treatments the applicant has received related to their post-traumatic stress diagnosis. _____

Has the applicant attempted suicide in the past or expressed suicidal ideation? Yes No

Is the applicant actively suicidal? Yes No

Has the applicant been treated in the past or currently treated for substance abuse? Yes No

Maine Paws for Veterans requires an applicant to be sober for 6 months.

Is the applicant currently sober? Yes No If yes, for how long? _____

How does applicant cope with anxiety and anger? _____

*This is to certify that the applicant is my patient.
I feel that they are capable of training and properly care for a service dog.*

Physician Signature: _____ Printed Name: _____

Address: _____ Phone Number: _____

Date: _____

Additional comments: _____
