The Battle Buddy Foundation
8859 Cincinnati-Dayton Rd. Suite 202
West Chester, OH 45069
www.tbbf.org

Service Dog Application

A completed application must include the following:

1. The completed application form *with signature*.
2. The Medical History form completed by your physician, primary care specialist or caseworker. *Note: no special form is needed – provide in whatever format is used in your facility.*
3. A copy of your DD 214 and other official document(s) from the VA verifying your Summary of Benefits or service-connected disability. If still on active duty, provide copy of PCS orders.
4. The Signed Referral Form from your Physician (page 7)
5. Personal Statement including what you are hoping to gain from The Battle Buddy Program

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Date: _____

Applicant's Name: _____ Nickname (if any): _____

Branch of Service: _____ Pay Grade/Rank: _____

Address: _____

City: _____ County: _____ State: _____ Zip: _____

Is this a ☐ *Temporary Address or* ☐ *Permanent Address*

Preferred means of communication: ☐ Phone ☐ E-mail

Daytime phone number: ☐ work ☐ home ☐ cell

Evening phone number: ☐ work ☐ home ☐ cell

Other (Please specify): _____ ☐ work ☐ home ☐ cell

E-mail address (work): _____ E-mail address (home): _____

Occupation: _____ Spouse's Occupation: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Marital Status: ☐Single ☐Married ☐Divorced Do you have children: ☐ Yes ☐ No If yes, how many and what age(s)? _____

Emergency Contact Information
Name: _____ Contact # _____

What is your primary disability? _____

_____

_____

_____

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If you have been diagnosed with post-traumatic stress disorder (PTSD), how acute are your symptoms, i.e., how often do you have flashbacks? How isolated are you? How angry do you get, and how often? How well do you sleep? _____

_____

_____

Are you in the VA system? ☐ Yes ☐ No Is your disability progressive? ☐ Yes ☐ No
Additional Information: _____

_____

Case Manager: _____ _____May we contact? ☐ Yes ☐ No

Phone: _____ E-mail: _____

Physician: _____ May we contact? ☐ Yes ☐ No

Address: _____

City: _____County: _____ State: _____Zip: _____

Phone: _____ E-mail: _____

Therapist: _____ May we contact? ☐ Yes ☐ No

Phone: _____ E-mail: _____

Therapist: _____ May we contact? ☐ Yes ☐ No

Phone: _____ E-mail: _____

Approximate weight: _____ Height: _____

What other medical problems do you have? _____

_____

How does this affect your daily living skills? _____

_____

_____

_____

Please check all that apply:

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

☐ Other: _____

Do you have any of the following?

☐ Allergies ☐ Depression ☐ Brittle bones

☐ Chronic pain ☐ Skin sensitivity ☐ Sensitivity to heat/cold

☐ Heightened emotions ☐ Balance

☐ Seizures If yes, what type, how often, what treatments/medications are you (or have you) using to control the seizures? _____

☐ Other: _____

Do you use any of the following?

☐ Prosthesis

☐ Leg brace

☐ Electric wheelchair

☐ Manual wheelchair

☐ Wrist brace

☐ Hearing aid

☐ Crutch / cane

☐ Walker

☐ Other:_____

Please list all those living with you:

Name	Relationship *(family member, friend, colleague)*	Gender M/F	Age	Home during the day	Allergic to Dogs
		☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No
		☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No
		☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No
		☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No
		☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No
		☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No
		☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No

Have you ever had a dog? ☐ Yes ☐ No If yes, was it a ☐ pet ☐ hunting dog ☐ therapy dog

Have you ever attended dog obedience classes? ☐ Yes ☐ No If yes, where? _____

Do you consider yourself knowledgeable about dogs? ☐ Yes ☐ No

What is the average number of hours per day the dog would spend alone? _____

Where would the dog be when alone? (TBBF dogs have been raised as house dogs)_____

Where would the dog sleep at night? (TBBF dogs have been raised as house dogs) _____

_____

May a TBBF representative visit you in your home for a personal interview? ☐ Yes ☐ No

How did you hear about TBBF's program?_____

_____

_____

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Filing an application does not guarantee receipt of a dog. There is no way to predict if or when an appropriate dog for you may become available. We will acknowledge receipt of your application and contact you if we have any questions.

_____(INITIAL): I AGREE TO MAINTAIN PROPER CARE OF MY SERVICE DOG SUCH AS: FEEDING, WATERING, KEEPING SHOTS UP TO DATE, REGULAR WALKS, BATHS, TAKING THE DOG TO THE VET FOR ILLNESS AND ANNUAL CHECK UPS. I AGREE TO MICROCHIP MY SERVICE DOG. I AGREE TO REGISTER MY SERVICE DOG WITH BASE ANIMAL CONTROL, THE STATE OF OHIO, AND/OR OTHER AGENCY REQUIRED BY MY PLACE OF RESIDENCY. I UNDERSTAND I AM TO MAINTAIN INSURANCE FOR MY SERVICE DOG THROUGH MY HOME OWNERS, RENTERS, OR A PRIVATE INSURANCE POLICY AND PROVIDE DOCUMENTATION SHOWING THE POLICY. IF AT ANY TIME I AM UNABLE TO MEET THE NEEDS OF THE DOG, I WILL NOTIFY THE BATTLE BUDDY FOUNDATION AND TURN THE DOG IN TO THE BATTLE BUDDY FOUNDATION. I WILL NOT GIVE MY DOG AWAY OR TAKE HIM/HER TO A SHELTER. IF THERE WERE TO BE ANY INCIDENT INVOLVING ANIMAL CONTROL, HOUSING, OR POLICE SUCH AS (BUT NOT LIMITED TO) A DOG BITE; I WILL NOTIFY THE BATTLE BUDDY FOUNDATION WITHIN 24 HOURS. I AGREE TO SURRENDER VEST/ID CARDS IMMEDIATELY FOLLOWING INCIDENT PENDING INVESTIGATION. UPON COMPLETION OF INVESTIGATION, I UNDERSTAND THAT IF I AM FOUND IN VIOLATION THE DOG WILL BE REMOVED. I AGREE TO PERSONALLY ACCEPT ALL RESPONSIBILTY AND LIABILITY OF ME AND MY SERVICE DOGS ACTIONS. AT NO TIME WILL I USE MY SERVICE DOG VEST ON ANY OTHER DOG OTHER THAN MY THE BATTLE BUDDY FOUNDATION DESIGNATED SERVICE DOG. AT NO TIME WILL I ALLOW ANYONE, INCLUDING FAMILY, TO HANDLE MY SERVICE DOG OUTSIDE THE HOME. AT NO TIME WILL MY SERVICE DOG BE ALLOWED OFF LEASH WHILE OUTSIDE MY HOME. IF AT ANYTIME I DO NOT FOLLOW ALL RULES AND GUIDELINES, I AGREE TO SURRENDER SERVICE VEST, ID CARDS, AND BE REMOVED FROM THE BATTLE BUDDY FOUNDATON PROGRAM.

***I understand that it is my responsibility to keep TBBF informed of changes in my address, phone numbers and E-mail address, as well as changes in my interest in receiving a TBBF-trained service dog. I understand my application will be kept on file for two years*.**

Applicant's Signature: _____ Date: _____

Print Name:_____

Personal Statement

Please explain why you want a TBBF service dog. **You may attach a one-page explanation.**

- If you have a physical disability and desire a service dog, please describe your level of physical limitations, any equipment you use for mobility, and how you believe the service dog would offer you more independence.
- If you have been diagnosed with a traumatic brain injury (TBI), what cognitive limitations do you have that might impact care of and your relationship with a service dog?

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THE BATTLE BUDDY FOUNDATION

To The Battle Buddy Foundation:

_____ (Patient Full Name) is my patient, and has been under my care since _____ (Date).

I am intimately familiar with his/her history and with the functional limitations imposed by his/her disability. He/She meets the definition of disability under the Americans with Disabilities Act, the Fair Housing Act, and the Rehabilitation Act of 1973.

Due to _____(List Patient's Disability), _____ (Patient's Full Name) has certain limitations regarding

_____ _____ (List Limitations).

In order to help alleviate these difficulties, and to enhance his/her ability to live independently and to fully function in daily life, I support (Patient's Full Name)'s _____ decision to obtain a service dog. A specially trained service dog will help to mitigate his/her disability and improve independence and quality of life by doing (List Tasks) _____ _____ for him/her.

Sincerely, _____ (Physician Name/Signature)

Please return this completed application to:

The Battle Buddy Foundation
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Suite 202
West Chester, OH 45069

Or scan and create a PDF document and send us an email attachment to: application@tbbf.org