www.sdtas.org/

PO BOX 174
Nisland, SD 57717

605-631-0669	*605-559-0245*	*605-559-0562*
Nisland, S D	*Fax*	*Spearfish, S D*

CLIENT APPLICATION

GENERAL INFORMATION

Date: ___/____/__________

Date of Birth: ____/_____/________

Last Name ______________________ First ____________________ Middle Initial ______

Address ____

Is this an ☐ Apartment ☐ Home ☐ Shared Housing ☐ Assisted Living

City ___________________________________ State_________________ Zip_________

Mailing Address, if different ____

Home Phone _________________ Cell _______________________

E-Mail ____

Are you a Veteran? ☐ Yes ☐ No

How did you learn about ***SDT Advocation Services***? ____________________________

____

Type of Dog you have or need?

☐ ESA (Emotional Support Amiinal)

☐ Service Dog

To be used for

☐ Mobility Assistance ☐ PTSD ☐ TBI ☐ Hearing Assistance

Breed of Service Dog __________________________________ Age___________________

Picture of dog veterinary records are required

What is your disability? ____

How long have you been disabled? ____

Do you have a support person/case worker ▫ Yes ▫ No If yes Name________________________

Phone_______________ Organization Works for_________________________________

Please describe how your disability affects your life and your current level of independence: _________

____

We require a release signed by you from your Physician allowing us to contact him/her if needed

Physicians Name ______________________________Phone_________________

We require a medical letter or prescription signed by a Doctor stating your need or the possible benefit from having a service dog, please attach a copy with your application.

All information provided is confidential and will not be shared by SDT Advocation Services

____ Date____/____/________
Name of person completing this form

____ Date____/____/________
Signature of Applicant

Comments: ____

____

____

____

____