



# NATIONAL ASSOCIATION OF SERVICE DOGS

*DOGS HELPING PEOPLE ENJOY BETTER LIVES*

Please fill out and fax to us at (877) FAX-NASD ~ (877) 329-6273 or email to: [forms@naservicedogs.org](mailto:forms@naservicedogs.org)

## MEDICAL DOCTOR'S STATEMENT

By signing this form I am requesting and/or recommending that my patient will receive benefits for his/her disability by ownership and/or through the use of a Service Dog as defined under the guidelines established by the Americans with Disabilities Act..

**Disclaimer:** By signing this form as a Medical Professional in no way shall myself or my Partners (if any) be liable for any actions by either the dog or its owner. Responsibility for the safety of others, the training of the service animal and the animal's actions in public places is and shall be the sole responsibility of the owner and/or caretaker of the service animal.

Patient Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient's Disability: \_\_\_\_\_

Please note: Patient's disability information is voluntary and is kept in the strictest of confidentiality. NASD will never released this information to anyone. This information is used solely to maintain a list of disabilities which benefit from the use of service dogs. This information is valuable in our efforts to lobby on behalf of people with disabilities to ensure their right to use and be accompanied by their service dogs in public places.

Doctor's Name: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Doctor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Email: \_\_\_\_\_

Doctor's Office Stamp (if available)

For more info please visit our website at [www.naservicedogs.org](http://www.naservicedogs.org) or email us at [info@naservicedogs.org](mailto:info@naservicedogs.org)  
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