

EQuality Dog Training  
Phone: (520) 878-3644  
Fax: (520) 207-8967  
e-mail: edt@equalitydogtraining.com



Physician's  
Statement

Patient's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

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

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

The patient listed above wants to train a dog at EQuality Dog Training. In those classes we teach people with disabilities, including hearing and visual impairment, to train their own dogs, involving the owners as much as possible in the training process. We therefore require the approval of their doctor. We would appreciate your answering the following questions.

In the person listed above currently patient of yours? \_\_\_\_\_ Does the patient have a disability? : \_\_\_\_\_

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Date

I, \_\_\_\_\_, give my permission for the above named physician to release the information requested in this form.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

This statement must be submitted with the enrollment application.