Wild Waggers

Working K9 Gear, Pet Accessories & Training

Program Application Form

Wild Waggers is only able to train dogs in the southeast region of Queensland, If you are outside this area, please contact us to discus a possible outcome.
Please fill out every question possible to you, there are three parts to the form; Part 1a/b is for you (the owner/handler) to fill out, Part 2 is for your GP, Psychiatrist, Psychologist or Community Health Nurse to fill out and, Part 3 is for your canines Veterinarian to complete.

Once all Documents are in place and completed, All pages must be scanned and emailed to wildwaggers@outlook.com to be reviewed; If you are unable to scan please contact for address to post or drop off and someone will be in contact with regarding the progress of your application.

PART 1a: Primary Handler Details

Please fill in all necessary details to the best of your ability, if you have any questions please let us know

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Full Name:*

Title | First Name | Last Name

Date Of Birth:*

Please enter your full DOB

Email:*

Example@example.com

Phone Number:*

Please enter a valid phone number

Gender:*

Gender:*

- [ ] Female
- [ ] Male
- [ ] Other

Address:*

Street Address

Street Address Line 2

City | State/Province | Zip/Post Code

What is the circumstance of your disability that requires you to need an Assistance Dog Trained?

- [ ] Psychical Disability
- [ ] Mental Disability
- [ ] Intellectual Disability

How would an Assistance Dog help with your disability and every day life?

PART 1b: Canine Details

Please fill in all necessary details regarding your dog, if you have any questions please let us know

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Dogs Name:*

Date Of Birth:*

Breed:*

Dogs Sex:*

- [ ] Female
- [ ] Male

Desexed:*

- [ ] YES
- [ ] NO

Microchip No:*

Why do you think your dog is a good fit for Assistance Dog Work?

Has your dog undertaken any previous training?

It is a requirement of the trainee period that you pay an additional cost for approved trainer provided by Wild Waggers and you must complete all training required. You as the handler must complete al training guided by Wild Waggers approved trainer.

- [ ] YES I Understand
- [ ] No I do not understand

PART 2: Medical Certificate

This form can only be completed by your Medical practitioner, Psychiatrist, Psychologist or your Community Health Nurse.

Full Name:*

Title | First Name | Last Name

Business Number:*

Email:*

Example@example.com

Gender:*

Address:*

Street Address

Street Address Line 2

City | State/Province | Zip/Post Code

What is your profession?

- [ ] Medical Practitioner
- [ ] Psychiatrist
- [ ] Psychologist
- [ ] Community Health Nurse

What is your patient's:*

Title | First Name | Last Name

Is your patient diagnosed with an intellectual, mental or physical disability?

- [ ] YES
- [ ] NO

What is their diagnosis?

Does your patient use mobility aids? If Yes Please Specify

For us to assist with the training of a potential/current Assistance Dog their primary handler needs to be classified as a person with a disability under the Disability Discrimination Act 1992. This means:

Disability, in reaction to a person, means:
(a) total or partial loss of the person's bodily or mental functions: or
(b) total or partial loss of a part of the body: or
(c) the presence in the body of organisms causing disease or illness : or
(d) the presence in the body of organisms capable of causing disease or illness: or
(e) the malfunction, malformation or disfigurement of a part of the person's body: or
(f) a disorder or malfunction that results in the person learning differently from a person without the disorder or malfunction: or
(g) a disorder, illness or disease that effects a person's thought processes, perception of reality, emotions or judgment or that results in disturbed behavior: and included a disability that:
(h) Presently exists: or
ⓘ previously existed but no longer exists: or
(j) may exist in the future; or
(k) is imputed to a person.
To avoid doubt, a disability that is otherwise covered by this definition includes behavior that is a symptom or manifestation of a disability.

Does your patient meet the definition of a disability as stated in the Disability Discrimination Act 1992

☐ YES

☐ NO

Your Signature

Date

PART 3: Veterinary Certificate

This form can only be completed by your dogs veterinarian .

Clients Full Name:*

Title | First Name | Last Name

Canines Name:*

Microchip No:*

Canines DOB:*

Canines Breed:*

Canines Weight:*

Dogs Sex:*

- Female
- Male

Desexed:*

- YES
- NO

Vaccination Details? (tick and fill applicable):*

- C5 Vaccination/Expires-
- C3 Vaccination/Expires-
- Bordetella/kennel cough/Expires-

Is the canine on effective program for the control of following?:*

- Heartworm
- Intestinal Parasites
- External Parasites

Overall Health Score:

- Excellent-no chronic disease or disorder
- Very Good-Minor complaints associated with normal ageing
- Good-Chronic conditions resulting in occasional flare ups (outline below)
- Poor-Chronic illness requiring on-going treatment

General Health:

Your Signature

Date