Medical Health Provider

Recommendation Form

AttachmentInjuredFfamilies@gmail.com

ALLIANCE FOR ATTACHMENT INJURED FAMILIES

This form is part of the scholarship application for families seeking a service dog. It must be completed by a licensed medical provider who is familiar with the applicant's condition. The purpose of this form is to help the scholarship committee understand whether and how a service animal may provide meaningful support to the applicant's health, safety, or daily functioning. Please answer the questions below to the best of your professional ability.

Applicant's Full Name: _____

Date of Birth: _____

Provider's Full Name: _____

Provider's Credentials (e.g., MD, DO, etc.): _____

License Number & State: _____

Agency/Practice Name: _____

Address: _____

Phone Number: _____

Email Address: _____

1. How long have you treated the applicant?

2. What is the applicant's primary diagnosis or condition (in general terms only, no detailed medical history required)?

3. Brief description of symptoms or functional impairments that a service canine could help address: *(e.g., night terrors, hypervigilance, emotional dysregulation, sensory issues, aggression, anxiety)*

4. In your professional opinion, would the applicant benefit from a trained service animal?

   ☐ Yes ☐ No

   If yes, what roles or tasks might the canine assist with?

   ☐ Emotional regulation support

   ☐ Safety or grounding during episodes

   ☐ Companionship to reduce isolation

   ☐ Support for caregiver or sibling trauma

   ☐ Behavioral de-escalation

   ☐ Other: _____

5. Are there any concerns or limitations you foresee in the applicant and their family's ability to care for or interact appropriately with a service animal?

6. Please include any additional comments or concerns here:

7. Based on your professional assessment, do you recommend a service animal as part of the applicant's treatment or support plan?

   ☐ Strongly Recommend ☐ Recommend ☐ Neutral ☐ Do Not Recommend

Provider Signature: _____ Date: _____