Health professional declaration

To be completed by a health professional.

I am currently practicing as a:

☐	Psychologist / Psychiatrist
☐	Physiotherapist / Osteopath
☐	Specialist (specify):
☐	Other Allied Health Professional (specify):

Please print using block letters

Health Professional's Name:	
Handler's Name:	
Duration of treatment:	

I declare that the following is true and accurate:

- I am not the applicant, or an immediate family member of the applicant; and
- I have read all the relevant information contained within this form, and verify that it is correct to the best of my knowledge; and
- I verify that the applicant has a disability and will require the services of an assistance dog to alleviate the effects of their disability.

Signature: ____

Date: ____________________

AHPRA Registration Number: _____________________________________

Professional Stamp (Must include name and address)

Please note: Changes in this section can be made only by the health practitioner and accompanied by their signature (not initials) and professional stamp.