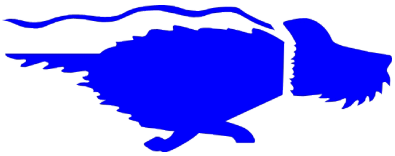

MrPAWS by Snow

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P O Box 17954
15453 E Golden Eagle Blvd.
Fountain Hills, AZ 85268
Tele: 480-837-0190 Fax: 866-591-3492
sales@mrpaws.com

PHYSICIAN'S STATEMENT

If your dog is for ***emotional support or PTSD***, your order must be accompanied by this form in order to validate your dog as a "working service dog." This is for our purposes only.

I, _____ give my permission for the below named physician to release the information requested in this form.

_____ _____
Name of patient Date

TO THE PHYSICIAN:

The individual listed above has stated that he has a condition which requires the assistance and constant companionship of a service dog. The Americans with Disabilities Act allows service dogs to accompany people with qualified disabilities into businesses that service the public. Please verify that it is your opinion that your patient has a qualifying disability by answering the following questions:

1. Is this person a patient of yours?_____
2. Is this person disabled?_____
3. What is the nature of his/her disability?_____
4. Is this person on medication or any other treatment?_____

Additional information_____

Physician Signature _____

Physician Name_____
Physician Address_____
Physician Tele_____ E-mail_____
Date _____