

# SERVICE DOG LETTER FROM DOCTOR

To Whom It May Concern:

I am a licensed medical professional duly authorized to practice medicine in Canada, and I certify that I have an ongoing therapeutic relationship with the individual named below. This individual has a disability as defined under applicable Canadian laws and regulations, and they rely on a trained service dog as a necessary part of their treatment and daily functioning.

## Patient Information:

Full Name: \_\_\_\_\_

Date of Birth (optional): \_\_\_\_\_

## Medical Professional Information:

Full Name: \_\_\_\_\_

Professional Title and Credentials: \_\_\_\_\_

License Number and Issuing Province: \_\_\_\_\_

Contact Information (Phone or Email): \_\_\_\_\_

## Service Dog Information:

Dog's Name: \_\_\_\_\_

Breed (optional): \_\_\_\_\_

Trained to Perform the Following Tasks or Work:  
\_\_\_\_\_

I certify that the patient requires the presence and assistance of their service dog to alleviate the effects of their disability and to assist with daily activities. The service dog is trained to perform specific tasks directly related to the patient's disability. This letter is provided to confirm the patient's need for their service dog in accordance with applicable Canadian laws, including the Canadian Human Rights Act and provincial human rights codes.

## Legal and Privacy Notice:

This letter is confidential and intended solely for the patient and any entities responsible for accommodating the patient's use of their service dog. It is provided in good faith to facilitate lawful accommodation as required by Canadian law. Unauthorized use or disclosure is prohibited. This document does not create any rights beyond those established by applicable law and should not be construed as a guarantee of service dog access beyond legal requirements.

## Acknowledgment:

I affirm under penalty of perjury that the information provided herein is true and accurate to the best of my knowledge and that I am authorized to make this certification. I understand that misrepresentation may be subject to legal penalties.

**MEDICAL PROFESSIONAL SIGNATURE**

**PATIENT ACKNOWLEDGMENT**

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

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