

ANNUAL VETERINARIAN CERTIFICATION OF THERAPY DOG

(Please use one form per dog)

Dog's Name: _____

Breed: _____ Age: _____

Owner's Name and Address:

Telephone # _____

Your Veterinarian is required to fill in the following information:

Vaccination Record (Please attach copy of current vaccination certificate)

Distemper	Date _____
Hepatitis	Date _____
Para-influenza	Date _____
Parvovirus	Date _____
Rabies	Date _____

I verify that to the best of my knowledge the above mentioned dog is physically fit and clean and able to participate in a visiting program to hospitals and nursing homes as a member of ST. JOHN AMBULANCE THERAPY DOGS.

Authorized Veterinarian's Signature: _____

Date: _____ Telephone #: _____

Address: _____