

ST. JOHN AMBULANCE THERAPY DOG PROGRAM

SUMMARY REPORT OF SUCCESSFUL THERAPY DOG (INITIAL) TEST

HELD ON _____ 19 ____

AT _____

| UNIT # | NAME, FULL ADDRESS & TELEPHONE # (please print) | DOG'S NAME | BREED | MEMBERSHIP APPLICATION ATTACHED (Y OR N) |
|----------|--|------------|-------|--|
| 1) _____ | _____ | _____ | _____ | _____ |
| 2) _____ | _____ | _____ | _____ | _____ |
| 3) _____ | _____ | _____ | _____ | _____ |
| 4) _____ | _____ | _____ | _____ | _____ |
| 5) _____ | _____ | _____ | _____ | _____ |
| 6) _____ | _____ | _____ | _____ | _____ |
| 7) _____ | _____ | _____ | _____ | _____ |
| 8) _____ | _____ | _____ | _____ | _____ |

PLEASE RECORD ANY ADDITIONAL COMMENTS ON THE REVERSE AND REFER TO DOG BY NUMBER

NOTE: PLEASE RETAIN ORIGINAL AND SEND COPIES WITH ACCOMPANYING DOCUMENTATION TO YOUR LOCAL THERAPY DOG COORDINATOR AND TO THE CHIEF EVALUATOR.

EVALUATOR'S SIGNATURE

EVALUATOR'S STAMP

DATE: _____

