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:_____

Stock Number: 600-015
01/10/96