ST. JOHN AMBULANCE THERAPY DOG PROGRAM

Veterinarian Certification

(Use one form per dog)

DOG'S NAME:

BREED: DATE OF BIRTH:

HANDLER'S NAME AND ADDRESS:

TELEPHONE: E-MAIL ADDRESS:

Your Veterinarian is required to fill in the following information:

Vaccination Record
(Please attach copy of current Rabies and additional vaccination certificates)

		Date Administered	Date To be re-administered
❒	Distemper		
❒	Para-influenza		
❒	Parvovirus		
❒	Rabies		
❒	Hepatitis		

Has this dog, to the best of your knowledge, ever been known to display any aggressive tendencies, either towards people or towards other animals, i.e. biting, etc.? ❒ YES ❒ NO
If yes, please clarify, i.e. fear aggressive, dominant aggressive, etc.

_____
_____
_____

I hereby certify above-mentioned dog is physically fit and clean and able to participate in a visiting program to hospitals and long-term care facilities as a member of the St. John Ambulance Therapy Dog Program (subject to the St. John Ambulance dog evaluation process).

VETERINARIAN'S SIGNATURE: VETERINARIAN'S NAME (PLEASE PRINT):

DATE: TELEPHONE:

ADDRESS: EMAIL: