



Annex G

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 vaccination certificate)

Table with 2 columns: Administered, Date To be re-administered. Rows include 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: