Therapy Dogs of Long Island

Dogs are Good Medicine!

therapydogsli.org
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Handler/Owner Questionnaire	
Owner/Handler Name	Dogs Name / D.O.B./ Breed
_____	_____
Email Address	Dogs Favorite Activity
_____	_____
Phone _____	Address_____
Availability Days/Times_____	_____
Occupation _____	Emergency Contact _____
How many hours a month for visits _____	Owner's Month and Year of Birth _____/_____

Please complete the following questionnaire		
How long have you owned your dog? (must be at least 6 months)	_____	
Is your dog friendly with strangers?	Yes ____	No ____
Is your dog up to date on the rabies & distemper vaccines? **Proof of vaccines must accompany this document.**	Yes ____	No ____
Is your dog in good health?	Yes ____	No ____
My dog and I have passed the Canine Good Citizen test within the last year. **The Certificate or test must accompany this document.**	Yes ____	No ____
Is your dog house broken?	Yes ____	No ____
I have full control of my dog while on a leash with a regular collar or I carry my dog.	Yes ____	No ____
I am willing to commit to at least 12 visits a year.	Yes ____	No ____
Has your dog every seriously injured or killed a dog or cat?	Yes ____	No ____
Is your dog taking any medication? If yes, please explain	Yes ____	No ____
Is your dog hand shy?	Yes ____	No ____
Has your dog ever growled or bitten a human?	Yes ____	No ____
Is your dog on a raw diet?	Yes ____	No ____

Signature_____ Date _____

Guardian_____ Date _____

_____

Guardian Name, Address & Phone

Email this form and your Proof of vaccines and CGC Certificate to therapydogsli@gmail.com

application