



## Mission Working Dogs

49 Ash Street #1343, Lewiston, ME 04243

info@missionworkingdogs.org



### Mission Working Dogs Therapy Dog Application

Please use this checklist to help you prepare your application.

1. Completed this application:
2. Current full-length photo via email or printed on 8.5x11” of the handler candidate and candidate dog:
3. \$50 non-refundable application fee (check or money order):
4. Veterinary Form (if owner-trained):
5. Veterinary Records (if owner-trained):

#### Applicant Information

Applicant Full Legal Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Physical Address (If different): \_\_\_\_\_

Phone Number: \_\_\_\_\_ Alt Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth : \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: \_\_\_\_\_

Have you ever been convicted of a felony or misdemeanor? \_\_\_\_\_

If Yes, please explain (may provide further explanation on another page if needed):

\_\_\_\_\_  
\_\_\_\_\_

Marital Status: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Personal Reference #1 Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Initial:



## Mission Working Dogs

49 Ash Street #1343, Lewiston, ME 04243

info@missionworkingdogs.org



Email: \_\_\_\_\_

Personal Reference #2 Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

Personal Reference #3 Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

Who will help with the dog if you become ill and cannot? \_\_\_\_\_

Helper's phone number: \_\_\_\_\_

How did you hear about us?

\_\_\_\_\_

Employment status: \_\_\_\_\_ Occupation: \_\_\_\_\_

Years experience: \_\_\_\_\_

Do you volunteer? \_\_\_\_\_ If yes, where? \_\_\_\_\_

Description of volunteer work and frequency:

\_\_\_\_\_

Are you a student? \_\_\_\_\_ If yes, where? \_\_\_\_\_

Highest level of education achieved? \_\_\_\_\_

How's your upper body and core strength? \_\_\_\_\_

Is one hand/arm stronger than the other? \_\_\_\_\_

Initial:



## Mission Working Dogs

49 Ash Street #1343, Lewiston, ME 04243

info@missionworkingdogs.org



### Background Information

Do you live in a House, Condo or Apartment? \_\_\_\_\_

Own or Rent? \_\_\_\_\_ One level living or multiple floors? \_\_\_\_\_

Do you have a yard? \_\_\_\_\_ Is the yard fenced? \_\_\_\_\_

Please describe your neighborhood:

\_\_\_\_\_

How many people are in your household? \_\_\_\_\_ Please list name, age, relationships:

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

4) \_\_\_\_\_

What are your hobbies/interests?

\_\_\_\_\_

\_\_\_\_\_

What's a typical day like for you?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you drive? \_\_\_\_\_ How often do you travel? \_\_\_\_\_

Please list any other pets in the household:

\_\_\_\_\_

Direct neighbors pets:

\_\_\_\_\_

Initial:



## Mission Working Dogs

49 Ash Street #1343, Lewiston, ME 04243

info@missionworkingdogs.org



### Therapy Dog Information

What Program are you applying for (Owner-Trained Therapy Dog or MWD Provided Therapy Dog)? \_\_\_\_\_

Have you had a Therapy Dog before? \_\_\_\_\_ Pet dog before? \_\_\_\_\_

Have you ever given away, surrendered, or sold a pet? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Have you ever attended dog training classes? \_\_\_\_\_

Where do you plan on working your therapy dog(facilities, people, etc.)?  
\_\_\_\_\_

How many hours a day/week do you expect to have your Therapy dog work?  
\_\_\_\_\_

Where will your Therapy Dog be during the day? \_\_\_\_\_

Where will your Therapy Dog be at night? \_\_\_\_\_

Where will your dog be expected to relieve itself? \_\_\_\_\_

Where will your dog be exercised? \_\_\_\_\_

Where will your dog have play/free time? \_\_\_\_\_

How many hours a day will your Therapy Dog be alone? \_\_\_\_\_

If accepted, will you be able to come to the training center for weekly classes to work with your dog until you are ready to be certified as a team? \_\_\_\_\_

If no, please explain: \_\_\_\_\_

If you had help filling out this application, please list the person who helped:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Contact information: \_\_\_\_\_

Initial:





## Mission Working Dogs

49 Ash Street #1343, Lewiston, ME 04243

info@missionworkingdogs.org



### Dog Information(if Owner-trained)

Dog's Name: \_\_\_\_\_ Breed: \_\_\_\_\_

Dog's DOB/Age: \_\_\_\_\_ Date of last physical: \_\_\_\_\_

Veterinarian Practice: \_\_\_\_\_

Veterinarian's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

***\*\*Please make sure you attach the Veterinary Form to this Application\*\****

Tell us about your dog and why you think he/she would make a good Therapy Dog?

---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---

Initial:



## Mission Working Dogs

49 Ash Street #1343, Lewiston, ME 04243

info@missionworkingdogs.org



### Consent to Contact

I, \_\_\_\_\_, give consent for staff from Mission Working Dogs to contact my veterinarian, references and helpers with regard to my possession of a fully trained therapy dog, ability to care for the dog, and any other necessary questions for the purpose of assessing my qualifications to have a therapy dog and ability to provide a suitable life for the dog. Mission Working Dogs may also conduct a criminal background check at any time before or during placement of a Therapy Dog with me.

I certify that, to the best of my knowledge, the information provided in this application represents my needs and present situation. I understand that failure to provide complete, accurate, and honest information will permanently disqualify me from being eligible to receive a Therapy Dog from Mission Working Dogs. This would also result in immediate removal from either the program or waiting list if I have already been accepted under false pretenses.

I further understand that Mission Working Dogs reserves the right to remove any accepted, or scheduled, applicant/candidate from the waiting list, at any time, for any reason. I understand that any person Mission Working Dogs does not feel would be a good fit for our program can also be denied any dog from the agency.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



## Mission Working Dogs

49 Ash Street #1343, Lewiston, ME 04243

info@missionworkingdogs.org



### Therapy Dog Veterinary Form

Owner's Name: \_\_\_\_\_ Dog's Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Date of Exam (must be within 3 months): \_\_\_\_\_

**Physical Examination Findings: N= Normal A=Abnormal NE=No Exam**

1. Attitude/Appearance	2. Oral Cavity/Teeth	3. Mucous Membranes	4. Eyes
5. Ears	6. Cardiovascular	7. Respiratory	8. Gastrointestinal
9. Musculoskeletal	10. Lymph Nodes	11. Urogenital	12. Integumentary
13. Nervous System	14. Pain	T _____ R _____	P _____ WT _____

Please explain any abnormal findings:





## Mission Working Dogs

49 Ash Street #1343, Lewiston, ME 04243

info@missionworkingdogs.org



### Vaccination History:

If vaccination wasn't administered, please provide vaccination titer results.

	<u>Date Given</u>	<u>Date Due</u>
Bordetella	_____	_____
Distemper	_____	_____
Parvovirus	_____	_____
Adenovirus	_____	_____
Parainfluenza	_____	_____
Leptospirosis	_____	_____
Rabies	_____	_____

### Laboratory Findings:

Must be performed annually

Fecal Examination: \_\_\_\_\_  
Date Results

Heartworm Testing: \_\_\_\_\_  
Date Results

**External and Internal Parasite Control(s) used and frequency (year round/seasonal):**



## Mission Working Dogs

49 Ash Street #1343, Lewiston, ME 04243

info@missionworkingdogs.org



### Medications currently used:

This canine will be used as a Mission Working Dogs Therapy Dog and will be visiting many public buildings. I certify that I have performed a physical examination of the canine described on this certificate and found him/her to be free of disease, in good health, fully vaccinated for zoonotic diseases, and negative for parasites. Further, this canine is physically able to participate in at least one hour (weekly) of group activity in a therapeutic setting. This Certificate of Health will be relied upon by medical facilities for one year from the date below.

\_\_\_\_\_  
Veterinarian's Name

\_\_\_\_\_  
Veterinarian's Signature

\_\_\_\_\_  
Clinic Phone Number

\_\_\_\_\_  
Clinic Name/Address

\_\_\_\_\_  
Clinic Email