



Mission Working Dogs
 152 Moxie's Place, Oxford ME 04270
 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: _____

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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? _____

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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:

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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: _____

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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: _____



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Therapy Dog Veterinary Form

Owner's Name: _____ Dog's Name: _____

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

Date of Birth: _____ Microchip #: _____

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:



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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):



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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