UF HEALTH JACKSONVILLE
VOLUNTEER SERVICES DEPARTMENT
Dog Therapy Volunteer Application Supplemental Form

Today's Date: _____

Name _____
Last First MI

Address _____ Apt # _____ City/State _____ Zip ___

Home phone _____ Daytime phone _____

Dog's Name _____ Age _____ Breed _____

Veterinarian's Name _____ Phone _____

Are you currently a member of a pet therapy program or organization? _____

If so, please list name and town it is located in _____

Day/Time available to participate in dog therapy program: _____

How often would you be available to volunteer (i.e. weekly, biweekly)? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Has the dog had any obedience training? _____

Does the dog have its AKC Canine Good Citizen Certificate? _____

How does the dog react to other dogs? _____

(OVER)

Does the dog dislike slippery floors? _____

How does the dog react to loud noises? _____

Is the dog afraid of strange objects? _____

Had the dog ever bitten anyone? _____

Does the dog like or dislike children? _____

Is the dog current on inoculations/ teeth cleaning? _____

Does the dog do any tricks? (ask me) _____

Is the dog friendly to strangers? _____

Does the dog jump on people? _____

Does the dog consume raw meat as a part of their diet? _____

Explain how you think the dog will react to hospital equipment (i.e. wheelchairs, crutches, noisy equipment, etc.) _____

_____

_____

_____

Any further comment _____

_____

_____

_____

Date _____ Applicant's Signature _____