U.S.A. Therapy Dogs, Inc.

Veterinarian Authorization

Owners Name_____

Address_____

_____

_____

Phone: Hm_____Cell_____

Pets Name: _____Male_____Female_____

Breed_____Spayed/Neutered Yes _____ No _____

Pets Date of Birth_____/_____/_____

Date of Annual Exam_____/_____/_____

Date of Rabies Vaccination_____/_____/_____ Expires: _____/_____/_____

Date of Distemper Vaccination_____/_____/_____ Expires: _____/_____/_____

Date of Leptospirosis Vaccination_____/_____/____ Expires: _____/_____/_____

Date of Bordetella Vaccination_____/_____/_____ Expires: _____/_____/____

Date of Fecal Check _____/_____/_____ Negative_____Positive_____

Date of Heart worm Check_____/_____/_____ Negative_____Positive_____

If dog has vaccine titer, pleases attach a copy of the results

Clinic Stamp_____Date: _____/_____/_____

Veterinarian Signature_____

***U.S.A. Therapy Dogs Office Only ***

_____ Date: _____/_____/_____

Ann Bruno Chief Medical Officer