Pet Therapy Program Application

First Name: Last Name:

Email: Telephone Number:

Dogs Name: Dogs Gender:

Dogs Breed: Dogs Birth Date:

Name of Your Veterinarian:

Telephone Number of Your Veterinarian:

What kind of training has your dog had?

How is your dog around children?

Is your dog shy of men or women?

How did you hear about us?

Are you 18 years of age or older?
    Yes
    No

Can you serve at least 1 year doing this work?
    Yes
    No
    No Sure

Are you willing to comply with hospital policy regarding mandatory annual flu shots?
    Yes
    No

Are you an employee of Broomfield Hospital?
    Yes
    No

Are you and you dog presently registered?
    Alliance of Therapy Dogs
    Pet Partners
    Therapy Dogs International
    I am not registered with any of the above

Do you have any therapy dog visiting experience?

You may return your response by email to Broomfieldvolunteers@uchealth.org or by mail to:

Broomfield Hospital
Volunteer Services Department
Attention: Julie Adams, Manager, Volunteer Services & Retail
11820 Destination Dr.
Broomfield, CO 80021