

EQuality Dog Training  
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Fax: (520) 207-8967  
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# Veterinarian's Statement

## Dog Training.

Client' s Name: \_\_\_\_\_ Dog' s Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of dog's last office visit: \_\_\_\_\_

Dog's general physical health: \_\_\_\_\_

Dog's mental health: \_\_\_\_\_

Is dog under treatment for any chronic or acute condition? \_\_\_\_\_

If so, please explain: \_\_\_\_\_

Dog's approximate age: \_\_\_\_\_ Weight: \_\_\_\_\_ M/F Date of Spay/Neutered \_\_\_\_\_

Is dog overweight? \_\_\_\_\_ Underweight? \_\_\_\_\_

Dates of the following: Eye Exam: \_\_\_\_\_ Internal Parasite Check: \_\_\_\_\_

DHLLP: \_\_\_\_\_ Bordetella: \_\_\_\_\_ (optional) Rabies Vaccination: \_\_\_\_\_

Has dog ever attempted to bite you or any of your staff? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please describe circumstances: \_\_\_\_\_

\_\_\_\_\_

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

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

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Date

I, \_\_\_\_\_, give permission for the above named veterinarian to release the information requested in this form to EQuality Dog Training.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

This statement must be submitted with the enrollment application.