2010 APPLICATION FOR MEMBERSHIP ** THERAPY DOGS INCORPORATED

TYPE OR PRINT LEGIBLY USING BLACK INK   *INDICATES REQUIRED INFORMATION FOR MEMBERSHIP

For each handler/dog team, send the applicable membership fee, **ORIGINAL COPY** of the completed and signed Application, Test and Release of Claims forms to the address below within six months of the test date.

You must attach a copy of proof of rabies vaccination

Membership classification and fees: All fees include 1 dog. Additional dogs $10 each.
New member processing fee $10
Single $25 -- one handler, one dog
$10 each additional evaluated member in the same household
Supporting $20 -- members who support TDInc. without a dog
Minimum age for membership is 16 years

***MEMBERSHIP check applicable entries:** New Member ___ Single___ Additional Member____ Supporting___
Existing Member (adding new dog)____________ Member ID#___________________

***APPLICANT Name** ____

***Street**____

City/State**____Zip**________________

***Phone (_____)**___________ **E-mail** ____

Dog's Call Name** ____Breed or Mix type** _______________
***Dog's date of birth if known, or approximate age (minimum 1 year)**_______________ **Male** _____ **Female**_____

I certify that I have read and that I understand the TDInc. Rules and Regulations and insurance coverage as set forth by TDInc. I agree to abide by these regulations when working my dog under the name of TDInc. My dog will wear the official red heart-shaped TDInc. identification tag and I understand that I will be covered for liability under the TDInc. insurance plan while participating in visits under the name of TDInc. I hereby certify that I will comply with all the TDInc. Rules and Regulations and provide the required annual veterinary care as set forth by TDInc. I further ascertain that my dog is in compliance with state and local laws regarding, but not limited to, vaccinations and licensing. I understand that as a TDInc. member, I am required to make a minimum of 4 visits with my dog per year.

APPLICANT
***SIGNATURE**____*Date_____________
*Age of Applicant (if minor) _______
***Signature of Parent/Guardian if applicable**____

*****REQUIRED*****

I have examined the dog listed on this application and believe that this dog is healthy, free of internal and external parasites *(**negative fecal exam-result date** ___________)* and is current on vaccines as required by law and appropriate for the area of residence.

Veterinarian or clinic (signature or stamp)
____ Date______________

NO ELECTRONIC CHECKS OR EFT'S WILL BE ACCEPTED
SEND CHECK OR MONEY ORDER IN U.S. FUNDS ONLY TO:THERAPY DOGS INCORPORATED
P.O. BOX 20227 CHEYENNE, WYOMING 82003 Phone: 1-877-843-7364
E-mail us at *therapydogsinc@qwestoffice.net* *http://www.therapydogs.com/*
THIS APPLICATION EXPIRES SIX MONTHS FROM DATE OF TEST