sibilities Unleashed

Therapy Visit Request

Date: _____

Name of person requesting visit: _____

Where will this visit take place? ☐ Nursing Home ☐ Medical ☐ School ☐ Retirement home ☐ Day Care (adult / child) ☐ Assisted Living ☐ Behavioral Health ☐ Library ☐ Hospice

☐ Other: _____

Name of facility: _____

Address: _____

_____

Facility Contact person: _____

Phone: _____Email: _____

Where will the teams need to report on their first visit? _____

Please check what you would like our therapy dog teams to do during their visit:

- ☐ Petting sessions
- ☐ Reading to the dogs
- ☐ Doing tricks with dogs
- ☐ Other _____
- ☐ Therapy interaction
- ☐ Work with Therapist/Teacher (AAT)
- ☐ Socialization activities

Please list days and times that you would like teams to visit: _____

_____

Please tell us the date you would like the visits to begin: _____

Please tell us the frequency you would like the visits to be: _____

How many teams (dog and handler) would you like to attend your facility at each visit? _____

Where will the dogs be able to have potty breaks? _____

Are there any additional requirements for your facility? (background checks, health screening, etc.) _____

If yes, please list: _____

Where will visits occur? (patient rooms, common area, etc.) _____

_____

Will you allow teams that are not fully certified yet? _____

By signing this form, I am certifying that our facility has approved the visits of therapy dogs from Pawsibilities Unleashed and I am authorized to request these visits.

_____ _____

Signature Date

Note: Please Email completed form to therapydoginquiry@pawsabiltiesunleashedky.org