FACILITY REQUEST FOR C.A.T. DOG SERVICE FORM

FACILITY INFORMATION

Facility Name: ______________________________ Application Date: ______________

Type of Facility: Hospital Nursing Home Assisted Living Adult Day Care Group Home

Other: ______________________ Number of Patients/Residents: ______________

Facility Address: ______________________________

City: ______________________ State: __________ Zip: ______________

Main Phone: ________ ______________ Fax: ______________________

Website Address: ______________________________

Contact Name: ______________________Title: ______________________

Contact Phone: ______________________ E-mail Address: ______________________

How did you hear about C.A.T? *(Newspaper, ad, member referral, etc.)*: ______________________

SERVICE SPECIFICS

Primary language spoken by your patients/residents: ______________________

Where will the C.A.T. Dogs be visiting?: Individual Rooms Common Areas Other: ______________

Are there any areas that are off limits to C.A.T. Dog Teams?: ______________________

How many teams would you ultimately like to have visiting at one time?: ______________________

How many teams would you like throughout the week?: ______________________

Days of the week you would like visits?: Monday Tuesday Wednesday Thursday Friday Saturday Sunday

What hours are available for visits?: ______________________

Will the Teams be accompanied by a representative of the facility for all of their visits?: Yes No

If Yes, who will be accompanying the Teams?: ______________________

Will the Teams be required to check/sign in with each visit? Yes. Check in location: ______________

Are there any special rules that you wish for the Volunteers to follow? No dogs on beds Close toe shoes No cologne

Other: ______________________________

Canine Assisted Therapy Volunteers are required to undergo a background check. Do you require additional background checks or other information?: Yes No
If "Yes", please describe your requirements: ______________________

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