St. John Ambulance Therapy Dog Certification Seminar Application

To: Provincial Evaluator
St. John Ambulance
565 Marshall Rd. RR # 2
Midland ON L4R 4K4

Tel: 705-528-1772
Fax: 705-528-0266

Name of Applicant: _____ Address: _____

Unit/Branch: _____ City: _____

Phone (Home): _____ Postal Code:_____

Phone (Work): _____ Fax: _____

Position currently held: (e.g. Evaluator, Ass. Evaluator, Coordinator other): _____

Position applied for: _____

Length of Service with St. John Ambulance: _____

Number of evaluations conducted or assisted with last year: _____

Number of dogs evaluated last year: _____

Date of Session you are planning to attend: _____

Comments or Topics you would like to discuss at the seminar: _____