



HEALTH CERTIFICATE

Date of Rabies Vaccine: _____

Date of Examination: _____

Expiration Date: _____

Note

If the vet is unavailable, please submit your record of vaccinations which will suffice for the health certification.

Last Name	First Name	M.I.	Phone Number
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Address	City & State	Zip	County
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Dog's Name	Breed	Color	Age	Sex
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This is to certify that the dog described above was examined by me on the date indicated and found to be free from symptoms of infectious, contagious, or communicable disease or known exposure thereto and that all common vaccines available for the species have been administered within the past year.

D.V.M

License No.

Address	City & State	Zip
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(*Canines for Christ* Therapy Dog Volunteer is responsible for having pet certified and returning this form)

www.k9forchrist.org
813-601-4937