The Child Life, Education and Creative Arts Therapy Department

Dear Paw Partners Pet Therapy Program Applicant:

Thank you for your interest in the Paw Partners Pet Therapy program at The Children's Hospital of Philadelphia. Paw Partners originated on the belief that dogs offer a therapeutic value to children that human family members and hospital staff cannot give. This program gives children the opportunity to interact safely with the dogs and receive their unconditional love and acceptance in the hopes of making the hospital environment more comfortable and less stressful. Our program involves trained volunteers and their dogs who visit the children at The Children's Hospital of Philadelphia. All volunteers are taken through an application process, given an interview and oriented to the pet therapy program by coordinators and/or current volunteers. In addition, all dogs will be required to have a medical and behavioral screening through the University of Pennsylvania's Veterinary Hospital (VHUP) to ensure they meet the requirements of the programs as well.

In this packet you will find information, guidelines, and forms necessary to apply for participation in the Paw Partners program. Your application cannot be processed unless we receive ALL of your information. Please refer to the checklist enclosed to ensure that all necessary information is mailed to:
"

The Children's Hospital of Philadelphia
Paw Partners Pet Therapy Program
Room 8540- Main Bldg.
34th Street and Civic Center Blvd.
Philadelphia, PA 19104-4399

We are excited about you and your dog's interest in the Paw Partners program. If you have any questions on any of the information in this packet please call me at 267-426-7839 or email me at virgilion@email.chop.edu.

Sincerely,

Natalie Virgilio
Events & Donations Coordinator
Child Life, Education and Creative Arts Therapy Department

Steps to Becoming a Paw Partners Volunteer

To ensure the safety of our patients as well as our volunteers and their pets, the following steps are required of all applicants to be part of the Paw Partners program.

1. Return the completed Paw Partners application packet:
   - Application for Volunteer program
   - Dog History form
   - Signed agreement to Guidelines
   - Copy of certificate from certification organization

2. Interview with the Volunteer Department/Paw Partners Coordinator

3. Be cleared by the hospital's Occupational Health Department and/or receive TB test if a recent screening has not been obtained by applicant.

4. Receive medical and behavioral screening (for dog) through the Veterinary Hospital at the University of Pennsylvania. All medical tests must come back negative.

5. Attend a 3 hour mandatory volunteer orientation.

6. Attend an orientation to the Paw Partners volunteer experience for 1 or 2 visits with your dog to get a feel for the program and how a typical volunteer visit runs.

7. Continue with unsupervised/independent visits once you are comfortable with your assignment.

THE CHILDREN'S HOSPITAL OF PHILADELPHIA
CHILD LIFE, EDUCATION & CREATIVE ARTS THERAPY DEPARTMENT

PAW PARTNERS GUIDELINES AND POLICIES

Please read the information below. It is very important that you are familiar with these guidelines and adhere to them. After you have read and agree to follow the guidelines, please sign and return the agreement.

Eligibility Criteria

1. Dog must be at least one (1) year old and have lived in the current household for at least six (6) months. All handlers must be at least eighteen (18) years of age.

2. Dog must be certified either through Therapy Dogs International, Therapy Dogs Incorporated, Delta Society of Comfort Caring Canines. **Proof of certification must be mailed to us**.

3. **Dog cannot be on a raw foods diet at any time during their participation in the program.** Raw food diets present an increased risk of pathologic bacterial and protozoal shedding and infection that can compromise the health of our patients.

4. The Veterinary Hospital of the University of Pennsylvania (VHUP) must medically and behaviorally test dogs whose owners apply for them to participate in the Paw Partners program following the completion of the hospital volunteer orientation process.

5. Veterinarian records must be updated twice a year (once a year at VHUP and once a year at your personal vet). If your dog spends any time in a kennel or becomes ill, a fecal sample needs to be cleared through VHUP (the appropriate collection container can be obtained from the Child Life Dept.).

6. In compliance with volunteer department procedures, owner must have current medical records form with all appropriate vaccinations tests, and health screening completed (this includes the necessary TB test).

7. Paw Partners volunteers must remain compliant with Volunteer department standards by completing all organizational mandatory education.

8. Paw Partners volunteers will commit to at least one (1) day per month.

Procedure for Paw Partners Visits

1. The owner/dog team will be on probation for a total of three (3) to five (5) visits. At which time an evaluation will be completed for permanent enrollment in the program.

2. Dog must be washed within 24 hours of the visit and dry upon entering the hospital (please refrains from using any flea and tick topical 2 days prior to visit).

3. Dog must be on a leash (except with obedience exercises which must be previously approved).

4. Dog must wear a **bandana** to identify that the dog is a Paw Partners dog.

5. Owner must wear an ID badge and a volunteer vest or polo at all times while in the hospital. ID badge is necessary for free parking.

6. In the event of incontinence, volunteer owner is responsible for contacting the appropriate department for proper clean up.

Undesirable Dog Behaviors

1. In the event of a dog bite to patient, family or staff member, volunteer owner and dog will be immediately escorted out of the building and dismissed from the program.

2. In the event of aggressive or inappropriate behaviors (e.g. uncontrolled barking, inability to follow commands) volunteer owner will be escorted out of the building. The Child Life, Education & Creative Arts Therapy Department will consult with VHUP behavioral specialist and owner to determine appropriateness of pet continuing in the program.

Death of a Dog

1. In the event of a death of a dog in the Canine assisted therapy program, the Child Life and Education Department requests notification of cause of death within 24 hours of actual death.

2. If cause of death unknown, the Child Life and Education Department will alert the hospitals Infection Control Department and will arrange for a complete necropsy to be performed at VHUP to determine cause of death and eliminate any potential questioning of harm to patients.

Please sign and return with application to the Paw Partners Program at The Children's Hospital *of* Philadelphia

I, ______________________________, have read the guidelines of the Paw Partners program at The Children's Hospital *of* Philadelphia and agree to abide by them. I also understand that any incident that is viewed as aggressive **or** inappropriate will result in the dismissal of my dog and myself from the Paw Partners program.

Signature ______________________________**Date**______________________________

Pet Therapy Certification Organizations

The following are organizations that will certify your dog to be a participant in a pet therapy program. They are all accredited organizations and will allow for your dog to be considered for participation in the Paw Partners Pet Therapy program at The Children's Hospital of Philadelphia. Please check the organizations website for local testing sites and dates.

Therapy Dogs International
88 Bartly Road
Flanders, NJ 07836
(973) 252-9800
www.tdi-dog.org
tdi@gti.net

Delta Society
875 124th Ave NE, Ste 101
Bellevue, WA 98005
(425) 226-7357
www.deltasociety.org
info@deltasociety.org

Therapy Dogs Inc.
P.O. Box 20227
Cheyenne WY 82003
(877) 843-7364
www.therapydogs.com
therapydogsinc@qwestoffice.net

Comfort Caring Canines
8135 Lare Street
Philadelphia, PA 19128
www.comfortcaringcanines.org
ccc@comfortcaringcanines.org

The Children's Hospital of Philadelphia
A pediatric healthcare network

PAW PARTNERS VOLUNTEER APPLICATION

The Hospital is an Equal Opportunity/Affirmative Action employer seeking qualified candidates regardless of race, religion, color, sex, age, marital status, national origin, gender preference, mental handicap or veteran's status, in conformity with applicable laws. This application is active for six months. If you have not been selected within six months and wish to remain in consideration for a volunteer position, you must reapply. ***Please print responses to all questions below***:

Date of Application:

Last Name: First: MI:

Home Phone: Cell Phone:

E-mail Address:

Street Address: City: State: Zip Code:

Are you eligible to work in the U.S.? ☐ Yes ☐ No Are you under the age of 18? ☐ Yes ☐ No

Paw Partners; Pet Therapy program:

Dog's Name:____

How did you learn about our volunteer programs? ☐ CHOP website ☐ CHOP Employee/Volunteer ☐ School/College
☐ Other Specify Name of Referral Source: ______________________________

EDUCATION	High School	College/University	Graduate/Professional	Trade or Business
School Name & Address				
No. of Years Completed				
List Major Course of Study				
Did You Graduate?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
List diploma/degree/ highest achievement/Year awarded				

Describe abilities, experience, special skills, languages and other qualifications, which may qualify you for the position for which you are applying.
____
____

Do you have any cultural, ethnic or religious reasons that would impact your ability to provide treatment or patient care under any and all conditions? ☐ Yes ☐ No
If yes, explain: ____
(***This question****, required by the Joint Commission on Accreditation of Healthcare Organization Standards,* ***must be completed***).

AVAILABILITY

Mornings____ **Afternoon____** **Evenings____**

Circle Day(s) **Monday** **Tuesday** **Wednesday** **Thursday** **Friday** **Saturday** **Sunday**

PERSONAL REFERENCE (no relatives please)

Name: ______________________ **Phone Number:** ______________________

Mailing Address: ____

Email Address: ____

Have you had previous experience working with children in any capacity? If so, please describe.

____

____

PREVIOUS VOLUNTEER EXPERIENCE

1. Organization____**Dates:** ____________________________
City/State: ____
Duties____

2. Organization____**Dates:** ____________________________
City/State: ____
Duties____

Please state briefly the reason(s) why you desire to become a member of the volunteer program at The Children's Hospital of Philadelphia.

____

____

Are you able to perform the duties of the job for which you are applying? ☐ Yes ☐ No

Are you a current CHOP Employee? ☐ Yes ☐ No
If yes, please supply the following information:
Department______________________________________**Date of hire:**_________________________
Direct Supervisor's Name: ____________________________**Phone Number:**________________________
Is your direct supervisor aware that you are applying to become a CHOP volunteer? ____ **YES** ____ **NO**
Are you currently or have you ever been on Counseling in regards to your job? ____ **YES** ____ **NO**
If yes, please explain:____

Direct Supervisor's Signature: ____

Have you applied previously to CHOP? Yes ☐ No
If yes, when? _________________________

Have you ever been employed at CHOP? ☐ Yes ☐ No
If yes, reason for leaving: _________________________

Is any family member a CHOP employee? ☐ Yes ☐ No
Name of family member: ______________________

Are you known to anyone, anywhere by another name?
☐ Yes ☐ No
If Yes what name(s)? ____________________________

Are you on lay-off and subject to recall with another employer? ☐ Yes ☐ No

Do you have commitments to another employer or business interest that might affect your volunteer commitment at CHOP? ☐ Yes ☐ No
If yes, explain: ____

AGREEMENT

I certify that the information provided on this application is true and complete to the best of my knowledge, and agree that falsified Information or significant omissions may disqualify me from further consideration for volunteering and, if I am accepted to be a volunteer, will result in my dismissal when discovered. I understand that, if accepted as a volunteer, I will be required to abide by all of the policies, rules and regulations of the Hospital. I authorize the Hospital to investigate all statements contained in this application and to make inquiries of my personal reference and medical history, as well as other related matters as may be necessary for arriving at a decision of acceptance into the volunteer program. I hereby release employers, schools or individuals from all liability in responding to inquiries relative to my volunteer application.

Signature of Applicant ____ **Date** ______________________

Dog History

Dog Name_______________________________ Breed __________________________________
Date of Birth_____________________________ Weight __________________________________
Coat Length______________________________ Sex ____________________________________
Is your dog a wolf hybrid? ____________

Certification____Number___________________
Organization____________________________________
Address____
Phone No. _________________________

Owner____
Address ____
City_______________________________________ State____________ Zip________________
Telephone: Home_________________________ Work______________________________
E-mail_______________________________________

Personal Veterinarian____
Address ____
City ____ State ____________ Zip _______________
Telephone ____________________________________
Any major medical history or illnesses? _____ if yes, explain________________________________
____
Is the dog currently on any medications? ____ if yes, list__________________________________
____

Comment on how your dog relates to:
Men: ____
Women:____
Children: ____

Does your dog dislike any of the following? Please explain:

___ other dogs ____
___ being excessively touched ____
___ tiled or slippery floors ____
___ strange objects ____
___ loud noises ____
___ other: ____

Signature____Date_______________________

Revised 4/09

THE CHILDREN'S HOSPITAL OF PHILADELPHIA
CHILD LIFE, EDUCATION & CREATIVE ARTS THERAPY DEPARTMENT

Paw Partners Pet Therapy

ANNUAL DOG HEALTH SCREENING
Personal Veterinarian

Owner:
Dog's Name:
Breed:_________________________ **Age:**_______ **Sex:** ☐Male ☐Female
Veterinarian's Name:____
Address:______________________**City**__________________**State**____**Zip**___________
Phone Number:_______________________________

The following needs to be completed by a Veterinarian:

1. Physical Exam:
   Date
   If abnormal, explain:

2. Routine Fecal Exam (for intestinal parasites):

   _____________________________ Results:___________________________________
   Date

3. Last DHLPP Booster: _
   Date
4. Rabies vaccination date: _________________ ☐1yr. ☐3yr.

5. Heartworm Exam: _____________________ Results:____________________________
   Date

6. Has the dog had Sarcoptic Mange within the last six (6) months?
   ☐ Yes ☐ No
   If yes, dog must demonstrate one (1) negative skin scraping. Results:
7. Has the dog had Dermatophytes (Ringworm) within the last year?
   ☐ Yes ☐ No
   If yes, a negative fungal culture and a negative woods light examination are required.
   Test performed: ___________________ Results:__________________________

I have examined the above dog and believe the information I have provided to be true.

____
Veterinarian's Signature

Print Name

____
Date

CHECKLIST

Before returning the application to the Child Life Department please read all of the information carefully and make sure all forms are complete and accurate. **Your application cannot be processed unless we receive all of the following information:**

- ❑ Application for the Volunteer Program
- ❑ Dog History Form
- ❑ Copy of certificate from Therapy Dogs International, Therapy Dogs, Inc., Delta Society, or Comfort Caring Canines.
- ❑ Signed agreement to the guidelines