

The AGILITY UNDERGROUND

Date: _____

Handler Information (Please Print):

First Name: _____ Last Name: _____

Street Address: _____ P.O. Box: _____

City: _____ State: _____ Zip: _____

E-mail address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Where did you hear about The Agility Underground?

When are you interested in starting training?

What is your availability times for lessons?

Monday: _____ Tuesday: _____ Wednesday: _____

Thursday: _____ Friday: _____ Saturday: _____

Dog's Information (Please Print):

Dog's Name: _____ Breed: _____ Age/ DOB: _____

Sex: Male Female Spayed/Neutered? Color & Markings: _____

Please describe your dogs previous training (if any.)

Please mail or fax form to Cloverleaf Animal Hospital.

P.O. Box 712 Westfield Center, Ohio 44251-0712

Phone: 330.948.2002

Fax: 330.948.4012

E-mail: agility@cloverleaf.org