MVMA CHARITIES
Massachusetts Veterinary Medical Association

STRAY ANIMAL PROGRAM

REQUEST FOR FUNDS

Name of town/city: _____

Name of contact Animal Control Officer: _____

Contact Phone number(s):

1. Home Work Cell _____

2. Home Work Cell _____

(Please circle a phone description for each number listed)

Mailing Address: _____

_____

Email Address: _____

NOTE: This request MUST include a receipt or statement from the service provider indicating the animal name/ID and total cost of services not yet paid. Funds request should be submitted within 30 days of last date of service.

Name/ID of Animal: _____

Breed_____

Sex_____

Date(s) of Service(s): _____

Total cost of Services: _____

Amount Requested: _____ (max. **100%** of total bill, up to yearly limit for town/city)

Service Provider (reimbursement is sent directly to service provider upon approval):

TREATING VETERINARIAN(S): _____

CLINIC NAME: _____

ADDRESS: _____

_____

CLINIC PHONE: _____

- OVER -

Please describe the circumstances in which this animal was found and/or rescued, and include a picture of the animal if possible.

PLEASE NOTE THAT ALL ABOVE INFORMATION MUST BE COMPLETED. INCOMPLETE REQUESTS WILL NOT BE PROCESSED.

As the submitting Animal Control Officer, I certify that the service(s) for which funds are being requested were provided to the stray animal listed above, I also certify that full or partial payment for the amount requested above has not been received. If duplicating payment is received in the future, an amount equal to the duplicated payment will be returned to MVMA Charities, Inc.

Print Name: _____ Signature: _____ Date: _____

Please return completed form to:
MVMA Charities, Inc., 163 Lakeside Avenue, Marlborough, MA 01752-4554