



STRAY ANIMAL PROGRAM
REQUEST FOR FUNDS

Name of town/city: _____

Name of contact Animal Control Officer: _____

Contact Phone number(s): _____ Mailing Address: _____

1. Home Work Cell _____

2. Home Work Cell _____ Email Address: _____

(Please circle a phone description for each number listed)

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)

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.

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

TREATING VETERINARIAN(S): _____

CLINIC NAME: _____

ADDRESS: _____

CLINIC PHONE: _____

