Caring Paws Pet Sitting Services, LLC

Veterinary Treatment Authorization

Client Name: _____

Address: _____

City: _____ ZIP: _____

Home phone: _____ Work phone: _____

Cell: _____ Other: _____

This form will be retained on file and will be used to authorize veterinary treatment in the event that your pet(s) require treatment during your absence, while in our care, and we are unable to contact you at the time. Should you change veterinarians please notify Caring Paws before service dates.

To whom it may concern: During my absence a representative of Caring Paws will be caring for my pet(s). I give Caring Paws my permission to transport my pets to my veterinarian or to an emergency clinic. In the event I cannot be reached, I authorize Caring Paws to act as an agent on my behalf regarding my pets' medical care. I accept full responsibility for charges incurred in the treatment of my pet(s), not to exceed the following amounts for each pet:

Pet(s) Name	Maximum Amount	Specific Limits of Care?
_____	$_____	_____
_____	$_____	_____
_____	$_____	_____
_____	$_____	_____

Caring Paws reserves the right to utilize the services of any available veterinary clinic. If time permits, I will attempt to utilize your primary veterinary clinic. If it is not practical to do so, the following information will be helpful if the clinic we utilize requires documentation from your primary clinic.

Veterinary Clinic: _____

Address: _____

City: _____ ZIP: _____

Phone: _____ Emergency Phone: _____

I authorize veterinary treatment for my animal(s) during my absence. I understand that Caring Paws assumes no responsibility for the loss of any pet and is released from all liability related to transportation, treatment and expense. I will be responsible for any and all charges incurred during treatment of my pet(s) to the maximum amounts and specific limits of this authorization.

Signature: _____ Date: _____