



MEDICAL EXPENSE ASSISTANCE REQUEST and WAIVER

THIS AGREEMENT is made between _____ ("Owner") and The Community Pet Project, Inc., a Florida non-profit corporation ("CPP"), and relates to the following animal ("Animal"):

Name of Animal: _____ Sex: M or F Spayed/Neutered: Y or N
Species: _____ Breed: _____
Color: _____ Approximate Age: _____
Weight: _____ Heartworm Status: +Positive or -Negative

Approved Veterinarian: Treatment is available through the Humane Society of Tampa Bay ("HSTB"), or from another Approved Veterinarian of the Owner/Foster's choice.

• **Indicate Preferred Veterinarian:**

Humane Society of Tampa Bay
- Or -

Other Approved Veterinarian (name, email and phone are required):

Name: _____

Email Address: _____

Phone Number: _____

Diagnosis and Treatment. Formal diagnosis of issue(s) or conditions(s) and treatment/medication required. (attach additional sheets if necessary):

Estimated Expense:

- Estimated Treatment Expense: \$_____ (If not using HSTB, attach veterinarian's estimate)
- Amount Owner will pay: \$_____
- Amount requested CPP pay: \$_____ (maximum \$500, per animal, per calendar year)



CPP agrees to pay **only** for the above Treatment(s) performed by the Approved Veterinarian, not to exceed the Estimated Expense. Actual amount paid by CPP will be communicated via Confirmation Email to Owner and Approved Veterinarian. The veterinary bills for Treatment listed above will be paid directly by CPP to the Approved Veterinarian. Owner will promptly remit copies of all invoices to CPP for payment and/or make advance arrangements for CPP to be invoiced directly.

Any treatments or medications not listed above will **not** be covered by CPP and will be the sole responsibility of the Owner.

Owner understands that CPP is not a medical provider and makes no representations or warranties, express or implied, regarding any medical care or treatment provided by the Approved Veterinarian. By his/her signature below, Owner authorizes the Approved Veterinarian to disclose any medical records or health care information related to diagnosis listed above to CPP upon request.

****All animals must be spayed or neutered to qualify for assistance. Extenuating circumstances will be discussed with the Owner and CPP's medical advisors. CPP's medical advisors will advise Owner of their decision via email, text or phone. CPP will assist in financial help for medical needs up to \$500 per animal per calendar year.**

"OWNER":

_____	_____	_____	_____
Printed Name	Signature	Date	
_____	_____	_____	_____
Street Address	City	State	Zip
_____	_____		
Telephone Number	E-Mail Address		

"CPP":

The Community Pet Project, Inc.

By: _____

Position: _____

Date: _____