



{CLINICADDRESS1}
 {CLINICCITY}, {CLINICSTATE} {CLINICPOSTALCODE}
 {CLINICPHONE}

Euthanasia Authorization {CURRENTDATE[SHORT]}
 {CURRENTDATE[SHORT]}

Client ID:	{ID}	Patient ID:	{PATIENTID}
Client Name:	{FULLNAME}	Name:	{NAME}
Address:	{ADDRESS1} {ADDRESS2} {CITY}, {STATE} {POSTALCODE}	Species:	{SPECIES}
		Breed:	{BREED}
		Sex:	{SEX}
Telephone:	{PHONENUMBER}	Color:	{COLOR}
Weight:	{CURRENTWEIGHT}	Markings:	{MARKINGS}
		Birth Date:	{BIRTHDATE[SHORT]}

I, the undersigned, do hereby certify that I am the owner (or duly authorized agent for the owner) of the animal described above, that I do hereby give the doctors of {CLINICNAME} permission to euthanize and dispose of said animal in whatever manner the said doctors of {CLINICNAME}, their agents, servants, or representatives deem fit. I also release the doctors, {CLINICNAME}, their agents, servants and representatives for any liability for so euthanizing and disposing of said animal.

_____ I do also certify that to the best of my knowledge the said animal has not bitten any person or animal during the last ten (10) days and has not been exposed to rabies.

_____ I know my animal has bitten a person or animal within the last ten (10) days. Date of bite _____
 By state law, our office has to submit tissue specimens for rabies testing.

- | | |
|----------------------------------------------|--------------------------------------------|
| _____ Standard Care of remains. | No additional charge. |
| _____ Communal Cremation | Cost varies with the weight of the animal. |
| _____ Private Cremation with ashes returned. | Cost varies with the weight of the animal. |

SIGNED {CLIENTSIGNATURE}