APPLICATION FOR DONATION from CABEZA FOUNDATION

P.O. Box 226723 • Miami, FL 33122
305.761.7766 • FAX: 305.639.2662

FOR OFFICIAL USE ONLY:

- ❒ RDVM Medical notes
- ❒ Driver's License verified
- ❒ Care Credit application attached
- ❒ Verification of Miami-Dade resident

Please note: This application may be rejected if incomplete.

FAX APPLICATIONS TO: 305.639.2662
Important to call alert us to of incoming fax.
Cases may be life threatening and in need of immediate attention.

VETERINARY USE ONLY:

Name of Veterinarian submitting application: _____ FL license # _____

Name of Clinic where services are performed: _____

Pet's name: _____ Breed: _____ Age: _____ Sex: _____

Date of onset for illness/injury: _____ Pet's diagnosis: _____

_____

_____

Comment for medical necessity: *(please briefly describe the pet's condition: life threatening, the treatment recommended, if any follow-up care is required after pet leaves your hospital and the chances of 100% return to a normal healthy life for the pet.)*

Life threatening: _____

_____

_____

_____

_____

Required Follow-up: _____

_____

_____

_____

_____

Recommended Treatment: _____

_____

_____

_____

_____

Chances of Normal Life: _____

_____

_____

_____

_____

VETERINARIAN CERTIFICATIONS:

- ❒ Medical notes including lab work, X-rays, etc. are attached to this application.
- ❒ A vaccine history for the pet is attached.
- ❒ I certify that this pet is Heartworm negative (for dogs) and Felv/FIV (for cats).
- ❒ Estimate for services rendered is attached and includes all follow-up care that will be required for this pet.
- ❒ To the best of my knowledge this pet does not come from an abusive household.
- ❒ To the best of my knowledge the family is capable of providing all necessary follow-up care to the pet.
- ❒ I have applied a 10% discount from my regular fees to this client.
- ❒ The pet is up to date on their Rabies vaccine and has had a Distemper/Parvo vaccine in the last 3 yars. If not, the vaccines are listed on the estimate.
- ❒ The estimate provided will not be exceeded for the care of this medical condition for this pet.

_____
Veterinarian's signature Date:

APPLICATION FOR DONATION from CABEZA FOUNDATION

P.O. Box 226723 • Miami, FL 33122
305.761.7766 • FAX: 305.639.2662

FOR OFFICIAL USE ONLY:

- ❒ RDVM Medical notes
- ❒ Driver's License verified
- ❒ Care Credit application attached
- ❒ Verification of Miami-Dade resident

Please note: This application may be rejected if incomplete.

FAX APPLICATIONS TO: 305.639.2662
Important to call alert us to of incoming fax.
Cases may be life threatening and in need of immediate attention.

APPLICANT'S INFORMATION:

Applicant's Name: _____

Address: _____ State: ____ Zip: _____

Phone: _____ Florida DL#: _____

Employer: _____ Annual Income: _____

Spouse's Name: _____

Address: _____ State: ____ Zip: _____

Phone: _____ Florida DL#: _____

Employer: _____ Annual Income: _____

Comment on financial assistance: *(please briefly describe why you require financial assistance.)*

_____

_____

Are you able to contribute any amount financially for the care of your pet?: ❒ Yes ❒ No If so, how much? _____

PET OWNER'S CERTIFICATION: I certify that the above information is true and correct. I certify that I am the owner of this pet and will comply with my veterinarian's recommendations for at home care for my pet and will have the pet rechecked when necessary to help resolve this medical condition.

_____
Applicant's signature Date:

CABEZA FOUNDATION *promotes responsible pet ownership. Therefore, we will be providing you with 1 year of pet health insurance through a national pet insurance company. We ask that you take responsibility of your pet's medical needs in the future and maintain their vaccines current, and keep them on monthly parasite control. Please attempt to renew their pet health insurance annually, in case another major medical condition arises in the future.*