



# MVMA Charities, Inc.

*A 501(c)3 Not-for-Profit Supporting Organization  
of the Massachusetts Veterinary Medical Association*

163 Lakeside Avenue, Marlborough, MA 01752-4554

Phone: 508-460-9333 \* Fax: 508-460-9969

Email: MVMACharitiesInc@massvet.org \* Website: www.massvet.org

## 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 \_\_\_\_\_

\_\_\_\_\_

3. Home Work Cell \_\_\_\_\_

Email Address: \_\_\_\_\_

(Please circle a phone description for each number listed)

Name/ID of Animal: \_\_\_\_\_

Date(s) of Service(s): \_\_\_\_\_

Total cost of Services: \_\_\_\_\_

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.

Amount Requested: \_\_\_\_\_ (max. 80% of total bill, up to yearly limit for town/city)

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

TREATING VETERINARIAN(S): \_\_\_\_\_

CLINIC NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CLINIC PHONE: \_\_\_\_\_

As the submitting Animal Control Officer, I certify that the service(s) for which funds are being requested were provided to the stray animal listed above, I also certify that full or partial payment for the amount requested above has not been received. If duplicating payment is received in the future, an amount equal to the duplicated payment will be returned to MVMA Charities, Inc.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please return completed form to:  
MVMA Charities, Inc., 163 Lakeside Avenue, Marlborough, MA 01752-4554