Autumn's Bed & Biscuit

Pet Sitting Services

Pet Owner(s) _____

Address_____City_____State_____Zip_____

Home #_____Cell #_____Cell #_____

Email Address _____ Emergency #_____

Veterinarian Address & Phone # _____

Veterinarian Release

*** If my pet has an injury, an illness, or for any reason needs medical attention while under the care of Autumn's Bed & Biscuit Pet Sitting Services, I authorize Glenda Gable or her family members to seek medical attention at my regular veterinarian office or the nearest vet's office open.**

*** I authorize payment up to $ _____ if I cannot be reached. I will assume full responsibility, upon my return, for payment and/or reimbursement for veterinary services rendered up to the above stated amount.**

*** If there is a situation with my pet in which I cannot be reached for a life or death decision, these are my wishes:**

_____

_____

Signed _____ **Date**_____

Services Provided:

Pet care dates at MY home _____

Price per day $_____ X _____ # of days = $_____ TOTAL DUE

Pet care dates at YOUR home _____

$ _____ per visit X _____ # of visits = $ _____ TOTAL DUE

PET OWNERS SIGNATURE _____

DATE _____ How did you hear of my service?_____

If your pet is staying in my home PLEASE INITIAL: _____ I understand that any pet not picked up within 10 days of expected return (without contact for extended arrangements and payment) will be considered ABANDONED and can be turned over to Animal Control per Florida Statute 705.19.