Physician Verification of Disabling Illness

To Whom It May Concern:

Please verify that in your opinion ____________________________ is disabled and needs assistance to care for his or her pet(s).

PAWS Niagara is a volunteer-based organization that helps improve the quality of life for persons with disabling illnesses by offering the emotional and practical support to keep the love and companionship of their pets, and by providing information on the benefits and risks of animal companionship.

Please provide the following information:

Date: __________________

Client Name: _____________________________

Diagnosis/Medical Condition of Client Pertaining to Terminal or Permanently Disabling Illness:____
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____
____
____

Treating Physician Name: ____

Treating Physician Signature: ____

Medical License Number: ____

Medical Facility: ____

Phone: ______________________________ Fax: _________________________

Website: www.pawsniagara.com Email: Lenkooperman@pawsniagara.com

If you have any questions, please feel free to contact:

Client Services Coordinator
PAWS Niagara
Phone:
Fax:

To be signed by prospective PAWS client:

I authorize Dr. ____________________________ to verify information regarding my application to PAWS.

Signature of PAWS applicant: ___________________________

Date: __________________