AUTHORIZATION FOR EUTHANASIA

Owner's Name_____ Phone _____

Address_____
Street City State Zip

Pet's Name_____

Species (Most likely Feline or Canine)_____ Breed_____

Color_____ Weight_____ Age_____ Gender_____

I, the undersigned, hereby certify that I am the owner, or authorized agent for the owner, of the animal described above. I understand that by signing this agreement I authorize the Cochrane Animal Hospital to humanely euthanize this animal and provide for final disposition of the remains. I also agree to release the clinic from any and all liability associated with the performance of this service.

I request the euthanasia of my pet to be performed as follows: **(please check one)**

- ☐ I request my pet be given a sedative before the euthanasia.
- ☐ I decline any sedation and request only the euthanasia for my pet.

I request the final disposition of my pet's remains to be as follows: **(please check one)**

- ☐ I request my pet's remains to be privately cremated & ashes returned to me.
- ☐ I request my pet's remains to be group cremated.
- ☐ I request my pet's remains to be returned for a home burial.

I also certify that, to the best of my knowledge, this patient has not bitten any person or animal in the past 10 days.

Signature **X**_____ Date_____

Witness Signature **X**_____ Date_____