HOSPITAL

Hospital Patient Pet Care

RELEASE OF LIABILITY, WAIVER OF CLAIMS AND ASSUMPTION OF RISK AGREEMENT

Please read carefully before signing.

By signing this document, you will waive certain legal rights, including the right to sue.

To: HOSPITAL and all officers, directors, agents, employees, volunteers and/or representatives (collectively, HOSPITAL):

1. I AGREE TO PARTICIPATE IN HOSPITAL PATIENT PET CARE PROGRAM (the "Program"). I understand that by participating in the Program I am agreeing to allow representatives of HOSPITAL to care for my pet(s) while I am a patient at HOSPITAL. I also understand that in order to care for my pet(s), representatives of HOSPITAL and, as deemed necessary by HOSPITAL, representatives from THIRD PARTY SERVICE PROVIDER, must enter my residence, and I hereby give such representatives of HOSPITAL and THIRD PARTY SERVICE PROVIDER permission to do so.

2. I HEREBY WAIVE ANY CLAIMS AGAINST HOSPITAL AND THIRD PARTY SERVICE PROVIDER AND RELEASE EACH OF HOSPITAL AND THIRD PARTY SERVICE PROVIDER FROM ANY AND ALL LEGAL LIABILITY to me and my family members for any loss, damage, injury or expense to me, my property, my family members or my pet(s) as a result of my participation in the Program, due to any cause whatsoever (including any and all claims based on negligence or any other legal theory), and agree not to sue or bring any legal action against HOSPITAL or THIRD PARTY SERVICE PROVIDER in connection with the Program.

3. In the event of my death or incapacity, this Agreement shall be effective and binding upon my heirs, next of kin, executors, administrators, assigns and representatives.

4. In entering into this Agreement and agreeing to participate in the Program, I am not relying upon any oral or written representations of HOSPITAL or THIRD PARTY SERVICE PROVIDER.

I HAVE READ AND UNDERSTAND THIS AGREEMENT, AND I AM AWARE THAT BY SIGNING THIS AGREEMENT I AM WAIVING CERTAIN LEGAL RIGHTS, INCLUDING THE RIGHT TO SUE HOSPITAL OR THIRD PARTY SERVICE PROVIDER.

_____ _____

Signature of Patient or authorized representative Date

_____ _____

Witness Date

HOSPITAL

Hospital Patient Pet Care

APARTMENT ACCESS FORM

Patient Information:

Patient Name:_____
Location/Room Number:_____ Room Phone Number:_____
Home Address:_____
Home Phone Number:_____
Primary Family Contact:_____ Phone:_____ Address:_____
Apartment Building Contact:_____ Phone:_____ Address:_____
Date(s) of Service Requested:_____

- Is there someone currently staying in your apartment/ do you share an apartment? ❒ Yes ❒ No
  If so, Name:_____ Phone or Other Contact Info_____
  _____
- Would this person agree to give access to HOSPITAL Patient Pet Care personnel or pet care provider designated by HOSPITAL? In other words, if that person is not at home, may we, or the designated provider, use your key to gain access? ❒ Yes ❒ No
- Do you agree to give your key to designated HOSPITAL Patient Pet Care personnel for the duration of your time in hospital, for the sole use of pet care? ❒ Yes ❒ No
- If you request, we would give your keys to a friend, relative or the super, name _____
  _____ Do we have your permission to do this? ❒ Yes ❒ No
- Does a neighbor or friend or building staff member have a key? ❒ Yes ❒ No
- Do they have written permission from you to use it? ❒ Yes ❒ No
- What is their name & How do we contact them?_____
  _____
- If they do have written permission, or even if they do not, do you at this time agree that we obtain keys from them in order to gain access to apartment, in consideration of the best health and comfort of your animals? ❒ Yes ❒ No
- To whom should the key(s) be returned after pet care services under HOSPITAL end?
- _____

Either the Patient Pet Care Coordinator, or a volunteer, or a licensed and bonded third-party provider will use the keys, fi
the sole purpose of the best health and comfort of your animals.

Do you understand and agree? ❒ Yes ❒ No

Special Instructions:

_____
_____

Authorization/Signature:_____ Relationship to Patient:_____
Date:_____

Form Completed By (Print):_____ Signature:_____

Notes:

HOSPITAL

Hospital Patient Pet Care
REQUEST FOR PET SERVICES

Patient Information:

Patient Name:_____
Location/Room Number:_____ Room Phone Number:_____
Home Address:_____
_____
Home Phone Number:_____
Primary Family Contact:_____ Phone:_____ Address:_____
Apartment Building Contact:_____ Phone:_____ Address:_____
Other Suggested Contact:_____ Phone:_____ Address:_____

May we talk to the above contacts re pet issues? ❒ Yes ❒ No

Date(s) of Service Requested: _____

Pet Information:

Name of Pet(s): Type of Pet(s): Age of Pet(s):

_____
_____

Medical Conditions and Medications (if any):

_____

ADVISORY: If for any reason, your pet needs be taken to Animal Care & Control, he/she will be spay-neutered if this has not been done already, with exemptions for service dogs, show animals, illness. Do you acknowledge? (*NOTE: NYC ONLY; will vary by community.)* ❒ Yes ❒ No

Pet Needs

❒ Feeding & Watering ❒ Litter Box Care ❒ Walking (How often?)_____ ❒ Tender Loving Care

❒ Vaccination Due Dates (approximately)_____

❒ Supplies (i.e. food, treats, litter) Specify Types & Brands:_____

❒ Other_____

Veterinarian Information:

Name:_____ Phone Number:_____
Address:_____
If boarding and/or veterinary care is required, do you consent to our assisting you with this? ❒ Yes ❒ No

Do you currently have pet care arrangements in place, even casually? ❒ Yes ❒ No

Who should we contact?_____ Phone_____
How does your pet behave with other animals?_____
How does your pet behave with people other than you?_____

ADVISORY: If he/she is perceived dangerous, we will need to call Animal Care & Control for assistance and possibly removal of the pet to shelter. Do you acknowledge? ❒ Yes ❒ No

Special Instructions:

_____

Authorization/Signature:_____ Relationship to Patient:_____
Date:_____
Form Completed By (Print):_____ Signature:_____

HOSPITAL

Hospital Patient Pet Care

For discussion only - Supplement to signed documents

Some items of concern to pet care provider,
to be discussed with patient by Patient Pet Care Coordinator or Volunteer
Many of the items here are included in for-signature documents.

The non-veterinary pet service provider requests that it have sole access to the apartment/home during the owner's absence. If that is not possible, the provider would like a list of others who may have keys/access, whether unexpected or not.

	Name	Address	Telephone
Super or doorman			
Neighbors			
Relatives			
Cleaning or repair persons			

Please advise whom you are expecting; if you know someone will be entering, and for what reasons.

_____

_____

Note: The non-veterinary provider would be pleased to do ordinary plant watering, but is not equipped for specialty plant maintenance.

Please advise whether any single property/possession is valued in excess of $2000.

_____

_____

Please advise if there are special restrictions on the environment for your possessions, pets or property, i.e., do not open the window, because…

_____

_____

HOSPITAL

Hospital Patient Pet Care

ACKNOWLEDGEMENT OF RETURN OF KEYS

My apartment keys were returned to me, the patient _____

or to my representative/friend _____

today.

_____
Patient OR Patient's
Authorized Representative
Signature

_____
Date

_____
Patient Pet Care Signature

_____
Date

Wtiness: _____

HOSPITAL

Hospital Patient Pet Care

RELEASE

HOSPITAL Patient Pet Care program has assisted you in making arrangements for your animal companion(s) with an independent third-party organization. HOSPITAL Patient Pet Care program and you consider that the quality of life of your animal companion is of high importance, but the decisions in this respect are now yours to make.

The terms of those arrangements have been decided by you and the third-party organization, as set forth in the attached document signed by you -- whether for transfer of custody or ownership, or whether your animal companion(s) may be placed for adoption, kept in care or euthanized. Whatever you have agreed with that organization, and whatever decisions and discretion you have entrusted to them, is entirely your agreement with them and your determination.

Please confirm by signing below that you release HOSPITAL Patient Pet Care program, HOSPITAL and their employees, volunteers, agents, directors and officers, and any veterinarians or veterinary consultants, from any responsibility or liability in connection with introducing you to one or more such third-party organizations or making arrangements with any such organization or for any provision of the attached or any related document.

Date: _____

_____
Signature of patient or authorized representative

_____
Print name of patient or authorized representative

HOSPITAL

Hospital Patient Pet Care

ASSISTANCE WITH ADOPTION AND RELINQUISHMENT

I have considered my options, and now choose to give the pet(s) identified below up for possible adoption.

I have made this decision after careful consideration and feel it is in the best interests of my pet(s) as well as myself.

I have asked HOSPITAL to assist me in this, process. For myself and my representatives and successors, I waive and agree not to assert, any present or future rights, claims, suits or otherwise against HOSPITAL, and all officers, directors, agents, employees and/or volunteers (collectively, "HOSPITAL") with respect to the disposition of this animal/these animals, including surrender to an animal welfare organization on the terms described in any accompanying relinquishment receipt or other document.

This document does not limit the terms of any other release, waiver or agreement between me and HOSPITAL.

Pet Name(s) _____

Type(s) _____

_____ Date: _____
Patient or Authorized Representative

_____ Date: _____
Patient Pet Care

Witness: _____ Date: _____

RELINQUISHMENT RECEIPT FOR ANIMAL SURRENDERED BY OWNER

To: ORGANIZATION

Receipt number

Animal ID #

Description of Animal

_____

_____

_____

_____

Owner/Owner's representative:

Name _____

Address _____

Telephone _____

Email _____

I acknowledge that my signature on this receipt relinquishes all claims of ownership to the animal described above. Neither my family, any representatives acting on my behalf, nor I myself may assert present or future rights, claims, suits or otherwise against ORGANIZATION with respect to this animal. I understand that ORGANIZATION will not return this animal to me, once left in its care, under any circumstances, unless otherwise approved by ORGANIZATION. I am also aware that the animal may be humanely euthanized if behavioral and/or medical problems render this animal unsuitable for adoption.

_____ _____

Owner's signature Witness

_____

Owner's representative signature

Date: _____

HOSPITAL

Hospital Patient Pet Care

Date:

Organization
and/or
Pet Hospital

Dear

Enclosed is a copy of the consent to veterinary care, providing the permission for HOSPITAL Patient Pet Care, acting for Patient X in this matter only, to arrange for veterinary services and to facilitate decisions for veterinary care of _____ , owned by Patient X, currently here in the Hospital.

Decisions relating to your services and to the treatment of the animal will be made by the patient or patient's representative. We, HOSPITAL Patient Pet Care program and HOSPITAL, will seek to facilitate those decisions and to assist in communications with the patient's representative and to the extent possible, with the patient, but we do not have authority in such matters. Re the above, we have discussed this with the patient and he/she agrees to veterinary care and procedures, as noted on the release, and has authorized us to provide this consent to you.

We appreciate your professional attention to the care of this animal, whose well-being is of such great importance to our patient.

Payment for services is the sole responsibility of the patient except as otherwise expressly authorized.

Sincerely,

Name
Program Coordinator
HOSPITAL Patient Pet Care

HOSPITAL

Hospital Patient Pet Care

Date:

Organization
and/or
Pet Hospital

Dear

Enclosed is a copy of the consent to boarding, providing the permission for HOSPITAL Patient Pet Care, acting for Patient X in this matter only, to facilitate decisions on boarding for _____, owned by Patient X, currently here in the Hospital.

Decisions relating to your services and to the treatment of the animal will be made by the patient or patient's representative. We, HOSPITAL Patient Pet Care program and HOSPITAL, will seek to facilitate those decisions and to assist in communications with the patient's representative and to the extent possible, with the patient, but we do not have authority in such matters. Re the above, we have discussed this with the patient and he/she agrees to the boarding, as noted on the release, and has authorized us to provide this consent to you.

We appreciate your professional attention to the care of this animal, whose well-being is of such great importance to our patient.

Payment for services is the sole responsibility of the patient except as otherwise expressly authorized.

Sincerely,

Name
Program Coordinator
HOSPITAL Patient Pet Care

HOSPITAL

Hospital Patient Pet Care

ASSISTANCE WITH VETERINARY CARE AND/OR BOARDING

Assistance with Veterinary Care and/or Boarding

I have asked HOSPITAL to assist me in the process of having my animal companion(s) provided with veterinary services and/or boarded.

For myself and my representatives and successors, I waive and agree not to assert, any present or future rights, claims, suits or otherwise against HOSPITAL, and all officers, directors, agents, employees and/or volunteers (collectively, "HOSPITAL") with respect to such veterinary services and/or boarding.

This document does not limit the terms of any other release, waiver or agreement between me and HOSPITAL.

Pet Name(s) _____

Type(s) _____

_____ Date: _____
Patient or Authorized Representative

_____ Date: _____
Patient Pet Care

Witness: _____ Date: _____

HOSPITAL

Hospital Patient Pet Care

WAIVER OF LIABILITY BY VOLUNTEER

I will not hold HOSPITAL Patient Pet Care, HOSPITAL or its employees, agents, directors and officers liable for any injury to me from handling an animal or otherwise in the course of my service as a volunteer in the HOSPITAL Patient Pet Care assistance program administered by HOSPITAL nor will HOSPITAL be held liable for any loss or damage to my property as a result of this voluntary service.

_____

Volunteer Signature

_____

Date

HOSPITAL

Hospital Patient Pet Care

Protocol for Custody of Keys and Access to Apartments of Clients
In Coordination with Pet Service Provider

HOSPITAL will obtain from its patient keys and permission for access to the patient's residence.

The patient or a representative of the patient (which may be HOSPITAL) will give HOSPITAL's Patient Pet Care Coordinator or volunteer and pet service provider permission to access the apartment for pet care services.

HOSPITAL's Patient Pet Care Coordinator or volunteer will turn over the apartment keys to the pet service provider under the applicable contract. It is optimal that the Patient Pet Care Coordinator or volunteer meet the pet service provider at the patient's residence to turn over keys at that point.

HOSPITAL will have verbally conveyed the following to the patient: [see Chain of Key Custody, Apartment Access and Property]

Pet service provider will use the keys consistently with the above.

Upon completion of the assignment pet service provider will, if possible, turn over the keys directly to Patient Pet Care Coordinator or Patient Pet Care volunteer, who will return them to the patient. Otherwise the keys will be returned to the patient or patient's representative against receipt.

HOSPITAL will take responsibility for use of the keys from that time, provided that HOSPITAL cannot give any release or agreement to pet service provider on behalf of the patient, HOSPITAL's authority is limited to accepting the keys from pet service provider and taking responsibility from the time and date of acceptance.

HOSPITAL

Hospital Patient Pet Care

ASSISTANCE WITH VETERINARY CARE – ADDITIONAL CONFIRMATION

I have asked HOSPITAL to assist me in the process of retaining veterinary services and/or boarding for my animal companion(s). [or the animal companion(s) belonging to _____, for whom I hold power of attorney or are guardian]. I consider that the quality of life of the animal companion is of high importance. I and/or the HOSPITAL Patient Pet Care program have been informed that certain services and procedures are recommended by the veterinarian.

These are:

_____

_____

My instructions are:

_____

_____

I understand that the terms and the agreement are between me and _____, and whatever decisions and discretion I have entrusted to them are entirely my agreement with them and my determination, and that I am responsible to pay or reimburse all fees and other charges for such veterinary services and/or boarding. [*note: IF PATIENT REIMBURSEMENT IS NOT POSSIBLE, TO BE DISCUSSED]*

For myself and my representatives and successors, I waive and agree not to assert, any present or future rights, claims, suits or otherwise against HOSPITAL, and all officers, directors, agents, employees and/or volunteers (collectively, "HOSPITAL") and any veterinarians or veterinary consultants with respect to such veterinary services and/or boarding.

This document does not limit the terms of any other release, waiver or agreement between me and HOSPITAL.

Pet Name(s) _____

Type(s) _____

_____ Date: _____
Patient or Authorized Representative

_____ Date: _____
Patient Pet Care

Witness: _____ Date: _____