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, f 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: