SPAY/NEUTER REBATE CERTIFICATE

PET OWNER PORTION **Pasco County Dog License #_____---_____**

REMINDER: RETURN THIS COMPLETED REBATE REQUEST WITHIN 30 DAYS OF SURGERY!

THIS IS TO CERTIFY THAT MY DOG, DESCRIBED BELOW, HAS BEEN EITHER SPAYED OR NEUTERED.

DESCRIPTION OF DOG: BREED_____SEX_____AGE_____COLOR_____

PET'S NAME_____OWNER'S PHONE # ( ) _____

SIGNATURE OF OWNER *PRINT NAME TO MATCH SIGNATURE*

* *

_____ _____

**(FULL LEGAL NAME ONLY, NO INITIALS)* **(FULL LEGAL NAME ONLY, NO INITIALS)*

PHYSICAL ADDRESS _____

CITY_____

FL, ZIP CODE _____

MAILING ADDRESS (IF DIFFERENT) _____

CITY_____

FL, ZIP CODE_____

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VETERINARIAN PORTION

BY MY SIGNATURE BELOW, I CERTIFY THAT:

*I HAVE PERFORMED AN ORCHIECTOMY (CASTRATION) OR OVARIOHYSTERECTOMY (SPAY) ON THE DOG DESCRIBED ABOVE.

*THE FEE CHARGED FOR THIS SURGERY WAS $40.00 OR MORE.

MY CLINIC/HOSPITAL IS AN OFFICIAL PASCO COUNTY ANIMAL LICENSING FACILITY.

VETERINARIAN NAME: (PLEASE PRINT) _____

CLINIC/HOSPITAL NAME: _____PHONE:_____

ADDRESS_____

_____

DATE STERILIZED_____ _____

VETERINARIAN'S SIGNATURE X_____

PET OWNER MAIL THIS FORM TO:

Pasco County Community Services

Att: Fiscal Support Services

8620 Galen Wilson Blvd

Port Richey, FL 34668