

Shaker Place Rehabilitation and Nursing Center

Documentation for Visiting Pets

Pet Owner's Name: _____

Pet Owner's Address: _____

Owner's Phone Number(s): _____ Home _____ Cell _____

Visiting Pet's Name: _____

Resident Pet will be visiting: _____ Room Number _____

Is your pet fully housebroken: _____ Yes _____ No

Name of Pet's Veterinarian: _____

Veterinarian's Phone Number: _____

Pet vaccination expiration date: _____

Confirmation of written statement from Veterinarian that animal is free of Ticks and/or Fleas:

_____ Yes _____ No

PLEASE ATTACH A COPY OF YOUR PET'S CURRENT VACCINATION

Procedure date: 7/15

