ALABAMA VETERINARY MEDICAL FOUNDATION SURGERY FORM
SPAY – NEUTER LICENSE PLATE PROGRAM

Permit number _____
*(Hospital must obtain before surgery by website **www.alvmf.org**, phone or fax 334.513.2993)*

Hospital name _____

ALVMA Member Veterinarian's Name _____

Owner/Medicaid cardholder Name _____

Address _____

City, State, Zip _____

Phone _____

COPIES ATTACHED: Medicaid card ☐ Photo ID ☐

Please attach copies of the pet owner's Medicaid card and Photo ID to this form. All testing and vaccination is at the discretion of the veterinarian and is at the owner's expense. We will only reimburse you for the spay/neuter surgeries.

Date of Surgery _____

CAT – COPAY $10.00
_____ Female ___ Male

DOG – COPAY $20.00
____ Female ____ Male

Pet Name _____ Color _____
Breed _____ Age _____

FOR ACCOUNTING PURPOSES RETURN THIS FORM WITH ORIGINAL SIGNATURES TO ALVMF
NO FAXES, PHOTOCOPIES, OR SIGNATURE STAMPS WILL BE ACCEPTED

I certify that the above spay/neuter surgery has been performed in accordance with program requirements.

_____
Signature of Participating Veterinarian (REQUIRED)
(Signature must be the veterinarian named at the top of the form)

I certify that I have had no more than a total of 2 pets in my household altered by veterinarians participating in the ALVMF spay neuter program during the current calendar year. I authorize the transfer of this information to ALVMF.

_____ Parent ☐ Guardian ☐
Signature of Pet Owner/Cardholder (REQUIRED)
Please indicate if the parent or guardian is signing this form on behalf of the minor Medicaid Cardholder. Please note any special circumstances below:

Notes: _____

AT THE END OF THE MONTH MAIL ORIGINAL OF THIS FORM WITH MEDICAID CARD AND DRIVER'S LICENSE COPIES ALONG WITH THE "PROGRAM REPORTING FORM" TO:

ALVMF - S/N PROGRAM
PO Box 640279
Pike Road, AL 36064

August 2020