

**Your Membership in "All Breed Rescue  
Network" Just Became More Valuable!**  
**APPLICATION FOR ABRN GRANT MONEY**

Grant funds can only be made for procedures performed by a *veterinarian who is licensed to practice in Colorado and is also a member of either the Colorado Veterinary Medical Association (CVMA) or the Denver Area Veterinary Medical Society (DAVMS)*. You can call 303-318-0447 to verify.

**Please note we require one application per request and one application per animal. Also, there is a \$500.00 per breed maximum for each grant year (August 1-July 31). The maximum reimbursement is \$250.00 per animal.**

General Medical, Spay/Neuter or Extraordinary Medical Expenses

(Invoices must be dated after 8-1-09)

- a) Complete all Sections of this application
- b) Return 3 copies of the application, with 3 copies of the paid veterinary invoice.
- c) Include a self addressed stamped envelope (so we may mail you a check)
- d) Mail the above 3 items to:

Karen Brown  
11460 E Parker Road  
Parker, CO  
80138-7813

Applications will be considered in the order they are received. Incomplete applications without all the necessary information cannot be accepted and you will be notified, if received in time. Completing this application does not guarantee reimbursement. We have limited funds available and must comply with the grant requirements.

**The program is based on a reimbursement requirement. You will need to pay your veterinary provider and submit your paid invoices to ABRN.**

***If you have submitted for reimbursement of these expenses to any other funding program, we will be unable to double indemnify you.***

**For ABRN use only (do not write below this line)**

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Name of Pet \_\_\_\_\_ Rescue Group \_\_\_\_\_  
Name of ABRN board member that approved this request \_\_\_\_\_  
Date request received \_\_\_\_\_ Amount Approved for Payment \_\_\_\_\_  
ABRN check number \_\_\_\_\_ Date mailed to Rescue Group \_\_\_\_\_

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**1. GROUP DATA**

ABRN Rescue Group Name \_\_\_\_\_

Contact Person (person completing this form): Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_

Phone numbers: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

E-mail \_\_\_\_\_

Best way to contact you regarding this matter \_\_\_\_\_

Name of animal being treated \_\_\_\_\_ Breed \_\_\_\_\_ Age \_\_\_\_\_

Does this animal have other health and/or behavior issues?  yes  no Please explain \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**2. FUNDING REQUEST**

Date of procedure \_\_\_\_\_

Veterinarian used for procedure:

Name:

\_\_\_\_\_  
(Must have complete information)

Clinic Name:

\_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail Address \_\_\_\_\_

