Renal Dysplasia Screening Reimbursement Form

Completed form may be emailed to treasurer@cairnterrierhealth.org

Or mail completed form to:

Foundation of the CTCA Treasurer
Pat Joyce
2372 Crestcliff Drive
Tucker, GA 94903

Regional Club: _____

Club Contact: _____

Mailing Address: _____

Phone Number: _____ E-mail: _____

Amount Requested ($25 per dog/maximum $400): _____

Date of Regional Club Health Clinic: _____

Board Certified Radiologist: _____

Number of Dogs X-rayed: _____

Number of Dogs X-rayed Normal: _____

Number of Dogs X-rayed Abnormal: _____

Reimbursement requirements:
1. Overall findings must be included.
2. Reimbursement form must be received no later than 6 months after the date of the clinic ***and*** prior to September 30th of that calendar year.
3. Examinations must be performed by a board certified radiologist in conjunction with a regional club health screening clinic.

Disbursements will only be made directly to regional clubs. (Disbursement to individual owners of dogs is the responsibility of the regional clubs.)

I certify that the aforementioned regional club is in compliance with the reimbursement requirements.

Signature: _____ Date: _____