New Jersey Department of Health
Infectious and Zoonotic Disease Program
PO Box 369
Trenton, NJ 08625-0369

Period of Fee Agreement
From: **7/1/20** To: **6/30/21**

ANIMAL POPULATION CONTROL PROGRAM
VETERINARIAN'S AGREEMENT

IDENTIFICATION			
Name of Facility			Vendor ID Number (F.T. No. or SSN) -
Street Address			County
City	State	Zip Code	Telephone Number
Name of Facility Representative		Title	

FEE SCHEDULE

For Spaying Female Dogs:
- 0 - 25 Pounds ..... $ _____
- 26 - 50 Pounds ..... $ _____
- 51 - 75 Pounds ..... $ _____
- Over 75 Pounds..... $ _____

For Female Cats of Any Weight..... $ _____

For Neutering Male Dogs:
- 0 - 25 Pounds .....$ _____
- 26 - 50 Pounds .....$ _____
- 51 - 75 Pounds .....$ _____
- Over 75 Pounds.....$ _____

For Male Cats of Any Weight .....$ _____

AGREEMENT

I certify that this fee schedule is accurate as outlined above and will remain in effect from this date to the above expiration date. The fees will be for the entire surgical procedure which shall mean herein examination and neutering, maintenance, discharge, removal of sutures, and post surgical complications. I understand that I will be reimbursed 80% of the above fees. I further agree that the fee for all pre-surgical immunizations administered shall be no more than $10 per pet and that reimbursement will be given upon receipt of vaccination certification, signed by the veterinarian and the owner of the animal, that the immunization has been administered. Pre-surgical immunization will be as defined by Public Law 1983, Chapter 172. Pre-surgical immunization against rabies is not reimbursed under Public Law 1983, Chapter 172. I also understand that any fees associated with any surgical complications are not subject to reimbursement from the Department of Health under this program.

I understand that if any of the above fees are determined to be unreasonable, I will not be eligible to participate. I further understand that as funds become depleted I will be notified in advance to stop accepting clients.

I agree to submit complete and correct monthly invoices, consent forms, proxy authorization forms, and pet owner co-payment fees no later than ten days immediately following the end of the monthly period.

I understand that I will not be reimbursed for surgeries performed on ineligible pets.

I understand that my veterinary facility must be inspected by the New Jersey Veterinary Medical Association and meet their certification standards. I further understand that I am responsible for verifying the eligibility of the pet owner.

I certify that I have read and understand all statements above.

VETERINARIANS PRACTICING AT THIS FACILITY

Name (Please Type / Print)	Professional License Number	Signature

Please sign and scan the form.
Then, email it as an attachment to: APC.DHSS@doh.nj.gov

STATE USE ONLY:	Date Fees Approved