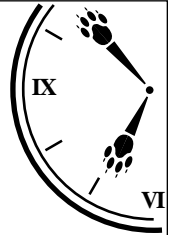


*Excellence in Dog Walking
& Pet Sitting*

Watch Dawg

Watching Everything from Pets to Plants
Serving the Windsor Areas



Client and Household Information

| | |
|--|--------------------------------|
| Name: | Street: |
| City: Zip: | Home Phone: |
| Office Phone: | Cell: |
| Referred by: | Email: |
| Spouse/Other : | Work Cell: |
| Where staying? | Contact Phone: |
| Where going? | How traveling? |
| Date/Time you will leave house: | Date/Time you return to house: |
| Do you own or rent your home? Own <input type="checkbox"/> Rent <input type="checkbox"/> | Landlord's contact Phone: |
| Email/Phone updates? Yes <input type="checkbox"/> No <input type="checkbox"/> | If yes, email or Phone No. : |

| EMERGENCY CONTACT(S) | Relationship | Telephone | Key to home? |
|----------------------|--------------|-----------|--|
| | | | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| | | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

OTHER PERSONS WHO MIGHT BE ENTERING YOUR HOME OR ON YOUR PROPERTY

| Name | Relationship | Key to home? | Date/ Time of Visit? |
|------|--------------|--|----------------------|
| | | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| | | Yes <input type="checkbox"/> No <input type="checkbox"/> | |

NOTE THE FOLLOWING INSTRUCTIONS

| | |
|---|---|
| Alarm/Gate Entry Password | Exit Password: |
| Company Name & Phone #: | Code Word: |
| Put Trash Out? Yes <input type="checkbox"/> No <input type="checkbox"/> | Your Trash Day is? |
| Location of Trash cans/dumpster: | Qty of Cans & Colors: |
| Bring in Mail Yes <input type="checkbox"/> No <input type="checkbox"/> | Location of mail box & key: |
| Alternate Blinds Yes <input type="checkbox"/> No <input type="checkbox"/> | Water Indoor Plants Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Alternate Lights Yes <input type="checkbox"/> No <input type="checkbox"/> | Water Outdoor Plants Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Turn on/off TV/Radio Yes <input type="checkbox"/> No <input type="checkbox"/> | |

PLEASE LIST THE LOCATION OF THE FOLLOWING

| | | |
|----------------------|-------------------|----------------------|
| Leashes | Toys | Carrier(s) |
| Food | Treats | Meds/Vitamins |
| Litter Box | Litter supplies | Brushes |
| Broom/vacuum | Can Opener | Doggie Towels |
| Scooper/Poop Bags | Cleaning Supplies | Fire extinguisher(s) |
| Water shut off valve | Breaker Box | Sprinkler valves |

Client Signature _____ Date _____