
**APPLICATION FOR FACILITY NAME
REGULATION 1093**

Part IV, section 41 of O.Reg.1093 reads:

- (2) A member may name the veterinary facility in which he or she carries on an independent or private practice of veterinary medicine with a designation approved by the Registrar.
- (3) The designation under subsection (2) shall contain,
- (a) a geographical reference appropriate to the location of the facility or the surname of a member who is or was associated with the practice;
 - (b) the word “animal”, “pet” or “veterinary” except,
 - (i) if the practice in or from the facility is restricted to one particular species, the name of that species or one of the words “animal”, “pet” or “veterinary” or both the name of the species and one of the words “animal”, “pet”, and “veterinary”; and
 - (ii) if the practice in or from the facility is restricted to poultry, the word “poultry” with or without the word “veterinary”; and
 - (c) an appropriate term required under section 11. for the class of certificate of accreditation of the facility. (***See Form- List Of Veterinary Facility Designations & Terms***)
- (3.1) If the Registrar is in doubt as to whether or not a designation meets the requirements set out in subsection (3), he or she shall refer the matter to the Accreditation Committee.
- (4) Neither the Registrar nor the Accreditation Committee shall approve the designation if of the opinion that it,
- (a) is inconsistent with subsection (3)
 - (b) is improper or unfitting; or
 - (c) may tend to be confused with the designation of another veterinary facility or the name of a professional corporation.

PLEASE HAVE THE NAME APPROVED BY THE CVO BEFORE YOU REGISTER THE NAME ANYWHERE ELSE.

NOTE: A name search will be carried out to attempt to identify similar names.



2106 Gordon Street,
Guelph, ON
N1L 1G6
Phone: 1- 800-424-2856 or 519-824-5600
Fax: 1- 888-662-9479 or 519 824-6497
Website: www.cvo.org
Accreditation Contact: Louise Hamilton
ext. 2230
lhamilto@cvo.org

APPLICATION FOR FACILITY NAME

(NB - The information collected on this form is used for the purpose of regulating the profession and practice of veterinary medicine. The immediate purpose for collecting this information is primarily to process your application for a facility name. For more information, see the CVO's Privacy Policy at www.cvo.org or contact CVO's Privacy Officer and Registrar, at Phone: (519) 824-5600 (Toll Free: 1-800-424-2856 (Ontario Only)).)

Date of application: _____

In accordance with Part IV, section 41 of Ontario Regulations 1093 pursuant to the Veterinarians Act 1989. *Refer to the cover page.*

I, Dr. _____

Please Print Name of Director/Owner

a licensed member of the College of Veterinarians of Ontario hereby make application for the practice name of

Facility name: **FIRST CHOICE:** _____

Note: If the first element chosen is a geographical reference, the significance of which is not obvious, please provide a brief explanation.

Located at Street No. or R.R. No.: _____

Lot No.: _____ Concession No.: _____

Township: _____ County: _____

City: _____ Postal Code: _____

Telephone No.: _____ Fax No.: _____

In the event that your proposed name is not authorized, please list alternative choices:

SECOND CHOICE: _____

Note: If the first element chosen is a geographical reference, the significance of which is not obvious, please provide a brief explanation.

THIRD CHOICE: _____

Note: If the first element chosen is a geographical reference, the significance of which is not obvious, please provide a brief explanation.

I confirm that (**check the** appropriate box):

I am the **owner** of, or **partner** in, the practice conducted in or from the facility that is the subject of this application,

OR

I am the **veterinary director** of the practice and am submitting to the College, the written authority of the owners or partners of the practice to provide the undertaking required below.

AND I CONFIRM THAT:

I am providing this written undertaking to be responsible for the facility.

I hold a general or restricted license, the conditions of which are consistent with the conditions of the Certificate of Accreditation.

Please indicate name(s) of **all** owner(s). **** Use separate sheet if required.*

Proposed Categories for the Facility: (check one or more)

***Please indicate number of mobiles.

<input type="checkbox"/>	Companion Animal Hospital	<input type="checkbox"/>	Food Producing Animal Hospital				
<input type="checkbox"/>	Companion Animal Office	<input type="checkbox"/>	# Food Producing Animal Mobile ¹				
<input type="checkbox"/>	Companion Animal Mobile Office	<input type="checkbox"/>	Equine Clinic				
<input type="checkbox"/>	# Companion Animal Mobile	<input type="checkbox"/>	# Equine Mobile ²				
<input type="checkbox"/>	Companion Animal Emergency Clinic	<input type="checkbox"/>	# Equine Emergency Mobile				
<input type="checkbox"/>	Companion Animal Spay-Neuter Clinic	<input type="checkbox"/>	Poultry Service				
<input type="checkbox"/>	Remote Companion Animal Mobile	<table border="1"><tr><td>D</td><td><input type="checkbox"/></td></tr><tr><td>O</td><td><input type="checkbox"/></td></tr></table>	D	<input type="checkbox"/>	O	<input type="checkbox"/>	Specialty Animal Hospital
D	<input type="checkbox"/>						
O	<input type="checkbox"/>						

PROPOSED OPENING DATE OF FACILITY: _____

Signature of Director/Owner: _____

***All mail will be addressed to you unless directed otherwise.*

Please indicate **Current Mailing Address.**

CONTACT PHONE NUMBER: _____

FOR OFFICE USE ONLY

File number assigned: _____

Date the name was discussed by the Committee: _____

Similar names identified: _____

Name authorized: _____

Authorized by the Registrar or Deputy Registrar: _____

¹ A Food Producing Animal Hospital or Mobile may treat both food producing animals and horses.

² An Equine Clinic or Mobile may treat **only** horses.