
APPLICATION FOR RENEWAL OF FACILITY NAME AND FACILITY INSPECTION

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 this application. 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)).

FILE NO. _____

Applicants: Please complete all of Sections A B & D and the pertinent portion(s) of Section C.

Date of Application: _____

In accordance with Part IV, Section 41 of REGULATION 1093.

I Dr. _____
Print name of Director/Owner (if the practice is being sold, this should be the name of the buyer)

a licensed member of the CVO, hereby make application for the following:

SECTION A: Reason for Renewal Request (check one or more):

- | | |
|--|--|
| <input type="checkbox"/> Facility Relocation | <input type="checkbox"/> Category Change _____ |
| <input type="checkbox"/> Facility Changing Ownership | <input type="checkbox"/> Adding A Category _____ |
| <input type="checkbox"/> Facility Name Change | <input type="checkbox"/> Name Renewal Only |

Note: If only a name change, NO INSPECTION IS REQUIRED

SECTION B: Information Prior to Change (Please complete all of this section)

(1) **Name of Facility:** _____

(2) **Practice Address:**

Street or R.R. No.: _____

Lot No.: _____ Conc. No.: _____ Township: _____

County: _____ City: _____ Postal Code: _____

Telephone No.: _____ Fax No.: _____

CONTACT PHONE NUMBER: (if differs from above) _____

MAILING ADDRESS (if differs from above) _____

SECTION B: Information Prior to the Change - cont (Please complete all of this section)

(3) **Practice Owner (or Seller):**

Print Name of Director/Owner

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

(4) **Existing Categories of Accreditation:** *(check one or more)*

**(please indicate number (#) of mobiles in the box)*

- | | | | | | | | |
|----------------------------|-------------------------------------|---|---|--------------------------|---|--------------------------|---------------------------|
| <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" style="display: inline-table; vertical-align: middle;"><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"/> | | | | | | |

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

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

SECTION C: Information Following the Change (Complete only those parts relevant to the request)

(1) New Practice Name: (if applicable)

Name of Facility: _____

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

i) _____

ii) _____

SECTION C: Information Following the Change - cont (Complete only those parts relevant to the request)

(2) New Address: (if applicable)

Street or R.R. No.: _____

Lot No.: _____ Conc. No.: _____ Township: _____

County: _____ City: _____ Postal Code: _____

Telephone No.: _____ Fax No.: _____

Email: _____

(3) Buyer: (if applicable)

Print Name of the **New** Director/Owner

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

(4) New Category(ies) of Accreditation: (check one or more)

(Please indicate number (#) of mobiles in the box)

<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 ³				
<input type="checkbox"/>	Companion Animal Mobile Office	<input type="checkbox"/>	Equine Clinic				
<input type="checkbox"/>	# Companion Animal Mobile	<input type="checkbox"/>	# Equine Mobile ⁴				
<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"/>						

³ A Food Producing Animal Mobile may treat both food producing animals and horses.

⁴ An Equine Mobile may treat **only** horses.

SECTION D: (Please complete all of this section)

PROPOSED DATE OF CHANGE: _____

In accordance with Part 1, section 10, clauses (a)-(d) of Ontario Regulation 1093 (formerly 140/90) established under subsection 8(1) of the Veterinarians Act:

I confirm that I, Dr. _____
Please Print Name

Check the **appropriate box**:

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

OR

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

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

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

Signature of Director/Owner: _____
(All mail will be addressed to you unless directed otherwise)

FOR OFFICE USE ONLY

Similar names identified: _____

Name Authorized on behalf of the Registrar: _____

Signature on behalf of the Registrar by: _____

Notes: _____
