



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: Aneeta Bharij, Ext. 2230
abharij@cvo.org

APPLICATION FOR RENEWAL OF CERTIFICATE OF ACCREDITATION

FILE NO. _____

Part VII, section 50, subsection (2), of Ontario Regulation 1093 states:

“A holder of a certificate of accreditation who meets the requirements of section 10 is eligible for a renewal of the certificate if an application for the renewal is submitted not earlier than five months and not later than three months before the expiry of the certificate.”

IMPORTANT:

Please note that the inspection is usually completed two to three months in advance of the expiration of the existing certificate(s) of accreditation in order to allow time for correction of any deficiencies noted or for *Requests for Exemption* to be processed.

Date of Application: _____

In accordance with Part 1, section 10, clauses (a)-(d) of Ontario Regulation 1093,

I, Dr. _____

Print name of Director/Owner:

hereby make application for inspection and accreditation of the following facility:

Name of Facility: _____

Street or R.R. No: _____

If RR - Lot No.: ____ Conc. No.: ____ Township: _____ County _____

City: _____ Postal Code: _____

Telephone No.: _____ Fax No.: _____

email address: _____

CONTACT PHONE NUMBER: _____ if different from above.

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 am providing the 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.

Category(ies) for which application is being made: (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"><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"/> | | | | | | |

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

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

Note: If you own more than one facility and wish the facilities to be inspected at the same time, please contact the Accreditation Co-ordinator.

Comments: _____

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

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