



**THE COLLEGE OF
VETERINARIANS OF
ONTARIO**

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Fax: 1- 888-662-9479 or 519 824-6497
Website: www.cvo.org
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**CONGENITAL DEAFNESS EVALUATION PROGRAM
AUTHORIZATION FORM**

NB – completed form must be received by CVO at least two weeks prior to event

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)).

Member's Name: _____

Address: _____

Phone: _____ Fax: _____

I hereby confirm that this is my request for authorization to conduct a congenital deafness evaluation program at the following location(s):

on the following date(s): _____

at the following time(s): _____

Check applicable clause

_____ I am a diplomate of the American College of Veterinary Internal Medicine, specialty of Neurology and a licensed member of the College of Veterinarians of Ontario and agree to abide by the College's Policy on Congenital Deafness Evaluation Programs, which I have received and read in full.

_____ I am a licensed member of the College of Veterinarians of Ontario and agree to abide by the College's Policy on Congenital Deafness Evaluation Programs, which I have received and read in full. The evaluations will be conducted by Dr. _____, who is a diplomate of the American College of Veterinary Internal Medicine, specialty of Neurology.

Date: _____
_____ College of Veterinarians of Ontario
Member's Signature

FOR OFFICE USE ONLY

Date received: _____

Authorized by: _____

Confirmation sent by: _____

AVMA Board Certified Veterinarian Licence # _____