



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

**RABIES VACCINATION CLINIC
AUTHORIZATION FORM**

Member's Name: _____

Address: _____

Phone: _____ Fax: _____

I hereby confirm that _____
has approached me to conduct a rabies vaccination clinic at the following location(s):

on the following date(s): _____

at the following time(s): _____

I am a licensed member of the College of Veterinarians of Ontario and agree to abide by the College's Regulations, Part VI, Exemptions, 45. (1) to (6), which I have received and read in full. I have also received and agree to abide by the College's policy on rabies vaccination clinics. **I confirm that I have notified all the veterinarians in our area of the date of the clinic, as required by subsection 45(1)(a) of the regulations, in order that they may participate in the rabies clinic, and have requested the cooperation of the medical officer of health for this area.**

College of Veterinarians of Ontario
Member's Signature

Date: _____

FOR OFFICE USE ONLY

Date received: _____

Authorized by: _____

Confirmation sent by: _____