CVO

THE COLLEGE OF VETERINARIANS OF ONTARIO

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 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):*

- ☐ Facility Relocation
- ☐ Category Change _______________
- ☐ Facility Changing Ownership
- ☐ Adding A Category _______________
- ☐ Facility Name Change
- ☐ 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)*

Box	Category	Box	Category
☐	Companion Animal Hospital	☐	Food Producing Animal Hospital
☐	Companion Animal Office	☐ #	Food Producing Animal Mobile[1]
☐	Companion Animal Mobile Office	☐	Equine Clinic
☐ #	Companion Animal Mobile	☐ #	Equine Mobile[2]
☐	Companion Animal Emergency Clinic	☐ #	Equine Emergency Mobile
☐	Companion Animal Spay-Neuter Clinic	☐	Poultry Service
☐	Remote Companion Animal Mobile	D ☐ / O ☐	Specialty Animal Hospital

[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)

☐	Companion Animal Hospital	☐	Food Producing Animal Hospital
☐	Companion Animal Office	☐ #	Food Producing Animal Mobile[3]
☐	Companion Animal Mobile Office	☐	Equine Clinic
☐ #	Companion Animal Mobile	☐ #	Equine Mobile[4]
☐	Companion Animal Emergency Clinic	☐ #	Equine Emergency Mobile
☐	Companion Animal Spay-Neuter Clinic	☐	Poultry Service
☐	Remote Companion Animal Mobile	D ☐ / O ☐	Specialty Animal Hospital

[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: ____

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