sladevet

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SLADE VETERINARY HOSPITAL DESTRUCTION OF FROZEN SEMEN FORM

If you choose to destroy frozen semen stored at Slade Veterinary Hospital, please fill out the following form and return to us at sladevetrepro@gmail.com.

STUD INFORMATION

Owner name _____
Address _____
Telephone _____ Email _____

For stud dogs with multiple owners, please list the primary contact person authorized to make all breeding-related decisions, understanding that this is the ONLY person who will be contacted by our staff in an effort to streamline all decisions and avoid any miscommunications.

Stud call name _____ Breed_____ Age _____
Registration number _____ Brucellosis test date (if available) _____

COLLECTION INFORMATION

Collection Date(s)_____ Number of frozen straws or vials _____
Reason for destruction _____
_____

AUTHORIZATION

I hereby authorize that I am the owner and I authorize Slade Veterinary Hospital to destroy the semen for the information listed above.

Owner Signature _____ Date _____

Print name _____

FOR OFFICE USE ONLY.

Basket Number _____
Cane ID _____ Straw ID _____

Date of destruction _____

Doctor name and signature _____

Witness name and signature _____