

Veterinarian/Client/Patient Relationship Validation Form

I. Producer

Producer Name: _____

Address: _____ City _____ Zip: _____

Farm Name and Location _____

Section: _____ Township: _____ County: _____

Type of Operation: (check all that apply)

_____ Cow-Calf

_____ Dairy Production (cull cows)

_____ Beef and/or Dairy Beef Grower

_____ Beef and/or Dairy Beef Grower-Finisher

II. Veterinarian

Name: _____, DVM

Address: _____ City: _____ Zip: _____

License No. _____ USDA Accreditation No. _____

I hereby certify that a valid Veterinarian/Client/Patient/Relationship (VCPR) is established for the above listed owner and will remain in force until canceled by either party or the verification expiration date is reached.

Veterinarian's Signature: _____

Date: _____

Return this form to: New York Beef Industry Council
PO Box 250
Westmoreland, NY 13490