EQUINE CARE PROGRAM

Equestrian Canada

VCPR VALIDATION FORM

Corresponds with Requirement 1.0

Facility owner:

Name: _____

Phone number: _____

Email: _____

Facility address:

_____

_____

Attending veterinarian:

Name: _____

Clinic: _____

Phone number: _____

Email: _____

Clinic address:

_____

_____

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

Veterinarian signature: _____

Date: _____

Facility owner signature: _____

Date: _____