

ANIMAL HOSPITAL OF FT LAUDERDALE
1630 East Oakland Park Blvd.
Ft. Lauderdale, FL 33334
Ph: (954)561-8777 Fax: (954)561-0944

FREEZING AUTHORIZATION

Date: _____

I hereby authorize the collection and freezing of semen from the below listed dog:

DOG'S NAME: _____

REGISTRATION BODY: _____

REGISTRATION NUMBER: _____

BREED: _____

NAME OF OWNER: _____

ADDRESS: _____

CITY,STATE,ZIP CODE: _____

The Animal Hospital of Ft. Lauderdale will exercise care to prevent any injury to your dog while in our care, both during and after collection, however, we accept no responsibility for accident or injury not caused by our negligence.

- I do
- I do not

AUTHORIZE the Animal Hospital of Ft. Lauderdale to release information on my dog to prospective clients.

Name and address of agent if any:

Signature _____