FORM 1

To be reviewed, signed and submitted to VQA Program. Please fully complete the form and print clearly.

VETERINARIAN CLIENT PATIENT RELATIONSHIP (VCPR) VALIDATION FORM

FARMER / MANAGER

Name____

Address____

City________________ State________________ Zip__________

Farm Name and Location______________________________

Section________________ Township________________ County __________

Premise ID Number________________ Phone____________________

Email____

Signature ______________________________ **Date** __________

VETERINARIAN

Name____

Clinic Name____________________________________

License No. or USDA Accreditation No.________________________

Address____

City________________ State________________ Zip__________

Phone Number________________ Email____________________

Email____

"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."

Veterinarian's Signature ________________________ **Date** __________

Submit completed VQA certification documentation (Form 1 and Form 2) to:

Veal Quality Assurance Program
2900 NE 60th Street, Suite 200
Gladstone, MO 64119
VQA@LookEast.com