EYE CLINIC REGISTRATION (please print)

Animal's Registered/Call Name: _____

Breed: _____ Sex: _____

Tattoo or Chip #: _____

Registration Number: _____ Date of Birth _____
D M Y

Owner's Name**:** _____

Co-Owner's Name**:** _____

Address _____

City _____ Province _____ Postal Code _____

E-Mail Address _____ Phone: _____

PLEASE CHECK PREFERENCE OF TIME

Friday Morning 9:00 to 10:30 _____ 10:45 to 12:00 _____

Friday Afternoon 1:30 to 3:00 _____ 3:15 to 5:30 _____

Saturday Morning 8:30 to 10:00 _____ 10:15 to 11:45 _____

Saturday Afternoon 1:00 to 2:00 _____

IMPORTANT NOTICE

Please note that the appointment time you will be given is for 15 to 20 minutes before the time at which you will get in to see the Specialist. Drops used to dilate the pupil take about that long

The organizers of the clinic and the owners of the premises where the clinic is held may not be held responsible for any loss or damage to persons attending or to their property.

TOTAL FEE ENCLOSED $_____ _____
Signature of Owner or Agent