EYE CLINIC REGISTRATION (please print)

Animal's Registered/C	all 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 Co	ode		
E-Mail Address		Phone:			
	PLEASE CHECK P	REFERENCE OF T	IME		
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				
	IMPORT	ANT NOTICE			
	pointment time you will be a he Specialist. Drops used to				e time at which
	clinic and the owners of the ses or damage to persons atter			eld may	not be held
TOTAL FEE ENCLOS	SED \$	Signature of	Owne	r or Age	 nt