OHIO VETERINARY MEDICAL LICENSING BOARD
-APPLICATION FOR VACCINE CLINIC -

NAME OF PARENT COMPANY / CLINIC SPONSER: _____

_____

LOCATION OF CLINIC: _____

_____

_____

PERMANENT ADDRESS: _____
(Where records for the clinic will be held.)

_____

_____

DATES OF OPERATION: _____

HOURS OF OPERATION: _____

PHONE NUMBER: _____

_____ _____
Signature of Supervising Veterinarian License Number

_____ _____
Signature of Supervising Veterinarian License Number

_____ _____
Signature of Supervising Veterinarian License Number

Please complete and return to:

Ohio Veterinary Medical Licensing Board
77 South High Street, 16th Floor
Columbus, Ohio 43215-6108
FAX: 614-644-9038
EMAIL: info@ovmlb.state.oh.us

Please review OAC 4741-1-16