Breeder: [Owner ID] - [First Name] [Middle Name] [Last Name]

Group Veterinary Health Certification Form

Veterinarian's Full Name:_____ State License # :_____

Clinic Name:_____

Address:_____

City:_____, State:_____ Zip Code:_____

Phone #: (_____)-_____-_____ FAX #: (_____)-_____-_____ Cell #: (_____)-_____-_____

Email Address:_____@_____ Web Site: http://.www._____

BREED	REGISTERED NAME	REGISTERED NO.	WHELPED	SEX	COLOR(S)	MICROCHIP NO.	YES **HEART** - No Murmur or Apparent Abnormality.	YES **EYES** - Free of Entropy.	YES **DENTAL** - Correct Bite for Breed.	YES **KNEES** - No Luxation in Patellae.

As a duly licensed veterinarian, I certify that the above information is true and correct to the best of my belief.

X_____ _____/_____/_____

Signature of Licensed Veterinarian Listed Above Date of Examinations

Once you have completed the update form, please either fax it to **1-800-422-1865** or mail it to: American Canine Association, Inc., PO Box 121107, Clermont, FL 34711