

**FUTURE SUPPLY AUTHORISATION FORM**

VETEX LIMITED
Please email to office@vetex.co.nz and return original copies to PO Box 960, Cambridge, 3450.

CLINIC & CONSULTATION DETAILS

Date of Consultation	Date of Expiry	Clinic/Practice	
Clinic Postal Address		Town/City	Postcode
Phone	Fax	Cellphone	
Authorising Veterinarian (Print Name)		Email	
Please notify me when the volume of RVM dispensed to the client exceeds <input type="checkbox"/> 80% <input type="checkbox"/> 90% <input type="checkbox"/> 100% of the authorised volume.			
I permit to an RVM with the same active ingredient of equal concentration/strength to be used if necessary <input type="checkbox"/>			

CLIENT DETAILS

Name of Owner/Entity/Company/Partnership			
Person(s) Responsible for Animal Treatment			
Physical Address		Town/City	Postcode
Home	Work	Cellphone	
Animal Group to be Treated (circle one) bovine equine ovine caprine swine other _____			

AUTHORISATION DETAILS (1)

Trade Name		Active Ingredient
Quantity/volume authorised for Future Supply (include units)		Strength/concentration (include units)
Complete or provide the following in the form of a 'Dairy Sheet' or 'Shed Chart'		
Dose (include units)	Frequency of treatments	Number of treatments (if applicable)
Administration Route	WITHHOLDING PERIOD – MILK (use units)	WITHHOLDING PERIOD – MEAT (use units)
Additional Prescription Notes/Precautions. Please write here any additional notes and precautions that you require on the dispensing label.		

Authorising Veterinarian _____

(signature)

Date _____

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VETEX LIMITED**AUTHORISATION DETAILS (2)**

Trade Name		Active Ingredient	
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Dose (include units)	Frequency of treatments	Number of treatments (if applicable)	
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AUTHORISATION DETAILS (3)

Trade Name		Active Ingredient	
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AUTHORISATION DETAILS (4)

Trade Name		Active Ingredient	
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AUTHORISATION DETAILS (6)

Trade Name	Active Ingredient	
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Trade Name		Active Ingredient	
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Trade Name	Active Ingredient	
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AUTHORISATION DETAILS (16)

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