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# VETERINARIAN/CLIENT/PATIENT RELATIONSHIP VALIDATION FORM

## I. Producer

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Farm Name & Location: \_\_\_\_\_  
(If different from above)

\_\_\_\_\_ County: \_\_\_\_\_

Certified Status:

Verified: \_\_\_\_\_ Review Date: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Type of Operation Certified: *(mark all that apply)*

Cow-calf  Dairy production (cull cows)

Beef and/or dairy beef growers  Beef and/or dairy beef grower-finisher

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## II. Veterinarian

Name: \_\_\_\_\_, DVM

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

SD License No. \_\_\_\_\_ USDA Accreditation No. \_\_\_\_\_

**I hereby certify that a valid Veterinarian/Client/Patient/Relationship (VCPR) is established for the above listed owner and will remain in force until canceled by either party or the verification expiration date is reached.**

Veterinarian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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