AUTHORIZATION FOR DESTRUCTION OF CANINE FROZEN SEMEN

Semen Owner:_____ Semen Co-Owner:_____

Address:_____ Address:_____

City: _____ City: _____

State:_____Zip:_____ State:_____Zip:_____

Phone:_____ Phone:_____

Email:_____ Email:_____

Registered Name of the Dog:_____

Call Name:_____ Breed: _____

Color:_____ Birthdate: _____

Registered #: _____ DNA Number :_____

Microchip # _____ Tattoo #_____

I/We request and authorize thawing and destruction of the canine semen for the identified dog listed above which is stored at Inver Grove Heights Animal Hospital, to be performed by an authorized team member.

Collection(s) # of semen to be destroyed: _____

Total # of breeding unit(s) to be destroyed: _____

Owner Name:_____Date: _____

Signature: _____

Co-Owner Name*:_____Date: _____

Signature: _____

*For destruction, Co-Owner signature required when a co-owner has been listed on file

INVER GROVE HEIGHTS
ANIMAL HOSPITAL

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