



Virology Division
Fax. (01) 615 7218
Tel. (01) 615 7259

Form: EVA-1

APPLICATION FOR SUPPLIES OF "ARTERVAC" FOR USE IN STALLIONS IN 2008

Veterinary Surgeon: _____

Address: _____

Telephone No: _____ Fax: _____ E-Mail: _____

Owner of Stallion (s): _____

Address: _____

| NAME OF STALLION (S): | Primary Vaccination (2 doses) | Booster Vaccination (1 dose) | Date of Last Vaccination |
|-----------------------|-------------------------------|------------------------------|--------------------------|
| 1 _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| 2 _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| 3 _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| 4 _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| 5 _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| 6 _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |

Total number of vaccine doses required →

APPLICATIONS THAT ARE NOT ACCOMPANIED BY AN IDENTIFIED BLOOD SAMPLE WILL NOT BE PROCESSED.

I undertake to blood sample each stallion 14-21 days after the second vaccination and subsequently as requested by the Department of Agriculture and Food.

Signature _____ Vs.

Date: ____/____/2008