

12000 Durham  
Washington, MI 48095



Phone: (586) 752-6217  
Fax: (586) 752-1532

A Division of Wilson Veterinary Hospital

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**SEMEN COLLECTION AND PROCESSING AUTHORIZATION**

I hereby authorize the collection and freezing of semen from the below listed dog:

Registered Name of Dog \_\_\_\_\_

Registration Body and Number \_\_\_\_\_ Breed \_\_\_\_\_

Birthdate \_\_\_\_\_ DNA Profile # \_\_\_\_\_

Call Name \_\_\_\_\_ Tattoo # \_\_\_\_\_ Microchip # \_\_\_\_\_

Color \_\_\_\_\_ Markings \_\_\_\_\_

Remarks \_\_\_\_\_

Semen Owner _____	Phone _____
Street _____	Cell _____
City, State, Zip _____	Work Phone _____
Email _____	Fax _____

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**Checklist:**

For Office Use Only:

Registration Certificate	Yes	No
Health Certificate	Yes	No
Bruceellosis Certificate	Yes	No
DNA Certificate	Yes	No