



ANNUAL RETURN /AUDIT

SEASON 200__ - 20__

NAME: OPERATOR _____ **ACCRED NO:** _____

ADDRESS: _____

PHONE NO: _____ **FAX NO:** _____

EMAIL: _____

INITIAL ACCREDITATION: Year: _____ **REFRESHER LAST DONE:** Year: _____

| DEER VELVETED: | RED | RUSA | ELK | FALLOW |
|-----------------------|------------|-------------|------------|---------------|
| NO FIRST CUT: | | | | |
| NO REGROWTH: | | | | |

METHOD OF VELVETING:

PHYSICAL RESTRAINT YES NO NERVE BLOCK YES NO

CHEMICAL YES NO RING BLOCK YES NO

| | AMT RECEIVED | AMT USED | AMT RETURNED |
|-----------------------|---------------------|-----------------|---------------------|
| LIGNOCAINE | mls | mls | mls |
| XYLAZINE | mls | mls | mls |
| YOHIMBINE - REVERSINE | mls | mls | mls |

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POST VELVETING DEATHS: YES

NO

POST MORTEM -
NO. PERFORMED

OPERATOR SIGNATURE:

DATE:

STANDARD OF FACILITIES:

Satisfactory

Unsatisfactory

STANDARD OF OPERATOR:

Satisfactory

Unsatisfactory

VETERINARY PRACTICE NAME

VET NAME (Please Print)

VET TAG
NUMBER

(If Applicable)

ADDRESS

TEL

FAX

EMAIL

SUPERVISING VET
SIGNATURE

DATE: