North Carolina Veterinary Medical Board

Agreement for Referral of Services

This agreement is to verify that “Receiving Practice” agrees to accept referrals from “Referring Practice” for the listed services.

1. Services being referred:

   Hospitalization: ___
   Radiology: ___
   Emergency: ___

2. “Referring Practice”

   Practice Name: ___________________________________________
   Location: ___________________________________________________
   Practice Owner: _____________________________________________  
   Practice Owner Signature: ______________________________________

3. “Receiving Practice”

   Practice Name: ___________________________________________
   Location: ___________________________________________________
   Practice Owner: _____________________________________________  
   Practice Owner Signature: ______________________________________

   Today’s Date: ____________________________
   Expiration Date*: ____________________________

   *If left blank, agreement will expire when either practice changes ownership.

Mail to: NCVMB, 1611 Jones Franklin Rd., Suite 106, Raleigh, NC 27606 or e-mail: cmoss@ncvmb.org