

NC Veterinary Medical Board

Closing Veterinary Practice Facility

This serves to notify the NC Veterinary Medical Board of the closing of a veterinary practice facility.

***** DO NOT ABBREVIATE FACILITY NAME *****

Name of Facility: _____

Street Address of Facility: _____

Mailing Address of Facility: _____

Date of Closing: _____

Name of Owner(s):

Name: _____ License Number: _____

Name: _____ License Number: _____

Name: _____ License Number: _____

Name of any associated professional entities: _____

Facility/Person name and address where patient records can be located:

(Patient records must be retained for a minimum of 3 years following the patient's last visit.)

Primary Contact Information:

Name: _____

Phone Number: _____ Email: _____

(Primary contact information will be given to clients who contact this office in search of patient records.)

Clients _____ were or _____ will be notified of the closing.

Notification of the closing was sent via:

_____ Mail, _____ E-Mail, _____ Social Media, _____ Phone Call, Other: _____

Signature: _____

Print Name: _____ Date: _____