

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: _____
Please print

Practice Owner Signature: _____

3. “Receiving Practice”

Practice Name: _____

Location: _____

Practice Owner: _____
Please print

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