



**Veterinary Feed Directive for Breeding Sheep
ChlorMax®
(chlortetracycline)**

Veterinarian: _____

Client: _____

Address: _____

Business or Home Address: _____

Phone #: _____

Phone #: _____

FAX or email: (optional) _____

FAX or email: (optional) _____

Indication, Drug Level, and Duration of Use: (specify additional required information)

Breeding sheep: Reducing the incidence of (vibriotic) abortion caused by *Campylobacter fetus* infection susceptible to chlortetracycline.

Drug level: _____ g/ton (to provide 80 mg/hd/day)

Duration of use: _____ days

USE OF FEED CONTAINING THIS VETERINARY FEED DIRECTIVE (VFD) DRUG IN A MANNER OTHER THAN AS DIRECTED ON THE LABELING (EXTRA-LABEL USE) IS NOT PERMITTED.

Approximate number of **Breeding Sheep** to be treated: _____

Premise or Location of animals: _____

Special Instructions and/or other animal identifications:

Affirmation of Intent (for combination VFD drugs):

This VFD only authorizes the use of the VFD drug(s) cited in this order and is not intended to authorize the use of such drug(s) in combination with any other animal drugs.



Warning: No withdrawal period required.



Date of VFD Issuance: _____ (dd/mm/yyyy)

Date of VFD Expiration: _____ (dd/mm/yyyy)
(Cannot exceed 6 months after issuance)

Veterinarian's signature: _____

Color Z Original – Veterinarian

Color X Copy – Supplier

Color Y Copy – Client

All parties must retain a copy of this VFD for 2 years after issuance