

Veterinary Feed Directive

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

Veterinarian: _____ Client: _____
Address: _____ Address: _____

(business or home)

Phone: _____ Phone: _____
Fax or email (optional): _____ Fax or email (optional): _____

Drug(s) Name: _____ Drug(s) Level: _____ g/ton Duration of use: _____
Species and Production Class: _____ Number of reorders authorized: _____

(If permitted by the drug approval)
Indication for use (as approved): _____
Caution (related to this medicated feed, if any): _____

**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 Animals: _____
Premises: _____
Other Identification (e.g., age, weight) (optional): _____
Special Instructions (if any): _____

Affirmation of intent (for combination VFD Drugs) (check box)*:

- 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.
- This VFD authorizes the use of the VFD drug(s) cited in this order in the following FDA-approved, conditionally approved or indexed combinations(s) in medicated feed that contains the VFD drug(s) as a component.

| Drug(s) | Drug Level(s) and any Special Instructions |
|---------|--|
| | |
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- This VFD only authorizes the use of the VFD drug(s) cited in this order any FDA-approved, conditionally approved or indexed combinations(s) in medicated feed that contains the VFD drug(s) as a component.

▶ Withdrawal Time (if any): This VFD Feed must be
withdrawn _____ days prior to slaughter. ◀

VFD Date of Issuance: _____ (Month/Day/Year)

VFD Expiration Date: _____ (Month/Day/Year)

Veterinarian's Signature: _____ (As specified in the approval; cannot exceed 6 months after issuance.)