

**Office Use Only**  
 APPL \_\_\_\_\_  
 RAD \_\_\_\_\_  
 CK \_\_\_\_\_



**Orthopedic Foundation for Animals**

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*www.offa.org*

A Not-For-Profit Organization

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**Application for Craniomandibular Osteopathy Database**

*Please type or print legibly. To ensure accuracy please enclose copy of the dog's registration papers*

Previous application number (if any):			Registration number: <input type="checkbox"/> AKC <input type="checkbox"/> CKC			Other registry name:		
						Other registry #:		
Registered name:			Sex:			Color:		
Breed:			Date of Birth (month-day-year):					
ID Number (if any): <input type="checkbox"/> Tattoo <input type="checkbox"/> Microchip			Registration number of sire:			Registration number of dam:		
Owner name:			Date radiograph taken (month-day-year):			Film no.:		
Co-Owner name:			Examining veterinarian's name or veterinary hospital:					
Mailing address:			Mailing Address:					
City:		State:	Zip/postal code:		City:		State:	Zip/postal code:
Phone:		E-mail:		Phone:		E-mail:		

*I hereby certify that the radiograph submitted is of the animal described on this application. I am aware that the radiographic image will be retained for the records of the Orthopedic Foundation for Animals, Inc. I understand that only normal results will be released to the public unless the initials of a registered owner appear in the authorization box below which permits the OFA to release abnormal results to the public.*

**Signature of owner or authorized representative** \_\_\_\_\_

<p><b>Authorization to Release Abnormal Results</b></p> <p><i>I hereby authorize the OFA to release the results of its radiographic evaluation of the animal described on this application to the public if the results are abnormal _____ (initials of registered owner).</i></p>
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**Veterinary Information**

This animal was restrained using:

- Physical Restraint only \_\_\_\_\_
- Chemical Restraint
  - Anesthesia \_\_\_\_\_ type \_\_\_\_\_
  - Tranquilizer \_\_\_\_\_ type \_\_\_\_\_
  - Other \_\_\_\_\_ type \_\_\_\_\_

**Instructions**

The required radiographic views are lateral and ventrodorsal projections of the skull.

Radiographs should be permanently identified in the film emulsion with:

- Registered name and/or number
- Name of veterinarian or hospital making the film
- Date of radiograph taken

<input type="checkbox"/> <b>I DID</b> verify tattoo/microchip on this dog	<input type="checkbox"/> <b>I DID NOT</b> verify tattoo/microchip on this dog
<b>Veterinarian Signature</b> _____	Specialty: <input type="checkbox"/> Practitioner, <input type="checkbox"/> Specialist _____
	Date _____

**Fees  
Animals Over 3 Months**

- Craniomandibular osteopathy database..... \$25.00

**Kennel Rate**—Individuals submitted as a group, owned/co-owned by same person.

- Minimum of 5 individuals..... \$15.00 per study

*Payments can be made by check, money order (U.S. funds drawn on a U.S. bank), cash, Visa, or Mastercard, payable to the Orthopedic Foundation for Animals.*

\_\_\_\_\_  
 Visa/Master Card Number                      Name on Card                      Exp Date                      CVV (security code)

*Affected Animals and Resubmits at No Charge*