Veterinary Feed Directive for Swine
ChlorMax®
(chlortetracycline)

Veterinarian:_____ Client: _____

Address: _____ Business or Home Address:_____

_____ _____

Phone #: _____ Phone #: _____

FAX or email: (optional) _____ FAX or email: (optional) _____

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Indications, Drug Level, and Duration of Use: (select one and specify additional required information)

☐ 1) Swine: Control of porcine proliferative enteropathies (ileitis) caused by *Lawsonia intracellularis* susceptible to chlortetracycline.
Drug level:_____g/ton (approximately 400 g/ton to provide 10mg/lb BW/day)
Duration of use:_____days (feed for not more than 14 days)

☐ 2) Swine: Treatment of bacterial enteritis caused by *Escherichia coli* and *Salmonella choleraesuis* and bacterial pneumonia caused by *Pasteurella multocida* susceptible to chlortetracycline.
Drug level:_____g/ton (approximately 400 g/ton to provide 10mg/lb BW/day)
Duration of use:_____days (feed for not more than 14 days)

☐ 3) Swine: Reduction in the incidence of cervical lymphadenitis (jowl abscesses) caused by Group E *Streptococci* susceptible to chlortetracycline.
Drug level:_____g/ton (50-100 g/ton)
Duration of use: _____days

☐ 4) Breeding Swine: Control of leptospirosis (reducing the incidence of abortion and shedding of *leptospirea*) caused by *Leptospira pomona* susceptible to chlortetracycline.
Drug level: 400 g/ton
Duration of use: _____days (feed continuously for not more than 14 days)

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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 ***Swine*** to be treated: _____

Premise or Location of animals: _____

Special Instructions and/or other animal identifications:

Affirmation of Intent (for combination VFD drugs**): check the appropriate 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 combination(s) in medicated feed that contains the VFD drug(s) as a component.
_____(List the specific approved combination)

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

Warning: Indication 1, 2, 3, 4: 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