Sequential VFD ID Number, if appropriate

Veterinary Feed Directive for Chickens
Aureomycin®
(chlortetracycline)

Veterinarian:_____ Client: _____

Address: _____ Business or Home Address:_____

_____ _____

Phone #: _____ Phone #: _____

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

****

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

☐ Broiler Chickens: For the treatment of chronic respiratory disease caused by *M. gallisepticum* susceptible to chlortetracycline.

Drug Concentration: 200 g/ton

Duration of feeding: _____ days (no more than the first 21 days of life)

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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 ***Chickens*** to be treated: _____

Premises 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.

	Drug(s) and Dose Range(s)	Specifications*
☐	227 g/ton amprolium and 3.6 g/ton ethopabate (AMPROL PLUS®) [NADA 36-361]	
☐	Other FDA-approved, conditionally approved, or indexed combination:	

*for complete information see the approved Type C medicated feed label

□ 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.

Withdrawal Period: 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