

**Main Hospital Number: (970) 297-5000**

[http://csu-cvmbs.colostate.edu/vth/](http://csu-cvmbs.colostate.edu/vth)

Teaching Activity Contact Number: (if applicable)

*Teaching Protocol Title*: Owner Informed Consent

*{complete the items in blue and convert to normal black text, remove instructions in blue; remove any lines that are not applicable to the specific teaching activity}*

I understand that the veterinarians at Colorado State University (CSU) are engaged in teaching for the improvement of animal health, patient care, education, clinical investigation, and scientific innovation through research activities. The detailed procedures of the *Teaching Protocol Title* occurring on *{add date(s) and times}* have been explained to me by:

Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Owner Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Animal Information:**

Name/Unique Identifying Number/Markings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Species: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth or Approximate Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Length of Ownership: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Acquired From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please initial the following lines to confirm and agree with the following statements:***

**\_\_\_\_\_\_**  I understand that participation in this teaching activity is voluntary and that my decision to have my pet/animal(s) participate or not participate will not impact my relationship with CSU.

**\_\_\_\_\_\_**  I understand that I will receive *{no compensation or other benefits or include any incentives here}* in exchange for volunteering my pet/animal(s) for use in this teaching activity.

\_\_\_\_\_\_ My pet/animal(s) must {specify any requirements, e.g. healthy, up to date on vaccinations, etc.} in order to be eligible to participate in this teaching activity. I hereby certify that to the best of my knowledge the above referenced animal(s) is/are in good health and not currently under medical treatment except for the following:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_ I certify that my pet/animal(s) has/have never bitten or otherwise attacked anyone.

\_\_\_\_\_\_ The purpose of this teaching activity is to *{add purpose/goal here}*.

**\_\_\_\_\_\_** As part of this teaching activity, my pet/animal(s) will undergo the following procedures {*add description of the procedures to be performed, e.g. sedation, palpation, etc., including number, time commitment, and any potential side effects}.*

**\_\_\_\_\_\_** I realize that although all precautions will be taken to prevent my pet/animal(s) from suffering any illness or injury as a participant in this teaching activity, it is still possible that my pet/animal(s) will be injured or develop illness. If this occurs, *{add who is responsible for treatment and payment associated with any illness or injury to participant}*.

**\_\_\_\_\_\_** I understand that any data and specimens collected during this teaching activity are the property of the teaching activity organizers/CSU and may be stored for future use.

**\_\_\_\_\_\_**  I give my permission to publish data and photos obtained from this teaching activity. I understand that my pet/animal(s) will not be identified individually without my permission.

\_\_\_\_\_\_ I may withdraw my pet/animal(s) from this teaching activity at any time without penalty.

**\_\_\_\_\_\_**  The veterinarian in charge may withdraw my pet/animal(s) from this teaching activity if he/she determines that my pet/animal(s) is/are adversely affected.

\_\_\_\_\_\_ I may discuss this teaching activity and involved procedures with my own veterinarian and ask his/her advice.

**\_\_\_\_\_\_**  I have had time to ask questions regarding this teaching activity and feel comfortable having my pet/animal(s) participate based on the information provided.

**\_\_\_\_\_\_**  I understand that the funding for this teaching activity is provided by {*enter funding source here if appropriate}.*

**\_\_\_\_\_\_** I certify that I own the above referenced animal(s) and that I agree to allow CSU to use the animal(s) for the above referenced animal use activity; I am not relinquishing ownership or control over said animal(s) to CSU.

As a result of discussion with Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and after reading the above, I voluntarily consent to participate in this teaching laboratory and will follow the instructions of the veterinarians-in-charge and organizers during the teaching activity.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Owner or authorized agent of the owner

Witnessed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_