

Reproduction Services Submission Request

Owner Name:	Kennel Name:		
Cell Phone:	Email:	Email:	
Address:	City:	State:	Zip:
Call Name:	DOB	Breed:	
Registered Name:			
AKC/ or other Reg #			
AKC Breed Health Testing Requires	ments completed date _		
(For list of requirements by breed, visit	https://www.akc.org/breed	der-programs/breed-health-t	resting-requirements/
Requesto	ed Services (please o	check to indicate)	
Request for reproduction co Request for Progesterone tir Request for insemination be Request for Semen Collection Request for Semen Evaluati Emergency C-Section Avail	ming Start date of he e performed at our facili- on, Freezing and Storag on only	eat cycle ty Estimated Date	
Planned Method of Breeding:	Туре	e of Semen to be used (ci	rcle):
Natural (at client's own facilit	ty) N/A		
Artificial Insemination		or Fresh Chilled	
Transcervical Insemination	Fresh	or Fresh Chilled or Fro	zen
Surgical Implant	Fresh	or Fresh Chilled or Fro	ozen
ProgesteroneUltrasound fo	appointment with Dr Ro testing for timing	n 28 days post breeding	
Please allow 1-2 business days for o on the number of new patients/client			d that we are limited
I understand the above protocols of given on this form is true and that I	•		•
Signature	Printed Name		ate