

Rabies pre-exposure vaccination****Date administered_____

Type of vaccine administered:_____

Date and Lot# used:_____

Doctor administering vaccine:

Name:_____

Address:_____

Telephone:_____

Serology: Date blood drawn_____ Rabies titer_____

****Copies of lab and MD reports must be attached.

Name, telephone, address and DEC license # of all assistants who will be handling RVS and who are directly supervised by me. All persons will be required to submit a separate RVS registration form with the county in order to participate in the rehabilitation of RVS.

| Name | Telephone # | Address | DEC License # |
|------|-------------|---------|---------------|
| | | | |

I have received and read the Westchester County Department of Health RVS rehabilitation protocol and its attachments.

I agree to rehabilitate RVS according to the mandates set forth by the New York State Department of Environmental Conservation, New York State Department of Health, New York State Department of Agriculture and Markets, Westchester County Department of Health, and any other applicable laws, rules, and regulations.

I agree to abide by all the directives of the Westchester County Department of Health concerning the rehabilitation of RVS and the suppression of rabies in Westchester County.

I understand that at no time may bats be rehabilitated in Westchester County.

I understand that I am fully liable for any adverse consequences as a result of my activities in the rehabilitation of RVS.

I understand that permission to rehabilitate RVS in Westchester County may be rescinded by the Westchester County Department of Health.

I do hereby testify that the above information is true and accurate.

Date_____ Signature_____

Print Name_____

Notarization:

Office Use Only:

Received by_____ Date_____

Approved by_____ Date_____
(Commissioner of Health)