ATLANTA CANINE
REPRODUCTION
685 Knox Bridge Trl, Canton, GA 30114
office@atlantacaninereproduction.com
770-974-3444

Authorization to Release Frozen Canine Semen

_____
Registered Name

_____
Registery and Number **Breed**

NUMBER OF BREEDING DOSES (Check ONE) ☐**1** ☐**2** ☐**3** ☐**Other**_____

Shipping TO: Veterinary Facility_____

Veterinarian's Name_____

Address_____ **Phone**_____

City, State, Zip_____ **Email**_____

Bitch Owner's Name_____

Address_____

City, State, ZIP_____

Phone_____**Email**_____

Date shipment should be scheduled to ARRIVE:_____ ☐ **Check for WILL CALL**

_____
Semen Owner's Name

_____
Address

_____
Phone **Email**

This is a TWO PAGE form. Please fill out BOTH pages*

Terms: Atlanta Canine Reproduction(ACR) makes no guarantees, expressed or implied, that conception will occur, or that the frozen sperm cells are viable, or will remain viable, after the cells are frozen. In the event of loss or damage of frozen semen due to natural causes such as weather, or fire, storage/shipping tank failure, or shipping accident/ damage, ACR will not be held liable for the loss or the replacement value of the frozen semen. Shipping costs are usually paid by the bitch owner. The semen owner is ultimately responsible for all costs. Any charge backs by the credit card holder listed above or on the recipient form will be reimbursed by the semen owner. Frozen semen shipments are not completed until the shipping tank is returned undamaged. Additional charges may be applied up to 6 months after shipment occurs. By my signature below, I authorize semen shipping services to be preformed for me. I agree to all statements made in this document preceding this signature and any statements in the following document. I understand that there is no guarantee of fertility or successful fertilization. I also understand that the shipper is not responsible for services rendered by other companies/individuals. Payment for services is due at the time of service. Other charges may be applied to my credit card at a later date, if additional services are necessary. I may or may not be notified of these additional charges prior to charging my credit card. Any charges may be made without my permission. In the event I initiate a charge back, I understand I will be charged additional fees. It is my responsibility to ensure all fees are paid.

Method of Payment: (Check one)☐VISA ☐MC ☐AMEX ☐DISC

Cardholder Name_____

Card Number _____-_____-_____-_____

Exp ____/_____ **CVV** _____

X_____

Owner's Signature **Date**