Veterinary Feed Directive

All parties must retain a copy of this VFD for 2 years after the date of issuance.

Veterinarian: _____ **Client:** _____

Address: _____ **Address:** _____
(business or home)

_____ _____

Phone: _____ **Phone:** _____

Fax or email (optional): _____ **Fax or email (optional):** _____

Drug(s) Name: TERRAMYCIN/OXYTETRACYCLINE **Drug(s) Level:** 6,400 **g/ton** **Duration of use:** _____

Species and Production Class: Honey Bees **No reorders (refills) authorized:** N/A

Indication for use (as approved): Foulbrood

Caution (related to this medicated feed, if any): _____

_____

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 Bees/Hives: _____

Premises: _____

Other Identification (e.g., age, weight) (optional): _____

Special Instructions (if any): _____

Affirmation of intent (for combination VFD Drugs) (check 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 combinations(s) in medicated feed that contains the VFD drug(s) as a component.**

Drug(s)	Drug Level(s) and any Special Instructions

☐ **This VFD only authorizes the use of the VFD drug(s) cited in this order any FDA-approved, conditionally approved or indexed combinations(s) in medicated feed that contains the VFD drug(s) as a component.**

Withdrawal Time (if any): This VFD Feed must be withdrawn 42 **days prior to honey flow.**

VFD Date of Issuance: _____ **(Month/Day/Year)**

VFD Expiration Date: _____ **(Month/Day/Year)**
(As specified in the approval; cannot exceed 6 months after issuance.)

Veterinarian's Signature: _____