



Return the form to:

Office of the Syndic  
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Fax: 450 771-0131  
bureau.syndic@omvq.qc.ca

## REPORT FORM FOR THE ILLEGAL PRACTICE OF VETERINARY MEDICINE AND UNAUTHORIZED USE OF THE VETERINARY TITLE

### TYPE OF VIOLATION (Please check one or more relevant boxes)

Dentistry:  Scaling  Tooth filing  Dental exam  Other

Surgical interventions:  Sterilization  Tail docking  Ear clipping  Declawing  Other

Complementary therapies:  Acupuncture  Osteopathy  Physiotherapy  Chiropractic  Other

Medical interventions:  Consultation  Advice  Prescription  Other

Medications:  Sale  Administration (medications, vaccines, other)  Other

Document falsification/use:  Health booklet  Vaccination certificate

Other: (Describe) \_\_\_\_\_

### DATE OF THE EVENT

Occurred on: \_\_\_\_\_ or from: \_\_\_\_\_ to: \_\_\_\_\_ Time: \_\_\_\_\_

### PLACE OF THE EVENT

Description of the location (residence, business, stable, farm or other): \_\_\_\_\_  
Street address: \_\_\_\_\_

### INDIVIDUAL OR COMPANY INVOLVED

Name of individual: \_\_\_\_\_  
Street address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Email: \_\_\_\_\_  
Facebook: \_\_\_\_\_ Website: \_\_\_\_\_  
Other relevant information: \_\_\_\_\_

Name of company: \_\_\_\_\_  
Street address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Email: \_\_\_\_\_  
Facebook: \_\_\_\_\_ Website: \_\_\_\_\_  
Other relevant information: \_\_\_\_\_

### ACCOUNT OF EVENTS (Detailed description of the event, names of witnesses, their role and contact information)

I have already contacted the Syndic about the event:  Yes  No

Initials: \_\_\_\_\_

**ACCOUNT OF EVENTS** (Detailed description of the event, names of witnesses, their role and contact information) - CONT.

\* If you need more space, please use an additional sheet of paper and include it as an attachment.

**LINKS AND ATTACHMENTS**

Relevant Web links: \_\_\_\_\_

Attachments:  Yes  No

Number of attachments: \_\_\_\_\_

**IDENTIFICATION OF THE PERSON FILING THE REPORT**

Last name: \_\_\_\_\_ First name: \_\_\_\_\_

Telephone: \_\_\_\_\_ (Preferably the number where you can be reached between 8:30 a.m. and 4:30 p.m.)

Email: \_\_\_\_\_

Do you authorize the Office of the Syndic to send you the relevant correspondence by email?  Yes  No

If you are a veterinarian, please indicate the facility where you practise: \_\_\_\_\_

Would you be willing to testify in court, if necessary:  Yes  No

**I understand that sending this form by email will have the same legal standing as a signed handwritten letter. Otherwise, I understand that I need to print, sign and send this form by mail to the Office of the Syndic:**

Yes  No

Signature of applicant: \_\_\_\_\_

**I certify that the information provided in this document is true and accurate. I agree to cooperate with the Office of the Syndic at any time during the inquiry process, answer questions and provide all information and documents requested in support of this inquiry until the matter is resolved.**

Date: \_\_\_\_\_

Initials: \_\_\_\_\_