



Owner of the Cairn Terrier: First name Last name

Address: Street Address
City or Town State ZIP

Home Phone () - Daytime (if different): () -

Email address: @ .

Dog's Full AKC Registered Name:

Dog's Call Name:

Has your dog been examined before by Dr Paul Scherlie or Dr Simon Petersen-Jones? YES No

Have you already provided Dr. Petersen-Jones a copy of this dog's pedigree? YES No

Do you know if your dog is related to dogs with ocular melanosis? YES No

If yes, please give details:

Have you noticed any eye abnormalities, or does your dog have a history of eye problems? YES No

If yes, please give details:

Do you give permission for us to take a blood sample from your dog if one is advised? YES No

Do you give permission for us to take cheek swabs from your dog if one is advised? YES No

Your signature: Today's date: / 2005

Please send registration and \$15 per Cairn Terrier to

CRCTC - Eye Clinic, c/o Jane Stump
22825 SE Tillstrom Rd., Gresham, OR 97080

Appointments will be scheduled for times starting Saturday morning October 1, 2005 at 9:00 AM.
If possible, you will be notified by phone Friday evening of your dog's appointment times.