

OWNER: Rich Mapple Phone: 216 292 6047
 ADDRESS (Street & No., City, Zip Code): 24419 Duffield Rd Akron OH 44321
 Animal Registered Name: Phlox & Sponsee
 Breed/Variety: Coat color/type: Permanent ID#: OAD1591800



CANINE EYE REGISTRATION FOUNDATION

Akron Eye Care For Animals
 Mark Bobofchak, DVM, DACVO
 1321 Centerview Circle
 Akron, OH 44321
 (330) 670-1300

325

For litters, add number.

REGISTRATION NO.											
0	0	0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9	9	9
0	0	0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9	9	9
0	0	0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9	9	9

"I hereby declare that the animal submitted for exam is the animal described above. Furthermore, I declare I am the owner or agent of the owner of this animal."

Signature: *[Handwritten Signature]*

PRESS FIRMLY. FILL COMPLETELY.

SEX: Male Female

BIRTH DATE: Jan 00 00 00, Feb 20 12, Mar 00 00, Apr 01 00, May 02 22, Jun 03 03, Jul 04 24, Aug 05 05, Sep 06 06, Oct 07 07, Nov 08 08, Dec 09 09

EXAM DATE: Jan 00 00 00, Feb 08 13, Mar 00 00, Apr 01 00, May 02 22, Jun 03 03, Jul 04 24, Aug 05 05, Sep 06 06, Oct 07 07, Nov 08 08, Dec 09 09

FOR CERF USE ONLY

BREED	COLOR
0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

748925

DO NOT MARK IN THIS AREA

RIGHT EYE	GLOBE	LEFT EYE
<input type="checkbox"/>	microphthalmos	<input type="checkbox"/>
<input type="checkbox"/>	dry eye	<input type="checkbox"/>
<input type="checkbox"/>	glaucoma	<input type="checkbox"/>
<input type="checkbox"/>	EYELIDS	<input type="checkbox"/>
<input type="checkbox"/>	entropion	<input type="checkbox"/>
<input type="checkbox"/>	ectropion	<input type="checkbox"/>
<input type="checkbox"/>	distichiasis	<input type="checkbox"/>
<input type="checkbox"/>	ectopic cilia	<input type="checkbox"/>
<input type="checkbox"/>	THIRD EYELID	<input type="checkbox"/>
<input type="checkbox"/>	cartilage anomaly/eversion	<input type="checkbox"/>
<input type="checkbox"/>	gland prolapse	<input type="checkbox"/>
<input type="checkbox"/>	plasmoma/atypical pannus	<input type="checkbox"/>
<input type="checkbox"/>	CORNEA	<input type="checkbox"/>
<input type="checkbox"/>	dystrophy -- epithelial/stromal	<input type="checkbox"/>
<input type="checkbox"/>	dystrophy -- endothelial	<input type="checkbox"/>
<input type="checkbox"/>	pannus	<input type="checkbox"/>
<input type="checkbox"/>	UVEA	<input type="checkbox"/>
<input type="checkbox"/>	cyst	<input type="checkbox"/>
<input type="checkbox"/>	iris coloboma	<input type="checkbox"/>
<input type="checkbox"/>	iris hypoplasia/sphincter dysplasia	<input type="checkbox"/>
<input type="checkbox"/>	pigmentary uveitis	<input type="checkbox"/>
<input type="checkbox"/>	uveal melanoma	<input type="checkbox"/>
<input type="checkbox"/>	persistent pupillary membranes	<input type="checkbox"/>
<input type="checkbox"/>	LENS	<input type="checkbox"/>
<input type="checkbox"/>	Diff. Inter. Punc. Punc. Inter. Diff.	<input type="checkbox"/>
<input type="checkbox"/>	anterior cortex	<input type="checkbox"/>
<input type="checkbox"/>	posterior cortex	<input type="checkbox"/>
<input type="checkbox"/>	equatorial cortex	<input type="checkbox"/>
<input type="checkbox"/>	anterior sutures	<input type="checkbox"/>
<input type="checkbox"/>	posterior sutures	<input type="checkbox"/>
<input type="checkbox"/>	nucleus	<input type="checkbox"/>
<input type="checkbox"/>	capsular	<input type="checkbox"/>
<input type="checkbox"/>	generalized	<input type="checkbox"/>
<input type="checkbox"/>	significance of above cataract unknown (describe in comments)	<input type="checkbox"/>
<input type="checkbox"/>	subluxation/luxation	<input type="checkbox"/>
<input type="checkbox"/>	VITREOUS	<input type="checkbox"/>
<input type="checkbox"/>	PHPV/PTVL	<input type="checkbox"/>
<input type="checkbox"/>	degeneration	<input type="checkbox"/>

RIGHT EYE	FUNDUS	LEFT EYE
<input type="checkbox"/>	retinal atrophy -- generalized	<input type="checkbox"/>
<input type="checkbox"/>	retinal dysplasia	<input type="checkbox"/>
<input type="checkbox"/>	retinopathy	<input type="checkbox"/>
<input type="checkbox"/>	choroidal hypoplasia	<input type="checkbox"/>
<input type="checkbox"/>	staphyloma/coloboma	<input type="checkbox"/>
<input type="checkbox"/>	retinal detachment	<input type="checkbox"/>
<input type="checkbox"/>	optic nerve coloboma	<input type="checkbox"/>
<input type="checkbox"/>	optic nerve hypoplasia	<input type="checkbox"/>
<input type="checkbox"/>	micropapilla	<input type="checkbox"/>

OTHER UNLISTED CONDITIONS suspected as inherited. Describe in comments.

OTHER conditions suspected as not inherited

NORMAL

DUPLICATE FORM

This dog's microchip or tattoo has been verified/scanned and matches the (permanent ID) number provided on the form.

I certify that I have performed this ophthalmic examination using pharmacologic mydriasis, ophthalmoscopy, and biomicroscopy.

Signature: *[Handwritten Signature]* Date: 7/8/13
 Diplomate, American College of Veterinary Ophthalmologists

COMMENTS

ACVO # 325

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

Please note to ensure proper registration this original owner's copy must be mailed directly to CERF