

**VOLUNTARY JOHNE'S DISEASE CONTROL PROGRAM**  
**RISK ASSESSMENT/HERD PLAN**  
**FEE BASIS REQUEST AND PAYMENT FORM**

OWNER NAME \_\_\_\_\_

DATE SUBMITTED \_\_\_\_\_

ADDRESS \_\_\_\_\_

TELEPHONE NUMBER \_\_\_\_\_

\_\_\_\_\_

ANIMAL TYPE \_\_\_\_\_

FARM NAME \_\_\_\_\_

**PLANNED**

ADDRESS \_\_\_\_\_

**ASSESSMENT DATE** \_\_\_\_\_

\_\_\_\_\_

COUNTY \_\_\_\_\_ TOWNSHIP \_\_\_\_\_ SECTION \_\_\_\_\_ RANGE \_\_\_\_\_

**APPROVAL** \_\_\_\_\_

**APPROVAL DATE** \_\_\_\_\_

**JOHNE'S PROGRAM ASSESSMENT**

<b>RISK ASSESSMENT/HERD PAYMENT</b>	<b>\$ .00</b>	Payment will be made only upon submission of a completed and signed herd risk assessment and herd management plan.
<b>First Year - \$100</b>		
<b>Annual Renewal - \$100</b>		
<b>TOTAL AMOUNT DUE:</b>	<b>\$ .00</b>	

I CERTIFY THAT THE NUMBER OF ANIMALS TESTED IS CORRECT, THAT THE SERVICES RENDERED WAS IN ACCORDANCE WITH MY CONTRACT/AGREEMENT.

**PLEASE MAKE PAYMENT TO:**

FEE BASIS VETERINARIAN  CLINIC

FEE BASIS VETERINARIAN SIGNATURE: \_\_\_\_\_

LICENSE NUMBER: \_\_\_\_\_

FEE BASIS VETERINARIAN NAME: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

(Please print)  
CLINIC NAME: \_\_\_\_\_

**OR**  
FEDERAL TAX ID NUMBER: \_\_\_\_\_

CLINIC ADDRESS: \_\_\_\_\_

CLINIC PHONE NUMBER: \_\_\_\_\_

CLINIC FAX NUMBER: \_\_\_\_\_

**Lansing Office**  
**517-373-1077 Melanie Brownlee or BrownleeM@michigan.gov**  
**517-241-1560 FAX**