

## REQUEST FOR RABIES VACCINATION DELAY

Maryland Department of Health and Mental Hygiene  
Center for Zoonotic and Vector-borne Diseases

*According to the Maryland Code of Regulations 10.06.02, the Public Health Veterinarian can temporarily or indefinitely delay a rabies vaccination requirement for a dog, cat, or ferret in the interest of public safety or for medical determinations or research. Each vaccination delay request is reviewed on an individual basis, and the submitting veterinarian may be asked to provide additional information as needed. Please submit the following information, including all associated medical information to support your request, for review.*

| <b>Veterinarian Information</b>                                                                                                                                    |                                    |  |  |                                   |        | <b>(PLEASE PRINT CLEARLY AND FILL IN ALL INFORMATION)</b> |                                 |                                 |                |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|--|--|-----------------------------------|--------|-----------------------------------------------------------|---------------------------------|---------------------------------|----------------|--|--|--|
| Name:                                                                                                                                                              |                                    |  |  |                                   |        | Maryland License #:                                       |                                 |                                 |                |  |  |  |
| Address:                                                                                                                                                           |                                    |  |  |                                   |        |                                                           |                                 |                                 |                |  |  |  |
| City:                                                                                                                                                              |                                    |  |  |                                   | State: |                                                           |                                 |                                 | Zip:           |  |  |  |
| Practice Name:                                                                                                                                                     |                                    |  |  |                                   |        |                                                           |                                 |                                 |                |  |  |  |
| Address:                                                                                                                                                           |                                    |  |  |                                   |        |                                                           |                                 |                                 |                |  |  |  |
| City:                                                                                                                                                              |                                    |  |  |                                   | State: |                                                           |                                 |                                 | Zip:           |  |  |  |
| Phone:                                                                                                                                                             |                                    |  |  |                                   | Fax:   |                                                           |                                 |                                 |                |  |  |  |
| <b>Patient Information</b>                                                                                                                                         |                                    |  |  |                                   |        |                                                           |                                 |                                 |                |  |  |  |
| Patient Name:                                                                                                                                                      |                                    |  |  |                                   |        | Age:                                                      |                                 |                                 | Date of birth: |  |  |  |
| Species:                                                                                                                                                           | <input type="checkbox"/> Feline    |  |  | <input type="checkbox"/> Canine   |        |                                                           | <input type="checkbox"/> Ferret |                                 |                |  |  |  |
| Breed:                                                                                                                                                             |                                    |  |  |                                   | Sex:   | <input type="checkbox"/> Male                             |                                 | <input type="checkbox"/> Female |                |  |  |  |
| Reproductive Status:                                                                                                                                               | <input type="checkbox"/> Spayed    |  |  | <input type="checkbox"/> Neutered |        |                                                           | <input type="checkbox"/> Intact |                                 |                |  |  |  |
| <b>Owner Information</b>                                                                                                                                           |                                    |  |  |                                   |        |                                                           |                                 |                                 |                |  |  |  |
| Owner Name:                                                                                                                                                        |                                    |  |  |                                   |        | Phone:                                                    |                                 |                                 |                |  |  |  |
| Address:                                                                                                                                                           |                                    |  |  |                                   |        |                                                           |                                 |                                 |                |  |  |  |
| City:                                                                                                                                                              |                                    |  |  |                                   | State: |                                                           |                                 |                                 | Zip:           |  |  |  |
| <b>Medical History of Animal</b>                                                                                                                                   |                                    |  |  |                                   |        |                                                           |                                 |                                 |                |  |  |  |
| Type of Delay requested:                                                                                                                                           | <input type="checkbox"/> Temporary |  |  |                                   |        | <input type="checkbox"/> Permanent                        |                                 |                                 |                |  |  |  |
| Reason for requesting Delay:                                                                                                                                       |                                    |  |  |                                   |        |                                                           |                                 |                                 |                |  |  |  |
|                                                                                                                                                                    |                                    |  |  |                                   |        |                                                           |                                 |                                 |                |  |  |  |
| Pre-existing conditions:                                                                                                                                           |                                    |  |  |                                   |        |                                                           |                                 |                                 |                |  |  |  |
|                                                                                                                                                                    |                                    |  |  |                                   |        |                                                           |                                 |                                 |                |  |  |  |
| Dates of diagnosis:                                                                                                                                                |                                    |  |  |                                   |        |                                                           |                                 |                                 |                |  |  |  |
| Clinical signs:                                                                                                                                                    |                                    |  |  |                                   |        |                                                           |                                 |                                 |                |  |  |  |
|                                                                                                                                                                    |                                    |  |  |                                   |        |                                                           |                                 |                                 |                |  |  |  |
| <b>Rabies Vaccination History</b>                                                                                                                                  |                                    |  |  |                                   |        |                                                           |                                 |                                 |                |  |  |  |
| List all previous rabies vaccinations given. Specify <b>date(s)</b> of vaccination, <b>type(s)</b> of vaccine given and the <b>manufacturer(s)</b> of the vaccine: |                                    |  |  |                                   |        |                                                           |                                 |                                 |                |  |  |  |
|                                                                                                                                                                    |                                    |  |  |                                   |        |                                                           |                                 |                                 |                |  |  |  |
|                                                                                                                                                                    |                                    |  |  |                                   |        |                                                           |                                 |                                 |                |  |  |  |
|                                                                                                                                                                    |                                    |  |  |                                   |        |                                                           |                                 |                                 |                |  |  |  |
| <b>Adverse Event Reporting</b>                                                                                                                                     |                                    |  |  |                                   |        |                                                           |                                 |                                 |                |  |  |  |
| Adverse reaction:                                                                                                                                                  |                                    |  |  |                                   |        |                                                           |                                 |                                 |                |  |  |  |
|                                                                                                                                                                    |                                    |  |  |                                   |        |                                                           |                                 |                                 |                |  |  |  |
| Has the event described here been reported to the USDA Center for Veterinary Biologics (1-800-752-6255)?                                                           |                                    |  |  |                                   |        |                                                           |                                 |                                 |                |  |  |  |
|                                                                                                                                                                    |                                    |  |  |                                   |        |                                                           |                                 |                                 |                |  |  |  |

Signature of Veterinarian

Date

Please submit this completed form to State Public Health Veterinarian, Maryland Department of Health and Mental Hygiene,  
Center for Zoonotic and Vector-borne Diseases, 201 West Preston Street, Room 317, Baltimore, MD 21201.  
Phone: 410-767-5649 Fax number: 410-383-2420 or 410-669-4215.