



License Ownership Transfer Form

Complete this form if you are transferring ownership of a Covetrus Software Product.

All fields are required unless specifically marked as optional.

- If you are the current owner of the license, please complete Part I.
- If you are the new owner of the license, please complete Part II.

EFFECTIVE DATE: _____

Part I – Current Owner’s Information

I am the current owner of the license identified. I am transferring all rights, title, and interest in and to the license to own with respect to the product (including the right to use any prior version or upgrades) to the new owner, identified below. The new owner has agreed to be bound by the terms of the product’s End User License Agreement / Service Agreement which may be updated by Covetrus from time to time.

I understand that by signing and submitting the Transfer of Ownership, I am relinquishing all rights to the product and my name will be eliminated from Covetrus’ customer records in connection with the product. If the transfer is being completed on behalf of a company or other organization, I represent and warrant that I have the authority to sign this transfer on behalf of the current registered owner.

Product(s) Being Transferred:

Practice Management Software

- ☐ Advantage+ ☐ Vetech Advantage ☐ AVImark ☐ DVM Manager ☐ eVetPractice
☐ ImproMed (Infinity) ☐ ImproMed Equine (TripleCrown)

Client Communication Services

- ☐ Rapport ☐ Vetstreet

Current Registered Owner:

Name(s)*: _____

Company Name: _____

Company Address: _____

Company Phone Number: _____

Email Address: _____

Selling Owner’s Signature(s): _____

*If there are multiple partners who share ownership, all applicable names and signatures are required.

Part II – New Owner’s Information

I, the undersigned, acknowledge receipt of this software and documentation. By signing, I confirm that I have read the End-Use License Agreement / Service Agreement included with the software package being transferred, which may be updated by Covetrus from time to time, and that I agree to be bound by its terms. I understand that any outstanding balances owed by the hospital will remain with the account.

New Registered Owner:

Name: * _____
Company Name: _____
Company Address: _____
Company Phone Number: _____
General Email Address: _____

*If new owner is a corporation please list the name(s) of the individual(s) authorized to make changes in secure areas of the program: _____

Clinic Information:

Primary Clinic Contact: _____

☐ (Optional) The clinic’s name, address or contact information needs to be changed as indicated below:

Business Name: _____ *Optional*
Business Phone Number: _____ *Optional*
Email address: _____ *Optional*
Mailing Address: _____ *Optional*

Support Coverages (Practice Management Software Only):

By default, we will continue with the existing level of support coverage unless/until you make changes.

Client Communication Services:

By default, we will continue with the existing services unless/until you make changes.

If you want to be contacted to discuss the following client communication services which are available to you, please indicate which one (*optional*).

☐ Rapport Subscription ☐ Vetstreet Subscription ☐ Postal Communications

Billing Information:

We need to have billing information on file which will be used to automatically pay for support coverage. You also have the option to pay all of your Covetrus bills automatically with a credit card (all major credit cards accepted) or Automated Clearing House (ACH) payment through a checking or savings account each month (US Accounts only.) Check the box below if you would also like to sign up for auto pay for all Covetrus bills.

Please note - All invoicing is processed in USD.

☐ (Optional) I authorize Covetrus to use the below payment information to automatically charge ANY open balance, for the clinic, at the point of sale. **Note that the following fields are required even if you don't select the authorization checkbox.**

Billing Address: _____

City, State, Zip: _____

Billing Email Address: _____

Last 4 digits of credit card/bank account to be charged: _____

(Upon receiving this completed form, a billing representative will contact you for the appropriate credit/ debit information for the billing card on file.)

Name and Title: _____

Contact Number: _____

Purchasing Owner's Signature: _____

If you would like to receive confirmation that your change of ownership process has been successfully completed, please provide your contact email address: _____

Please return the completed form to the license transfer department:

Email: US-CGSS_LicenseTransfer@covetrus.com

Fax: 866-365-7945

Or mail to the address below:

Address: ATTN License Transfer Dept.
3800 Horizon Blvd. Suite 201
Trevose, PA, 19053