INSTITUTIONAL ANIMAL CARE AND USE COMMITTEE
CERVICAL DISLOCATION OR DECAPITATION AUTHORIZATION MEMO

Principal Investigator:____.
Control Number #: ______________________________________

Title:____.
____.

****THE BOTTOM PORTION TO BE COMPLETED BY IACUC AUTHORIZEDVETERINARIAN***

UAC Veterinarian:___________________________. Procedure Review Date:__________.

Technique:

☐ Cervical Dislocation ☐ Decapitation

Species: ____
Person(s) Performing Procedure: ____
____.

COMMENTS:

____.
____.
____.
____.

Pre-Sedation Waiver:

☐ Approved ☐ Disapproved

Signature UAC/IACUC Veterinarian: ______________________________________
This form is to be filed with the IACUC Coordinator to finalize approval of the above noted protocol