



VETERINARY PRACTICE PROFILE

Acquisition

SELLER'S INFORMATION				
Name:		Practice Name:		
Street Address:		City:	State:	ZIP Code:
Business Phone number:		Fax Number:	Email Address:	
BUYER'S EDUCATION AND WORK HISTORY				
School:			Graduation Date:	
Job Title #1:	Practice Name:	City:	State:	Date employed (MM/YYYY):
Job Title #2:	Practice Name:	City:	State:	Date employed (MM/YYYY):
Have you ever owned a practice? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you currently own any other practice? <input type="checkbox"/> Yes <input type="checkbox"/> No		
REVENUE AND PROCEDURE DATA				
Small Animal ____% Large Animal ____% Exotic ____% Other ____%				
Are there any procedures you're unable to perform? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes list procedure(s):		
Are there any additional procedures you can perform? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes list procedure(s):		
Number of doctor vacation/sick days in prior calendar year:		In Current year (YTD):		
Historically, which quarter of the year is the practice's most productive? <input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4 Least Productive <input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4				
OFFICE PROFILE				
Office Size (in Sq. ft.):		Total number of operatories:		Total equipped operatories:
Quality of office improvements: <i>(check one)</i> <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor				
Quality of office equipment: <i>(check one)</i> <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor			Radiography: <i>(check one)</i> <input type="checkbox"/> Digital <input type="checkbox"/> Film-Based	
Equipment included with practice:				
Are there any imminent equipment needs? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, please list and explain the related cost of implementation:				



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OFFICE PROFILE						
Current office hours						
MON:	TUS:	WEN:	THU:	FRI:	SAT:	SUN:
<input type="checkbox"/> New Lease <input type="checkbox"/> Assumption		Date of lease expires: (MM/DD/YYYY)				
Renewal options?		Office location				
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> 1 st floor <input type="checkbox"/> 2 nd floor <input type="checkbox"/> 3 rd floor <input type="checkbox"/> 4 th floor				
Building type: (check one) <input type="checkbox"/> Free-standing <input type="checkbox"/> Shopping Center <input type="checkbox"/> Medical complex <input type="checkbox"/> Other professional center						
Title	Name	Salary or Commission	Hours	Years Employed	Production (Annual)	
Owner doctor						
Associate #1						
Associate #2						
Front desk #3						
Front desk #2						
Assistant #1						
Assistant #2						
Other #1						
Other#2						
Is staff aware of the sale? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If any staff are in the seller's immediate/extended family, list here _____						
If not all staff are staying with practice after sale, list those leaving _____						
How long has seller been at this location?			Will seller remain after sale? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you performed a chart audit <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, how long? _____ months _____ years			
If yes, approx. how many files _____			Estimated annual compensation _____			
Please describe your primary reasons for purchasing this practice:						
Please describe any changes you will implement at this practice and future goals:						