Veterinary Certificate of Examination for Mortality Coverage

EQUISPORT INSURANCE AGENCY, INC.

Applicant: Producer: Date:

Horse's Name:_____ Date of Birth*:_____ Sex:_____ Ht.:_____ Breed: _____

Current and/or Intended Use:_____ Level:_____

Color: I.D. #'s – Tattoo: USEF: FEI: Other:

For Quarter Horses, Appaloosas, or Paints that have an ancestor known to carry HYPP, please indicate the horse's HYPP status. *(Circle one.)* **N/N N/H H/H N/A**

Describe type of work the horse has been in the last six months. If at rest or turned out, why?

Pulse and Respiration normal at rest and after work?	Yes ☐	No ☐
Heart auscultation normal at rest and after work?	Yes ☐	No ☐
Respiration auscultation normal at rest and after work?	Yes ☐	No ☐
Temperature normal?	Yes ☐	No ☐
Eyes clinically normal?	Yes ☐	No ☐
Palpations normal?		
Back	Yes ☐	No ☐
Stifles	Yes ☐	No ☐
Knees	Yes ☐	No ☐
Hocks	Yes ☐	No ☐
Fetlocks	Yes ☐	No ☐
Tendons and Ligaments	Yes ☐	No ☐
(Please note any swelling, heat, stiffness and/or pain for any answer "No".)		
Hoof tester results negative?	Yes ☐	No ☐
Properly shod?	Yes ☐	No ☐
Is the stabling and turn out safe and adequate?	Yes ☐	No ☐
Are you the usual veterinarian for the applicant?	Yes ☐	No ☐

If any are answered no, please explain on a separate page.

Type and schedule of worming program:_____

_____

Has the horse ever had colic surgery?	Yes ☐	No ☐
Subject to or any previous history of colic?	Yes ☐	No ☐
History or evidence of a bleeder?	Yes ☐	No ☐
History or evidence of nerving?	Yes ☐	No ☐
Any evidence or history of laminitis, club foot, or P3 rotation?	Yes ☐	No ☐
Any evidence of infection or disease?	Yes ☐	No ☐
Contagious diseases on premises or locally?	Yes ☐	No ☐
Is there evidence of objectionable habits? Vices?	Yes ☐	No ☐
Any history of uncharacteristic behavior in the last 24 months?	Yes ☐	No ☐
Any major conformation faults, which may affect the horse for its intended use, short or long term?	Yes ☐	No ☐
Any evidence of lameness jogging straight or on circles in both directions?	Yes ☐	No ☐
Any evidence of bone or joint disease?	Yes ☐	No ☐

If any are answered yes, please explain on a separate page.

If the horse is a stallion, are both testicles evident?	Yes ☐	No ☐
If the horse is a mare, is she in foal?	Yes ☐	No ☐
If the horse is a mare, any history of dystocia?	Yes ☐	No ☐
Any symptoms detrimental to satisfactory breeding?	Yes ☐	No ☐

Please explain on a separate page any abnormal answers.

Are you aware if the horse has received any performance enhancing procedures, including intramuscular and/or joint injections, any type of medication long or short term, or any preventative treatments in the last 12 months? If yes, explain.

Have you or any other veterinarians attended the horse for any ailment, injury, lameness, or medical problem in the last 12 months? If yes, explain.

Are there any pre-existing conditions, history of lameness, or additional medical facts that should be brought to the attention of the Insurance Company?

Does the horse have present evidence of tendonitis / desmitis? If so, describe.

Has an X-ray or ultrasound examination been performed on the horse in the last 12 months? If so, why and what were the results?

Is the horse sound for the use intended?

Has horse ever undergone surgery? If so, describe type of surgery, date and recovery.

Are you aware of any condition past or present that could require surgical or medical attention in the next 12 months?

Give your general evaluation for the above named horse, and your professional opinion on soundness, both short and long-term, for its intended use.

I (print name)_____, do certify that I am a graduate veterinarian holding a current license as such to practice in the State of _____, and that I have on this day examined the above named horse.

Veterinarian's signature:_____ Phone:_____ Date:_____

I (print name)_____, as the Owner or representative for the owner as the primary trainer and/or caretaker, have provided to the veterinarian to the best of my ability accurate and complete information on the above named horse.

Owner, trainer, or primary caretaker's signature:_____ Date:_____

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