

EXAMINATION FOR FULL LOSS OF USE AND MORTALITY COVERAGE

EQUINE INSURANCE SPECIALISTS

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Applicant: _____	Producer: _____	Date: _____
Horse's Name: _____	Date of Birth: _____	Sex: _____ Ht.: _____ Breed: _____
Current and/or Intended Use: _____		Level: _____
Color: _____	I.D. #'s - Tattoo: _____	AHSA: _____ 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 <input type="checkbox"/>	No <input type="checkbox"/>	Has the horse ever had colic surgery?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart auscultation normal at rest and after work?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Subject to or any previous history of colic?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Respiration auscultation normal at rest and after work?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	History or evidence of a bleeder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Temperature normal?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	History or evidence of nerving?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Eyes clinically normal?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Evidence of firing or blistering	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Palpations normal?			Any evidence or history of laminitis, club foot or P3 rotation?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Back	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Any evidence of infection or disease?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Stifles	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Contagious diseases on premises or locally?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Knees	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Is there evidence of objectionable habits? Vices?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hocks	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Any history of uncharacteristic behavior in the last 24 months?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Fetlocks	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Any major conformation faults, which may affect the horse for its intended use, short or long term?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tendons and Ligaments	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Any evidence of lameness jogging straight or on circles in both directions?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(Please note any swelling, heat, stiffness and/or pain for any answer "No".)			Any evidence of bone or joint disease?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hoof tester results negative?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If any are answered yes, please explain on a separate page.		
Properly shod?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If the horse is a stallion, are both testicles evident?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the stabling and turn out safe and adequate?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If the horse is a mare, is she in foal?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If any are answered no, please explain on a separate page.	If the horse is a mare, any history of dystocia? Yes <input type="checkbox"/> No <input type="checkbox"/>
Type and schedule of worming program: _____	Any symptoms detrimental to satisfactory breeding? Yes <input type="checkbox"/> No <input type="checkbox"/>
Drug Screen Results: Required for horses valued over \$25,000. Must be taken at the time of the exam. Please attach results.	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? Yes No

Have you or any other veterinarians attended the horse for any ailment, injury, lameness, or medical problem in the last 12 months? Yes No

Are you aware of any pre-existing conditions? Yes No

Has the horse ever undergone surgery? Yes No

Are you aware of any condition, past or present, that could require surgical or medical attention in the next 12 months? Yes No

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

Active and Passive Flexion Test Results: Active test with the horse jogging immediately on a hard surface.
 Written Evaluation:

X-rays: Must be current within 3 months. Please list below all radiographic findings, especially those that may affect the horse's long and short-term intended use. If possible, use any previous X-rays for comparisons, i.e. navicular. All views listed below are required for Full Loss of Use coverage. If additional views were taken, please describe results. Use a separate page if necessary. **Note: NSF and WNL are not acceptable descriptions for findings.**

Front Feet – Lateromedial, dorsal ventral, navicular skyline:

Front Fetlocks – A/P views:

Hind Fetlocks – A/P views:

Hocks – Lateral projection, craniocaudal projection, both oblique:

Stifles – Lateromedial views:

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 best of my ability accurate and complete information on the above named horse.

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