



**VETERINARIAN'S STATEMENT OF EXAMINATION  
FOR MORTALITY INSURANCE**

The purpose of this examination is to identify and examine the involved horse in accordance with this Certificate, and to report to the company any medical facts known to you and/or obtained by you in the examination. Horses should be examined in motion.

I, \_\_\_\_\_ do hereby certify that I am a veterinarian specializing in Equine Practice, holding a current license to practice medicine in the state of \_\_\_\_\_ and have this day examined:

|                         |     |       |     |       |
|-------------------------|-----|-------|-----|-------|
| Name                    | Age | Color | Sex | Breed |
| Sire                    | Dam |       |     |       |
| Markings/Tattoo # _____ |     |       |     |       |

Owned by: \_\_\_\_\_  

|      |         |
|------|---------|
| Name | Address |
|------|---------|

|                                     |                |  |                |
|-------------------------------------|----------------|--|----------------|
| Pulse and respiration normal?       | Yes ( ) No ( ) | History or evidence of laminitis?        | Yes ( ) No ( ) |
| Temperature normal?                 | Yes ( ) No ( ) | History or evidence of nerving?          | Yes ( ) No ( ) |
| Eyes clinically normal?             | Yes ( ) No ( ) | Has horse been castrated?                | Yes ( ) No ( ) |
| Heart auscultated?                  | Yes ( ) No ( ) | Any evidence of other surgery?           | Yes ( ) No ( ) |
| History or evidence of bleeder?     | Yes ( ) No ( ) | If mare, is she reported in foal?        | Yes ( ) No ( ) |
| Vaccinated against WEST NILE VIRUS? | Yes ( ) No ( ) | If male, are both testicles evident?     | Yes ( ) No ( ) |
| Has horse ever had colic surgery?   | Yes ( ) No ( ) | Genitalia of normal size and consistency | Yes ( ) No ( ) |

If any surgery has been performed, describe type of surgery and give date of surgery (please give recovery status) \_\_\_\_\_

Is there any likelihood of future danger to life or limb as a result of such surgery? \_\_\_\_\_

Any clinical evidence of lameness, faulty conformation (angular, flexural, laxity), joint swelling or localized limb edema, or other abnormal conditions? If yes, give details \_\_\_\_\_

Is the stabling adequate? \_\_\_\_\_ Is there evidence of vices or objectionable habits? \_\_\_\_\_

In your opinion or to your knowledge, are there any additional medical facts that should be brought to the attention of the Company? If yes, give details, including date(s) \_\_\_\_\_

Are there currently any contagious diseases on the owner's farm? Give details \_\_\_\_\_

Has official E.I.A. Test been run: \_\_\_\_\_ Date? \_\_\_\_\_ Lab No. \_\_\_\_\_ Result \_\_\_\_\_

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**ADDITIONAL FOR FOALS 24 HOURS TO 30 DAYS:**      Date & Time of Birth \_\_\_\_\_

|   |                |   |                |
|---|----------------|---|----------------|
| Was birth normal with no complications? | Yes ( ) No ( ) | Any flexural deformities?                           | Yes ( ) No ( ) |
| Was foal born premature/dysmature?      | Yes ( ) No ( ) | Does foal have patent urachus?                      | Yes ( ) No ( ) |
| Did foal stand and nurse normally?      | Yes ( ) No ( ) | Does foal show any signs of colic?                  | Yes ( ) No ( ) |
| Is umbilicus dry and normal?            | Yes ( ) No ( ) | Any evidence of cleft palate?                       | Yes ( ) No ( ) |
| Is there any evidence of diarrhea?      | Yes ( ) No ( ) | Is there evidence of a hernia (umbilical/inguinal)? | Yes ( ) No ( ) |

If under 8 days old, has Meconium been or reported by attending staff/owner to have been passed normally? \_\_\_\_\_

Is foal's appearance and behavior consistent with normal gestation/parturition? \_\_\_\_\_

IgG Reading(s) and Date(s) taken \_\_\_\_\_ White Blood Count & date taken \_\_\_\_\_

Has foal received any medication, plasma or colostrum supplement? \_\_\_\_\_ If yes, give date(s) \_\_\_\_\_

Is foal presently on any medications, including antibiotics? Yes ( ) No ( ) Are they prophylactic or therapeutic treatment? \_\_\_\_\_

What antibiotic is being administered and how long will it be administered? \_\_\_\_\_

Is there any history or evidence of rib fracture(s) \_\_\_\_\_ If yes, how many ribs are fractured? \_\_\_\_\_

*This certificate has been completed by the examining veterinarian to the best of his or her ability as a licensed veterinarian.*

|                              |                          |                  |
|------------------------------|--------------------------|------------------|
| Date and Time of Examination | Veterinarian's Signature | Telephone Number |
|------------------------------|--------------------------|------------------|

|            |                        |
|------------|------------------------|
| Print Name | Veterinarian's Address |
|------------|------------------------|