APX INSURANCE

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VETERINARIAN EXAMINATION FORM

Horse(s) Owner: _____

Horse(s) Examined:

1. Name: _____ Age: _____ Breed: _____ Sex: _____ Use: _____

2. Name: _____ Age: _____ Breed: _____ Sex: _____ Use: _____

Please Answer "Yes" Or "No" To The Following Questions:	Horse (1)	Horse (2)
1. Conformation Faults?		
2. Eyes Or Vision Defects?		
3. Operations Performed?		
4. Vices Or Objectionable Habits?		
5. Heart Defects Or Heart Murmurs?		
6. Lameness Or Unsoundness Of Limbs?		
7. Bleeding, Nerving, Firing Or Blistering?		
8. Medical Facts Affecting Life, Health Or Use?		
9. Gastrointestinal Disorders Or Colic Incidents?		
10. Pulse, Respiration Or Temperature Abnormalities?		
11. Dangers To Life Or Limb Related To An Illness, Injury Or Disease?		
12. Indications Of Contagious Disease On The Premises Or In The Area?		

Additional Questions:		
1. If Male, Has He Been Gelded?		
2. If Male, Any Problems With Testicles?		
3. If Female, Is She In Foal? (Provide Due Date)		
4. If Female, Any Breeding Or Foaling Problems?		

Questions For Foals Under 31 Days (Not Examined Before 24 Hours):		
Date And Time Of Birth:	Horse (1): _____	Horse (2): _____
1. Is CBC Normal?		
2. Is The Foal An Orphan?		
3. IgG Level (Provide Measurement)		
4. Has The Foal Received Any Medication?		
5. Were There Any Foaling Complications?		
6. Was Urination Or Bowel Movement Abnormal?		

Please Explain Any "Yes" Answers, Including Dates And Treatment Given. Also Advise How Any Operation, Illness Or Disease Will Affect The Life, Health Or Use Of The Animal: _____

I Have Examined The Horse(s) Named Above, At Rest And While In Motion.

Date Of Exam: _____

Time Of Exam: _____ Veterinarian's Signature: _____

Veterinarian's Name: _____

Address: _____

Telephone Number: _____ Fax Number: _____

COVERAGE IS BOUND ONLY WHEN A BINDER HAS BEEN ISSUED BY EQUIDAE INSURANCE