OLD COLONY INSURANCE SERVICE, INC. Phone: 859-255-3355 Fax: 859-231-6503

VET CERTIFICATE FOR EQUINE 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

Owned by: _____

Name Address

Pulse and respiration normal?	Yes ( ) No ( )	History or evidence of nerving	Yes ( ) No ( )
Temperature normal?	Yes ( ) No ( )	Has horse been castrated?	Yes ( ) No ( )
Eyes clinically normal?	Yes ( ) No ( )	Any report or clinical evidence of	
Heart ausculated?	Yes ( ) No ( )	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 ( )

The external genitalia of this breeding stallion appear normal in size and consistency for his age and breed Yes ( ) No ( )

If any surgery has been performed, describe type of surgery and give date of surgery_____

_____

If surgery has been performed, has horse clinically recovered? _____

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

Any clinical evidence of lameness, faulty conformation or other abnormal conditions?_____

_____

Is the stabling adequate? _____

In your opinion or to your knowledge, are there any additional medical facts that should be brought to the attention of the Company?

_____

_____

Is there evidence of vices or objectionable habits?_____

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

ADDITIONAL FOR FOALS 24 HOURS TO 45 DAYS:

Was birth normal with no complications?	Yes ( ) No ( )	Date & Time of Birth _____	
Was foal born premature?	Yes ( ) No ( )	Any flexural deformities?	Yes ( ) No ( )
Is umbilicus dry and normal?	Yes ( ) No ( )	Does foal have patent urachus?	Yes ( ) No ( )
Did foal stand and nurse normally?	Yes ( ) No ( )	White Blood Count _____	

IgG Reading(s) and Date(s) taken _____

Has foal received any medication, plasma or colostrums supplement? _____ If yes, give date(s)_____

Is a nurse mare being used for this foal? Yes ( ) No ( ) If so, has nurse mare accepted the foal? Yes ( ) No ( )

Additional Remarks or Information: _____

_____

Date of examination: _____ Time of examination: _____

By: _____ Address: _____

Print name City, State, Zip Code

_____ Phone: _____

Signature