

**LIVESTOCK INSURANCE MANAGERS**

PO Box 30101, 1624 – 33<sup>rd</sup> Street W.

Saskatoon, Saskatchewan

S7L 7M6

PH. – 306-244-8181

Fax – 306-244-8183

**VETERINARY CERTIFICATE OF EXAMINATION**

NAME OF INSURED \_\_\_\_\_

The animal(s) being examined for insurance should be moved about to demonstrate soundness of limb and freedom of movement. Careful examination should be made as to housing conditions and the presence of contagious disease.

I, the undersigned, do certify that I have on this date examined:

<u>NAME</u>	<u>COLOUR</u>	<u>SEX</u>	<u>DATE OF BIRTH</u>
1. _____			
2. _____			
3. _____			
4. _____			
5. _____			

Pulse & Respiration Normal?	1. <input type="checkbox"/> Yes <input type="checkbox"/> No	2. <input type="checkbox"/> Yes <input type="checkbox"/> No	3. <input type="checkbox"/> Yes <input type="checkbox"/> No	4. <input type="checkbox"/> Yes <input type="checkbox"/> No	5. <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Auscultated and found normal?	1. <input type="checkbox"/> Yes <input type="checkbox"/> No	2. <input type="checkbox"/> Yes <input type="checkbox"/> No	3. <input type="checkbox"/> Yes <input type="checkbox"/> No	4. <input type="checkbox"/> Yes <input type="checkbox"/> No	5. <input type="checkbox"/> Yes <input type="checkbox"/> No
Temperature normal?	1. <input type="checkbox"/> Yes <input type="checkbox"/> No	2. <input type="checkbox"/> Yes <input type="checkbox"/> No	3. <input type="checkbox"/> Yes <input type="checkbox"/> No	4. <input type="checkbox"/> Yes <input type="checkbox"/> No	5. <input type="checkbox"/> Yes <input type="checkbox"/> No
Teeth normal?	1. <input type="checkbox"/> Yes <input type="checkbox"/> No	2. <input type="checkbox"/> Yes <input type="checkbox"/> No	3. <input type="checkbox"/> Yes <input type="checkbox"/> No	4. <input type="checkbox"/> Yes <input type="checkbox"/> No	5. <input type="checkbox"/> Yes <input type="checkbox"/> No
Glands normal?	1. <input type="checkbox"/> Yes <input type="checkbox"/> No	2. <input type="checkbox"/> Yes <input type="checkbox"/> No	3. <input type="checkbox"/> Yes <input type="checkbox"/> No	4. <input type="checkbox"/> Yes <input type="checkbox"/> No	5. <input type="checkbox"/> Yes <input type="checkbox"/> No
Any history of flukes?	1. <input type="checkbox"/> Yes <input type="checkbox"/> No	2. <input type="checkbox"/> Yes <input type="checkbox"/> No	3. <input type="checkbox"/> Yes <input type="checkbox"/> No	4. <input type="checkbox"/> Yes <input type="checkbox"/> No	5. <input type="checkbox"/> Yes <input type="checkbox"/> No
Any history of colic or ulcers?	1. <input type="checkbox"/> Yes <input type="checkbox"/> No	2. <input type="checkbox"/> Yes <input type="checkbox"/> No	3. <input type="checkbox"/> Yes <input type="checkbox"/> No	4. <input type="checkbox"/> Yes <input type="checkbox"/> No	5. <input type="checkbox"/> Yes <input type="checkbox"/> No
If male, are both testicles evident?	1. <input type="checkbox"/> Yes <input type="checkbox"/> No	2. <input type="checkbox"/> Yes <input type="checkbox"/> No	3. <input type="checkbox"/> Yes <input type="checkbox"/> No	4. <input type="checkbox"/> Yes <input type="checkbox"/> No	5. <input type="checkbox"/> Yes <input type="checkbox"/> No
If female, any history of dystocia? (i.e. prolapsed uterus)	1. <input type="checkbox"/> Yes <input type="checkbox"/> No	2. <input type="checkbox"/> Yes <input type="checkbox"/> No	3. <input type="checkbox"/> Yes <input type="checkbox"/> No	4. <input type="checkbox"/> Yes <input type="checkbox"/> No	5. <input type="checkbox"/> Yes <input type="checkbox"/> No
Has any surgery been performed? (If yes, give details below)	1. <input type="checkbox"/> Yes <input type="checkbox"/> No	2. <input type="checkbox"/> Yes <input type="checkbox"/> No	3. <input type="checkbox"/> Yes <input type="checkbox"/> No	4. <input type="checkbox"/> Yes <input type="checkbox"/> No	5. <input type="checkbox"/> Yes <input type="checkbox"/> No

**FEET & LEGS:**

Does any animal have any physical deformities, disease or infection of Pads? \_\_\_\_\_

Describe any lameness problems: \_\_\_\_\_

**PARASITES – Internal and External:**

Date and Results of last Blood Test:	1. _____	2. _____	3. _____	4. _____	5. _____
Date of last Worming:	1. _____	2. _____	3. _____	4. _____	5. _____
Date of last Tetanus Vaccination:	1. _____	2. _____	3. _____	4. _____	5. _____
Date of last Enterotoxemia Vaccination:	1. _____	2. _____	3. _____	4. _____	5. _____
Fecal Sample taken? _____ Results:	1. _____	2. _____	3. _____	4. _____	5. _____

ARE THERE ANY MEDICAL FACTS THAT SHOULD BE BROUGHT TO THE ATTENTION OF THE INSURANCE COMPANY OR ANY REASON WHY THE ANIMAL(S) SHOULD NOT BE INSURED: \_\_\_\_\_

EXCEPT AS NOTED ABOVE, I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE ANIMAL(S) IS/ARE HEALTHY AND IN SOUND CONDITION.

Name (Please Print): \_\_\_\_\_ Address: \_\_\_\_\_

Date: \_\_\_\_\_ Phone No(\_\_\_\_) \_\_\_\_\_ Signature: \_\_\_\_\_