

Name of Pet: _____ Policyowner: _____ Policy Number: _____

PART 1 – VETERINARY PROFESSIONAL’S PHYSICAL EXAM RESULTS											
CLINIC STAMP (IF APPLICABLE)	WITHIN NORMAL LIMITS FOR BREED AND AGE	LAMENESS, SWELLING OF THE LIMB, OR PAIN ON LIMB PALPATION	EFFUSION, CREPITUS OR THICKENING OF JOINT CAPSULE	DECREASED OR ABNORMAL RANGE OF MOTION	NECK OR BACK PAIN	TIBIAL THRUST OR CRANIAL DRAWER	ANGULAR LIMB DEFORMITY	LUXATING PATELLA	INTERVERTEBRAL DISC DISEASE (IVDD)	ELBOW DYSPLASIA	HIP DYSPLASIA OR POSITIVE ORTOLANI SIGN
FRONT LEGS SHOULDER, CARPUS, & ELBOW	<input type="checkbox"/>										
REAR LEGS HIP, TARSUS, AND STIFLE	<input type="checkbox"/>										
SPINE, SKULL, AND THORAX	<input type="checkbox"/>										
PART 2 – PROFESSIONAL OBSERVATIONS											
Discuss any findings. Address any orthopedic conditions or clinical signs in pet's history prior to this examination.											
PART 3 – DECLARATION											
TO BE COMPLETED BY EXAMINING VETERINARY PROFESSIONAL ONLY											
I certify that the information given in this form is truthful, accurate and complete.											
DVM SIGNATURE											
PRINTED NAME											
EXAM DATE	MM	DD	YYYY								
PART 4 – CLINIC / HOSPITAL INFORMATION											
CLINIC / HOSPITAL NAME								PHONE			
ADDRESS				CITY			STATE	ZIP			

Fax completed form to: 1-402-633-1088 or email scanned form to: Placeholder@physiciansmutual.com