

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					

SUBMIT TO:

My Account

Fax 402-633-1207

Physicians Mutual Insurance Company
PO Box 2316
Omaha, NE 68172-4081