Endoscopic Examination

Please enter requested information and send this form and **DVD OR USB** to address below.

PLEASE INCLUDE AT LEAST TWO MINUTES OF DIRECT OBSERVATION

OF LARYNGEAL MOVEMENT

Horse Name: _____Date of Procedure:_____

Registration Number: _____ Location of Procedure:_____

Clinician Name: _____

Owner Name:

Signature: _____

Area Examined:

Nasal passages: _____ ❑ Epiglottis*: _____

Ethmoid Area:_____❑ Arytenoids*: _____

Pharynx*: _____❑ Ventricles*:_____

G.P. Openings: _____❑ Trachea: _____

Soft Palate: _____❑ Guttural Pouches: _____

Endoscopic Report:

*Mark Lesions

Comments:

_____
_____
_____
_____
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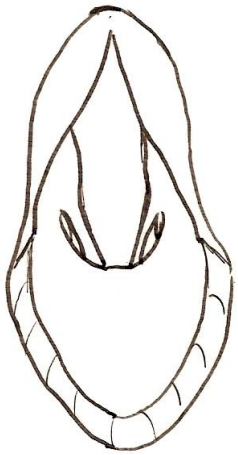
_____
_____



PAYMENT ($150 per exam)

Visa, Mastercard or Discover accepted

Card #_____

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Checks or Money orders also accepted in *US FUNDS*

Return form and USB/DVD to:

KWPN of North America, KWPN-NA
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Lexington, KY 40511
Phone: 859-225-5331 ❖ Fax: 859-544-0366 ❖ E-mail: drew@kwpn-na.org