



P.O. Box 644 • Powhatan, VA • 23139  
 Ph. (804) 598-3759 • Fax (804)598-1035

**Equine Wellness Program Application**

Owner's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Mailing Address: Street: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Physical Address(If different than mailing address)

Street: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Patient's Name (s)	Plan Option	Plan Cost

For additional horses, please use a second enrollment form.

<b>Total Annual Cost:</b>
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*(Total Annual Cost does not reflect any additional charges incurred for treatments, exams or dental work not indicated in the individual wellness plans.)*

**\*\*\* Payment in full is required on the date of sign-up. \*\*\***

**Payment Option (circle one)**

Cash                  Check                  M/C                  Visa                  American Express                  Discover

Credit Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Check Number: \_\_\_\_\_

Date Enrolled: \_\_\_\_\_