



# 150-Day Layoff Report

## Delaware Park

Approved (Y/N): \_\_\_\_\_

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

Initials: \_\_\_\_\_

**Trainers must complete this form for any horse\* that has not raced for 150 days or more. The form shall be submitted to Dr. Susan Botts, susan.botts@delaware.gov, prior to entry. The form shall be submitted a minimum of 30 days\*\* before entry, and is valid for 60 days from the date of submission. \*Does not apply to first-time starters. \*\*This requirement may be waived by Dr. Botts.**

Horse Name/Tattoo or Microchip #: \_\_\_\_\_

Horse's Age: \_\_\_\_\_ First-Time Starter (Y/N): \_\_\_\_\_ Date/Track of Last Race: \_\_\_\_\_

Planned Date/Track of Entry: \_\_\_\_\_

Owner: \_\_\_\_\_ Phone/Email: \_\_\_\_\_

Trainer: \_\_\_\_\_ Phone/Email: \_\_\_\_\_

Primary Veterinarian: \_\_\_\_\_ Phone/Email: \_\_\_\_\_

**Reason for layoff (MUST BE COMPLETED):** \_\_\_\_\_

How long has this horse been in your care? \_\_\_\_\_

(If less than 30 days) Previous Trainer: \_\_\_\_\_ Phone/Email: \_\_\_\_\_

Was surgery performed on this horse during the layoff? **Yes** **No**

If yes, provide the date, type of surgery and veterinarian:

\_\_\_\_\_  
\_\_\_\_\_

Surgery Discharge Documents: **Attached** **Not Attached**

Has this horse ever been treated with bisphosphonates (e.g., Tildren, Osphos)? **Yes** **No**

Is the horse on any medication, including trainer or veterinary administrations? **Yes** **No**

List all current medications/treatments and applicable diagnosis:

\_\_\_\_\_  
\_\_\_\_\_

Has the horse been treated with shockwave therapy since its last race? **Yes** **No**

If yes, provide the veterinarian, dates and the area of the horse's body treated for all treatments:

\_\_\_\_\_  
\_\_\_\_\_

Diagnostic tests (radiographs, scans, bloodwork etc.) performed since last race. Provide veterinarian, dates, details and results: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Intra-articular joint injections performed since last race. Provide veterinarian, dates and details (body part and medication): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**To the best of my knowledge, the information provided is accurate and up to date.**

Signature: \_\_\_\_\_

Submitted by (print name/title/date): \_\_\_\_\_

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**For Official Use Only:**

- |   |     |    |             |
|---|-----|----|-------------|
| • Additional Layoffs of 60 or More Days       | Yes | No |             |
| • Surgery Discharge Documents                 | Yes | No | NA          |
| • Diagnostic Reports                          | Yes | No | NA          |
| • Intra-articular and Joint Injection Reports | Yes | No | NA          |
| • Anabolic Steroid Treatment                  | Yes | No | NA          |
| • Additional Medical History Since Report     | Yes | No |             |
| • Workout History                             | Yes | No |             |
| • Past Performance History                    | Yes | No |             |
| • Exam History from InCompass                 | Yes | No |             |
| • Examination Required                        | Yes | No |             |
| • Observed Workout/Blood Test Required        | Yes | No |             |
| • Approved for Entry                          | Yes | No | Date: _____ |

**Approved by (Print/Sign):** \_\_\_\_\_