Certificate of Training · Case Study Submission · EXAMPLE

PRACTITIONER REFERENCE EXAMPLE

Worked Example — PROG Case

Chronic partial cranial cruciate tear · 8-week PROG course · Module 9 Lesson 9.4

How to use this example

This is a fully filled-out sample submission showing what a strong PROG case looks like in the template. The patient, owner, and clinic are fictional. Use this example to calibrate your own writing — the level of specificity, the way protocol math is shown, the honest framing of the week-4 plateau, and the operational reflection. A submission written at this level scores in the 'Approved' band (70+) under the 7-dimension rubric. Your own cases will read differently because every case is different — copy the structural discipline, not the content.

Section 1 — Patient Demographics (anonymized)

Case route	Module 9 — PROG (Lesson 9.4)
Case title	6yo Lab-mix MN, R partial CCL tear, 8-wk PROG course
Species	Dog
Breed	Labrador retriever mix (medium-to-large frame)
Age at case start	6 years 4 months
Body weight	78 lb (35.4 kg) at case start
Sex / repro status	MN (neutered at ~10 mo)
Region	Mountain West, USA
Case date range	October 2025 to January 2026 (8-week course + week-12 reassessment)

Section 2 — Presenting Complaint & Diagnostic Workup

Chief complaint at presentation

Chronic intermittent right hindlimb lameness of approximately 6 months' duration, with marked worsening over the 8 weeks before presentation. Owner declined orthopedic surgical referral for financial and recovery-tolerance reasons and was seeking a non-surgical option.

History of present illness

Owner first noticed brief toe-touching lameness on the right hind after vigorous off-leash exercise approximately 6 months prior to presentation. Lameness initially resolved within 24–48 hours of rest. Over the subsequent 4 months the recovery interval shortened and the lameness became daily — present

after any exercise lasting more than 15 minutes and noted on rising from rest. In the 8 weeks before presentation the dog began intermittently three-legging the affected limb, particularly in the morning. Prior treatments: carprofen 4.4 mg/kg PO q24h × 14 days produced partial improvement but lameness returned within 5 days of stopping; strict 4-week activity restriction reduced acute episodes but lameness returned to baseline within 1 week of resumed normal activity. Orthopedic surgical consultation recommended TPLO at an estimated $6,800; owner declined surgery and was referred for non-surgical options.

Relevant past medical history

No prior orthopedic injuries or surgeries. Chronic seasonal atopic dermatitis controlled with cytopoint q4–6wk; otherwise unremarkable. No chronic NSAIDs prior to this episode. Annual wellness bloodwork within normal limits.

Physical examination findings

BCS 6/9 (mildly overweight). Vitals within normal limits (T 101.4, HR 92, RR 24). Gait at intake: grade 2/5 right hindlimb lameness on lead, worsening to 3/5 with brief trotting. Orthopedic exam under light sedation (dexmedetomidine + butorphanol, IM, reversed): positive cranial drawer right stifle (clearly appreciable, partial), positive tibial compression test, mild medial buttress consistent with chronic ligament instability, moderate joint effusion, ROM ~90% of contralateral with discomfort at full extension. Pain-on-palpation score 7/10 at intake. Left stifle stable; hip ROM symmetric and non-painful bilaterally. Low back palpation unremarkable.

Diagnostic workup performed

Two-view stifle radiographs (mediolateral and craniocaudal, sedated): mild-to-moderate joint effusion with cranial displacement of the infrapatellar fat pad on the lateral view; early periarticular osteophytosis on the trochlear ridges and tibial plateau consistent with chronic stifle pathology; no evidence of fracture or neoplasia; no avulsion fragments. Contralateral stifle radiographed for comparison: no effusion, no osteophytosis. CBC/Chem panel within normal limits (within 30 days of case start). Anonymized radiograph screenshots attached (Section 7).

Diagnosis

Chronic partial cranial cruciate ligament tear (right stifle) with secondary stifle osteoarthritis. Confirmed by positive cranial drawer, positive tibial compression, joint effusion, and radiographic osteophytosis. Clinical diagnosis; arthroscopic confirmation declined.

Section 3 — OG Protocol Applied

Module Lesson referenced	Module 9 Lesson 9.4 — PROG / Joint OG per Dr. Bridge 3:3:3:1 stock formula; 1 mL per joint, weekly × 8 weeks; week-12 reassessment.
OG source / batch	PurO3 Veterinary Ozonated Glycerin, batch [redacted]; received with COA. In-clinic peroxide ppm spot-check confirmed in-spec (≥10,000 ppm equivalent) at receipt and again at week 4.

OG concentration used	3:3:3:1 PROG stock — by ratio (PROG is not weight-based, per Lesson 9.4).
Stock formula prepared	Per session: 0.45 mL OG + 0.45 mL Vitamin B12 (1000 IU/mL) + 0.45 mL Lidocaine 2% PLAIN + 0.15 mL 8.4% $NaHCO_3$ = 1.5 mL stock (1 mL injected, ~0.5 mL loss margin per Lesson 9.4 chart).
Buffering confirmation	8.4% $NaHCO_3$ included in the stock recipe at the prescribed 1-of-10 ratio (PROG is pre-buffered by design — see Lesson 9.4).
Lidocaine verification	Vial label confirmed 'Lidocaine HCl 2% — preservative-free, WITHOUT epinephrine' before EACH session prep. Verified by name on the chart for each visit. (Per Bridge clinical review, epinephrine-containing lidocaine degrades PROG outcomes — Module 9 Lesson 9.4 critical note.)
Warming temperature	Not applicable — PROG is administered at room temperature (warming guidance applies to Module 10 IP/IV/bladder/uterine routes).
DMSO addition	None this case. Patient was a young-to-middle-aged dog with a discrete cruciate-tear indication; pain on palpation present but not the dominant feature; base 3:3:3:1 was indicated (DMSO addition is selective per the DMSO+OG dosing guidance).
Sedation	Not used during PROG injections. Two-handler restraint per Lesson 9.4. (Light sedation was used once, at intake, for the orthopedic exam and radiographs only.)
Administration technique	Stifle injection per Lesson 9.4 / Tribute demonstration: patient in lateral recumbency; flex the knee, palpate patellar ligament and tibial plateau, displace patella laterally with non-injecting thumb, 22 ga × 1.5-inch needle inserted at ~45° across the joint between femoral condyles; brief aspiration (no blood); 1 mL stock injected slowly over ~8 seconds; needle withdrawn; firm digital pressure 30–60 seconds. No deviations from Lesson 9.4 protocol on any of the 8 sessions.
Session count	8 weekly PROG injections scheduled; 8 completed. Week-12 (post-injection 4) comprehensive reassessment also completed.

Why this protocol was chosen

4-question framework: (1) OG-responsive indication — chronic partial CCL tear is a Bridge anchor PROG indication (Module 9 Lesson 9.4, ~1,000-case experience base, 90–95% response). (2) Patient candidacy — young-to-middle-aged dog, BCS 6, no comorbidities, no contraindications. (3) Team readiness — practitioner had observed the Tribute demonstration video, completed Module 9, and had performed 4 supervised PROG injections at an OGPro-affiliated practice prior to this case. (4) Owner engagement — owner had declined surgery, was committed to weekly visits, signed the Injectable OG Consent & Waiver, and received the PROG Joint Injection Owner Handout at intake.

Section 4 — Course of Treatment

Before measurements (baseline, intake)

- Lameness grade: 2/5 at walk on lead, 3/5 at trot on lead
- Pain on palpation, right stifle: 7/10 (owner-reported flinch + verbal vocalization on full extension)
- Range of motion: ~90% of contralateral; full extension elicited pain
- Cranial drawer: positive, partial; tibial compression: positive
- Joint effusion: moderate, palpable medial and lateral to patellar ligament
- Owner-reported daily lameness episodes: every day for past 8 weeks
- BCS: 6/9 (78 lb)
- Photos / video: lateral standing photo and 10-second walking video at intake (anonymized — clinic background cropped, no collar tag visible). Attached Section 7.

Session-by-session summary

Visit	Pain/ Lameness	Tolerance	Owner-reported observations / clinician notes
Wk 1	7/10 · 2-3/5	Excellent	First injection. Brief flinch at needle entry. 1 mL delivered slowly. Mild stiffness × 12 hr post-injection per owner; ate dinner normally. No NSAIDs given. Owner re-issued handout.
Wk 2	6/10 · 2/5	Excellent	Owner reports 'maybe a little better — hard to tell.' Effusion unchanged. Injection per protocol; no adverse events.
Wk 3	4/10 · 1-2/5	Excellent	Owner notes clear improvement: 'first morning he didn't limp.' Effusion subjectively reduced. Pain on palpation noticeably less.
Wk 4	5/10 · 2/5	Good	Plateau / mild regression. Owner reports 2 'lame days' this week after a longer-than-usual hike on Saturday. Reassured per Lesson 9.4 — improvement is not strictly linear; the week 3-4 plateau is described in Bridge's clinical experience. Reinforced leash-walking-only-during-treatment guidance.
Wk 5	3/10 · 1/5	Excellent	Improvement resumed. Owner reports zero lame mornings this week.
Wk 6	2/10 · 0-1/5	Excellent	Effusion not palpable. Cranial drawer still detectable but reduced. Owner: 'lameness is rare now.'

Wk 7	1-2/10 · 0/5	Excellent	Brief stiffness on rising 2 days this week per owner; resolves within 30 sec of moving. Otherwise normal.
Wk 8	1/10 · 0/5	Excellent	Final injection. ROM 100% of contralateral; full extension non-painful. Cranial drawer minimally detectable (chronic structural change expected to remain). Owner verbally and visibly thrilled. Reassessment scheduled for week 12.

Between-session recheck findings

Each weekly visit included brief reassessment before the injection: pain-on-palpation score, gait observation on a 5-meter lead walk, owner-reported lameness frequency since prior visit, and effusion palpation. Trend tabulated above. The week-4 plateau was the only meaningful deviation from a steady downward trajectory, and was managed with reassurance and reinforcement of activity-restriction guidance rather than a protocol change. No NSAIDs were administered during the 8-week course (per the owner handout — NSAIDs may blunt the regenerative response that makes PROG work).

After measurements (week 12 reassessment, 4 weeks after final injection)

- Lameness grade: 0/5 at walk and trot on lead
- Pain on palpation, right stifle: 1/10
- Range of motion: 100% of contralateral; full extension non-painful
- Cranial drawer: minimally detectable (residual structural change expected; clinical signs absent)
- Joint effusion: not palpable
- Owner-reported lameness episodes in prior 30 days: zero
- Activity: gradually returned to normal off-leash exercise over weeks 9–12 per owner; tolerating 45-min hikes
- BCS: 6/9 (77 lb) — weight-loss recommendation re-issued for joint preservation
- Photos / video: matched lateral standing photo and 10-second walking video at week 12 — clear gait restoration. Anonymized. Attached Section 7.

Section 5 — Outcome Assessment

Clinical response category	Meaningful response (80% bucket per Dr. Bridge's 80/10/10
Objective measures of outcome	Pain on palpation 7/10 → 1/10 (86% reduction). Lameness grade 2-3/5 → 0/5. ROM ~90% → 100% of contralateral. Owner-reported lameness episodes: daily for 8 weeks → zero in past 30 days. Joint effusion moderate → not palpable. Cranial drawer remains minimally positive (chronic structural change), but clinical signs of instability resolved.
Owner-reported quality of life	Owner reports the dog is 'back to himself' — initiating play with the household's other dog, choosing the longer hike at trail forks, and rising from rest without the morning hesitation that had become routine. Owner specifically named the return of voluntary stair-climbing as the most meaningful change.

Duration of response	Response holding at week 12 (4 weeks after final injection). Patient discharged with monitoring plan: owner will report any return of lameness; recheck scheduled at 6 months and 12 months. Booster series will be considered at 12 months only if regression is observed (per Lesson 9.4 — most full-course PROG patients hold response durably).

Honest framing

This case landed in the meaningful-response (80%) bucket — the most common PROG outcome and the outcome the protocol is designed to produce. It is NOT a 'cure' (the cranial drawer is still detectable; a torn cruciate ligament does not become an untorn cruciate ligament). What changed is that the joint stabilized clinically, inflammation resolved, and the dog returned to function. That is what PROG does. Owner communication throughout used this exact framing — 'we're going to give the joint the chance to repair around the existing damage' — not 'we're going to fix the tear.' Per Module 12 Lesson 12.3 no-claims discipline, no curative language was used in any owner-facing material on this

Section 6 — Lessons Learned & Reflection

What I would do differently on the next similar case

I would baseline more objective measures. Pain-on-palpation scoring and lameness grading are practitioner-dependent; on the next PROG case I will add (a) timed stand-from-sit videos at intake and at each odd-numbered visit, (b) a short owner-reported diary (3 questions, daily) to capture lameness frequency without recall bias, and (c) circumferential thigh measurement bilaterally to track muscle mass changes over the 8-week course. I would also screen the contralateral stifle and both hips more deliberately at intake — patients with chronic unilateral CCL pathology often have compensatory issues that are easier to identify before treatment than after.

What surprised me about this case

The week-4 plateau. The patient had been steadily improving through weeks 1–3 and then visibly regressed at week 4. My instinct was to second-guess the protocol — should I add DMSO? Should I switch to twice-weekly? Should I refer? I went back to Lesson 9.4 and re-read the section on the typical PROG response curve, where Bridge specifically describes that improvement is not strictly linear and that the week 3-4 mark is where many practitioners abandon a protocol that is still working. I held the protocol unchanged. Improvement resumed at week 5. The lesson was: trust the schedule. The 8-week course is not 8 visits stacked together, it is a single regenerative process that takes 8 weeks to deliver.

How this case refined my understanding of the OG framework

Two refinements. First, the time-release character of OG matters at the protocol level, not just the molecular level — the reason PROG is 8 weekly visits and not 1 mega-dose is the same reason OG itself is time-release peroxide and not a peroxide bolus. The architecture of the molecule and the architecture of the protocol mirror each other. Second, the 'integrative voice' that Module 12 teaches is harder than it

sounds when an owner is visibly upset at week 4. Saying 'this is normal, we hold the course' requires confidence in the protocol that comes from understanding why it works, not just what to do. I would not have held the schedule at week 4 without the Bridge case-base context from Module 9.

Operational lesson for the clinic

Three workflow items. (1) Pre-printed PROG stock-prep cards posted at the injection station cut prep time from ~6 minutes to ~3 minutes per visit and eliminated mental-math errors on the 0.45/0.45/0.45/0.15 mL split. (2) A 15-minute standing appointment slot is the right unit for PROG follow-up visits (vs. our default 20-minute orthopedic slot) — the injection itself is brief, owner education is front-loaded at week 1, and the schedule efficiency lets us run more cases concurrently. (3) Front-desk briefing is required: this is an 8-visit commitment plus a 9th reassessment. CSR scheduling staff need to schedule all 9 visits at intake, not one at a time. We had one near-miss where week 6 was scheduled outside the protocol window because the owner had asked to push it; a CSR who understood the protocol would have flagged that and rerouted to one of the practitioner's evening slots.

Section 7 — Attestations & Attachments

By submitting this case study, I attest that:

☑ **The owner gave informed consent for de-identified educational use of this case (signed consent on file in the patient chart, dated within the case window).**

☑ **All identifying information has been removed per the anonymization standards in the Before-you-begin instructions (no patient name, no owner name, no clinic name, region only, date ranges in month-year format).**

☑ **The OG protocol executed matches the referenced Module Lesson; any deviations are documented in Section 3 with clinical rationale (this case had no deviations).**

☑ **The case chart is complete and retained in clinic records per Module 12 Lesson 12.2 documentation standards.**

☑ **The outcome reporting in Section 5 is truthful and not embellished.**

☑ **The files attached (photos, imaging, lab screenshots, chart excerpts) are authentic and properly anonymized.**

Files attached to this submission (example)

- Before — lateral standing photo, intake (anonymized; collar tag and clinic background cropped)
- Before — 10-second lead-walking video, intake
- After — matched lateral standing photo, week 12
- After — matched 10-second lead-walking video, week 12
- Radiograph screenshots — mediolateral and craniocaudal stifle views, intake (DICOM metadata stripped)

- Anonymized chart excerpt — 8-visit treatment summary log (Module 12 Lesson 12.2 chart elements present: batch ID per visit, volume, prep details, observations, vitals trend, owner-reported response, staff attribution, recheck schedule)
- Anonymized signed Injectable OG Consent & Waiver (client and patient identifiers redacted; signature block dated within case window)

Reviewer estimate — how this example would score

The 7-dimension rubric is reviewer-facing (Dr. Bridge and designated OGPro reviewers); learners do not score themselves. The estimate below is offered only to help you calibrate what 'Approved' looks like in practice. A real score will reflect the reviewer's judgment.

Dimension	Est. score	Reviewer rationale
Patient selection (15)	13	4-question framework explicitly walked through; indication, candidacy, team, owner all addressed with module references.
Protocol fidelity (20)	19	Stock formula, lidocaine verification, technique, schedule, and 8-visit count all match Lesson 9.4. No deviations to document.
Documentation completeness (15)	13	Module 12 Lesson 12.2 elements present in the chart excerpt. Could be marginally stronger with explicit batch-ID-per-visit table inline rather than referenced.
Clinical judgment (20)	18	Week-4 plateau handled correctly with the 80/10/10 frame; held protocol; no inappropriate escalation.
Owner communication (10)	9	Consent + waiver + handout + red-flag education described. Integrative voice maintained. No claims language.
Outcome reporting (10)	9	Honest, quantitative, named the 80% bucket explicitly, did not overclaim a structural cure.
Reflection & learning (10)	9	Substantive — protocol-trust lesson, operational workflow lessons, and a specific next-case adjustment proposal.
TOTAL	**90 / 100**	**Comfortably in the Approved (70+) band.**

End of Worked Example · Use as a structural reference; your own cases will read differently because every case is different.

Patient, owner, and clinic details in this example are fictional and constructed for instructional use.