
Equine Specialist in Mental Health and Learning Workshop & Practical Testing Application



SKILLS FOR WORKING WITH MENTAL HEALTH AND EDUCATION PROFESSIONALS AND THEIR CLIENTS

PROFILE FORM

Please complete this form and send it to the host site you are attending your workshop and practical exam.

Name: _____ Email: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: Day: _____ Evening _____

Please attach another piece of paper or write on the back of this form, if necessary:

Are you a Path Intl. Certified Therapeutic Riding Instructor? If yes, what level or specialty, Registered, Advanced, Master, Driving?

Equine Experience: Please tell us about any Certifications you have with an Equine Organization (examples would be Pony Club, CHA, USDF, USEA, ARICP, Eagala, etc....)

Organization: _____ Level: _____

Organization: _____ Level: _____

Organization: _____ Level: _____

Are you currently or have you ever been affiliated with an Equine Facilitated Mental Health or Educational Program? Please give us the name and describe your work there.

Do you have experience working with Mental Health or Special Educational Clients in any setting? Please tell us where and what kind.

Describe other Equine experience you have:

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PATH INTL. PHOTO RELEASE FORM

I hereby consent to and authorize the use and reproduction by the Professional Association of Therapeutic Horsemanship International (PATH Intl.) of any and all photographs/video taken of me/my son/my daughter/my ward for promotional printed materials, educational activities, PATH Intl.'s website, and exhibitions or for any other use for the benefit of PATH Intl. and equine assisted activities.

Signature: _____ Date: _____

For PATH Intl. Records:

Name: _____ Name of person(s) in photo _____

Address: _____ City: _____ State: _____ Zip: _____

Phone/email: _____

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

Please complete this form and send it with your application and payment to the host site

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of (enter the host site name) _____, I authorize the workshop Instructors or their designees to:

1. Secure and retain medical treatment and transportation if needed.
2. Release pertinent information upon request to the authorized individual or agency involved in the medical emergency treatment.

Participant's Name: _____ DOB: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: Primary: _____ Secondary: _____

In the event I cannot be reached:

Contact: _____ Phone: _____

Contact: _____ Phone: _____

Physician Name: _____ Phone: _____

Health Insurance Co.: _____ Phone: _____

Allergies to medications: _____

Current Medications: _____

One of the following must be completed:

Consent Plan:

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person listed below is unable to be reached.

Consent Signature: _____ Date: _____
(Participant, Parent or Guardian)

Print Name: _____ Phone: _____

Address: (if different from participant) _____

Non-Consent Plan:

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of (enter the workshop site) _____.
In the event emergency treatment/aid is required, I wish the following procedures to take place: (explain below)

Non-Consent Signature: _____ Date: _____
(Participant, Parent or Guardian)

Print Name: _____ Phone: _____

Address: (if different from participant) _____

Equine Specialist in Mental Health and Learning

Liability Release Form

I, _____, would like to participate in the PATH Intl. On-Site Equine Specialist in Mental Health and Learning Workshop and Skills Testing. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to me are greater than the risks assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against PATH Intl., it's Board of Trustees, employees and Faculty/Evaluators for any and all injuries and/or losses I may sustain while participating in the PATH Intl. Instructor Workshop and/or On-Site Registered Certification.

Signature: _____ Date: _____
(Candidate)

Many disabilities or injuries have accompanying conditions that pose special physical risks during exercise. Horseback riding is exercise, as are other activities involved in this Workshop and/or Skills Test, such as handling and working around horses. I understand that PATH Intl. and the Host Site recommends that I seek the advice of a physician before participating in activities that involve exercise, riding, handling or being near horses.

I understand that if I have a disability/disabilities, injury or physical condition that might affect my ability to ride, handle, or be around horses at the PATH Intl. Instructor Workshop and/or On-Site Registered Certification, I will need to apply for an exemption or accommodation as outlined in the Accommodation or Exemption Policy.

Signature: _____ Date: _____
(Candidate)

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APPLICATION-send to the host site

Name: _____ Email: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: Day: _____ Evening _____

Check all that apply:

- I am at least 21 years old (This is required to attend the workshop/testing)
- I am a PATH Intl. Member. Member Number _____
- I have called the PATH Intl. office to pay any membership needed (if applicable)
- I plan to participate in the workshop only
- I plan to participate in the workshop and practical testing
- I plan to participate in the practical testing only
- I do not need an accommodation of any kind to complete the practical testing
- I do need an accommodation to complete the practical testing and have contact the PATH Intl. office to request it

NOTE: You must be a PATH Intl. member to attend

I have enclosed with my application:

- Emergency Medical Forms
- Profile Form
- Payment and/or payment information

Payment Information:

Tuition covers all materials, breakfast or snack and lunches. Please ask the host site for a copy of their refund policy. PATH Intl. is not responsible for refunds.

Cost of workshop is determined by the host site.

Memberships are paid directly to PATH Intl.

Check the form of payment included with this application:

- Check
- Credit Card

Amount Enclosed: _____ Check #: _____.

Credit Card information: Circle One: VISA MasterCard American Express

Credit Card number: _____ Exp. Date: _____

Name as appears on card: _____

Signature: _____ Date: _____