EQUINE FACILITATED MENTAL HEALTH ASSOCIATION

Equine Specialist Workshop

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

PROFILE FORM

Please complete this form and send it with your application and payment to the host site you are attending your workshop.
Registration deadlines and fees are set by the host site, please contact them for details.

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 NARHA 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:

NARHA PHOTO RELEASE FORM

I hereby consent to and authorize the use and reproduction by the North American Riding for the Handicapped Association (NARHA) of any and all photographs taken of me/my son/my daughter/my ward for promotional printed materials, educational activities, NARHA's website, and exhibitions or for any other use for the benefit of NARHA and equine assisted activities.

Signature: ____Date: _________________

For NARHA 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) ____

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APPLICATION

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.)
- ☐ I am a NARHA Member. Member Number ________________
- ☐ I am an EFMHA Member.
- ☐ I have called the NARHA office to pay any memberships needed. (if applicable)

NOTE: You must be a NARHA and EFMHA member to attend, if you are neither you must pay membership fees directly to the NARHA office, $45 for a NARHA membership and $30 for an EFMHA membership. If you are a NARHA member but not an EFMHA member please call the NARHA office to pay the $30 EFMHA Membership.

I have enclosed with my application:

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

Payment Information:
Cost of workshop: Tuition covers all materials, lunches, and snacks. Maximum number of applicants: 24 at each location
Please ask the host site for a copy of their refund policy. NARHA is not responsible for refunds.

Cost of workshop is determined by the host site.

Memberships are paid directly to NARHA.

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: ______________________