Any changes to your center’s information must be submitted to Professional Association of Therapeutic Horsemanship International within 30 days. All changes must be made using this form. Changes received via telephone or email will not be accepted.

Name of PATH Intl. Center ________________________________  Center Membership Number ___________________________

Address __________________________ City __________________________ State ____________ Zip ___________

The above listed PATH Intl. Center has made changes in the following areas:

1. Change in center name, contact information or contact person:  ❑ Yes  ❑ No
   If yes, attach a sheet detailing new information (be specific): list both old and new information.

2. Change in location of program activities:  ❑ Yes  ❑ No
   If yes, check the appropriate box and attach a sheet detailing new information (be specific)
   and include a Self-Study form:
   ❑ This location is in addition to the location for program activities previously listed with PATH Intl.
   ❑ This location replaces the location for program activities previously listed with PATH Intl.
   ❑ Removing one or more locations.

3. Change in personnel:  ❑ Yes  ❑ No
   If yes, check the appropriate box and attach a sheet detailing new information (be specific):
   ❑ Add instructor(s) - (and please note their level of PATH Intl. certification as well)
   ❑ Remove instructor(s)
   ❑ Add instructor who replaces another instructor
   ❑ Add or remove executive director/program director/development director

4. Change in program activities:  ❑ Yes  ❑ No
   If yes, check the appropriate box
   Add Delete: Name and Credentials Date Added/Removed Self-Study
   Driving ❑ ❑ __________________________ __________________________ ❑
   Hippotherapy* ❑ ❑ __________________________ __________________________ ❑
   Equine-Facilitated Psychotherapy* ❑ ❑ __________________________ __________________________ ❑
   Interactive Vaulting ❑ ❑ __________________________ __________________________ ❑
   Therapeutic Riding ❑ ❑ __________________________ __________________________ ❑

*Include credentialing documentation of therapist when adding hippotherapy or equine-facilitated psychotherapy

Notes (you may also use the back of this form or an additional sheet for notes):

By signing this form, I verify that the information provided is accurate to the best of my knowledge and that the center is in full compliance with all mandatory and applicable standards in accordance with current PATH Intl. center membership requirements.

Signature (must be an authorized individual for the center) __________________________
Printed Name __________________________ Date __________________________

Complete and mail or fax to: PATH Intl., PO Box 33150, Denver, CO 80233, fax: (303) 252-4610