



Therapeutic Program Questionnaire

Named Insured:
Location Address:

Policy #:

Submit with a completed Commercial Equine Liability application. This is not a binder. An incomplete or unsigned questionnaire is not acceptable.

YOUR OPERATION

- Which of the following do you offer?
 Therapeutic Riding Hippo-therapy Driving Vaulting
 Psychotherapy: EAP, EAL, EAT Explain:
 Other If other, please explain:
- Provide a brief description of the operation.
- Are there any lessons, sessions or any other similar types of activities taking place in the ring/arena at the same time as the therapeutic activities? Yes No
If yes, please explain:
- Is this part of any school curriculum, recreational center, or in conjunction with a city or county program? Yes No
If so, describe:

Is additional insured required? Yes No Certificate only? Yes No

- Is the program accredited? (Example: Path, Eagala) Yes No
By whom?
How many years accredited?

***Please attach certification**

- Have you ever contributed to a claim or accident or found negligent in any past equine activity? Yes No
If yes, explain:

***Submit 3-year hard copy loss runs. Provide an explanation if loss history is not available.**

7. Describe in general the disabilities of the riders/participants.

Are any participants / clients:

- Adjudicated, troubled or at risk youth
- Boys/Girls homes
- Corporate, team building or retreats
- Overnight exposures
- Nursing home/care facility visits
- Vaulting
- Pulling
- Clubs providing therapies
- Any risk that ties the client to the horse
- Swimming

8. What is the minimum age group accepted for the program?

9. Do you use side walkers? Yes No
If so, what is the ratio of staff to participants?
Staff Participants

10. Number of participants at one time:
Number of horses at one time:

11. Do you have written emergency procedures? Yes No

12. Describe the training program for the volunteers/trainees.

13. Do you provide transportation for participants? Yes No
If so, describe:

Do you use your own vehicle or employee vehicle?

14. Do you attend off premises shows or demonstrations with participants? Yes No
If so, describe:

15. Do you hold:
 Clinics Exhibitions Demonstrations Camps Fundraisers
 Other Activities for non-students None
If so, describe:

16. Do you have a web site or Facebook page? Yes No
What is the address?

17. What is your experience in these operations?

18. List all personnel including instructors, employees, trainees, volunteers & therapists to date (update annually)

| Name | Experience Level | # Years Employed by Insured | Certified? If so, by whom | Duties | Background Check Completed Y/N |
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(Continue on blank paper if needed)

19. Has any instructor, employee, trainee, volunteer, or therapist had any history of violence or criminal conviction? Yes No

HORSE EXPERIENCE

20. List all horses used in the program (updated annually)

| Name | Bred/Age | Years in Program | Previous Experience or Training |
|------|----------|------------------|---------------------------------|
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21. Has any horse ever shown aggressive behavior or caused or contributed to bodily injury or property damage? Yes No

If yes, explain:

22. Describe the criteria used in selecting horses for the program:

23. Describe the equipment or props used in the program:

24. Are there any horses used in the program that are: non-owned leased rented

If so, describe:

If leased, is there a written lease agreement signed? Yes No

RELEASES/WAIVERS/PROFESSIONAL LIABILITY

Submit the following if applicable to your operation

- Sample copy of Medical Release and/or Intake forms being used for riders
- Sample copy of hold harmless/release of liability agreement
- Sample copy of volunteer waiver/release of liability
- Copy of Professional Liability Insurance held by the therapist
- Copy of the employee/volunteer handbook, rules, guidelines & safety training
- Copy of written emergency procedures

The company reserves the right to decline coverage for omission of any part of this questionnaire. In addition, a loss control survey or inspection may be required/requested. If the company requires that a loss control survey be conducted of your operation, you agree to provide the company representative access to your operation and documents required to complete this survey.

Please provide the name of the party to contact for this inspection/survey.

Insured signature:

Date:

Agent's signature:

Date: