



Therapeutic Riding & Equine Assisted Therapy Questionnaire

Name of Applicant _____

Agency _____

Email _____ Website _____

General Questions

Yes No

1. Operating Name for Therapeutic Riding Operations _____

2. Please select the organization(s) with which you hold accreditations/certifications/licenses:

PATH EAGALA Other _____

Note: Ineligible for the program if you are not PATH certified.

3. Do you abide by all your accrediting/certifying/licensing organization's safety guidelines?

4. How many years have you managed or provided a therapeutic riding program? _____

5. Do you hold and maintain Adult and Child CPR and basic First Aid certifications?

6. Do you obtain medical permission forms and keep them on record for all clients?

7. Do you obtain signed Release/Hold Harmless forms and keep them on record for all clients?

8. Who is involved in the therapy?

Employees Officers Volunteers Independent Contractors Guardians

If Volunteers, How many? _____

9. Activities Offered:

- | | |
|--|---|
| <input type="checkbox"/> Equine Assisted Therapy (No Riding) | <input type="checkbox"/> Recreational Riding for Riders with Disabilities |
| <input type="checkbox"/> Hippotherapy | <input type="checkbox"/> Competitions for Riders with Disabilities |
| <input type="checkbox"/> Therapeutic Driving | <input type="checkbox"/> Therapeutic Riding |
| <input type="checkbox"/> Therapeutic Vaulting | |

10. What is the average number of therapy clients treated weekly? _____

What is the maximum number of clients in a single session? _____

11. Who provides the horses used in therapy session? Owned by you Leased from Others

12. How are horses evaluated for suitability for use in the therapy program?

13. What facilities are used for the therapeutic equine operations?

Enclosed Indoor Arena Fenced Outdoor Arena Trails

Other, please describe: _____

14. What safety equipment/perimeters are required while mounted?

General Questions

	Yes	No
15. Do you have an "at-risk" type program? If yes , describe the types of at-risk patients you accept (<i>i.e. broken homes, domestic violence, gang-related violence, etc.</i>)	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you provide equine therapy to anyone who could be considered dangerous to themselves or others? If yes , please describe:	<input type="checkbox"/>	<input type="checkbox"/>
17. What fundraising activities do you employ?		
18. What non-equine activities are offered to your equine-therapy clients?		
19. Do you bring any of your animals in any structures not intended for such animals? <i>(i.e. elevators, nursing homes, etc.)</i>	<input type="checkbox"/>	<input type="checkbox"/>
20. Is Abuse & Molestation Liability Coverage desired? If yes , please complete the separate Abuse & Molestation Liability Questionnaire.	<input type="checkbox"/>	<input type="checkbox"/>

The undersigned Authorized Representative of the Applicant declares that, to the best of his/her knowledge and belief, the statements set forth in this supplemental application and its attachments and other materials submitted to the Company are true and complete and may be relied upon.

Signature of Applicant's Authorized Representative _____

Name *(Printed)* _____

Title _____ Date _____

Max number of horses used at one time: _____

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Annual Gross Receipts for Therapeutic activities: _____