Registration Forms for the Equine Specialist in Mental Health and Learning Workshop

Please Complete All Pages of the Registration Packet & Print Legibly

Name:____

PATH #: ____

Address:____

City:________________________ State:________ Zip:____________

Cell Phone:____________________ Home Phone:____________________

E-mail:____

Center Affiliation (Name): ________________________________

Address: ____

Dietary Restrictions: □None □Vegetarian □Gluten Free □Other

If other, please describe:________________________________

____

____

Do you have any specific requests with regards to travel arrangements and the skills test day? ______________

____

____

____

____

Registration Forms for the Equine Specialist in Mental Health and Learning Workshop

Name:____

CONFIDENTIALITY POLICY

Maintaining the confidentiality of our participants' medical and sensitive information is of utmost importance to the staff at Dream Catchers. Participants and their families have a right to privacy that gives them control over the dissemination of their medical or other sensitive information. Dream Catchers staff and volunteers will preserve this right of confidentiality for all individuals in its program. DC staff, volunteers, and workshop participants will keep confidential all medical, social, referral, personal, and financial information regarding a person and his/her family. All participants, their families, volunteers, employees, and guests have a right to confidentiality. Equine Facilitated Psychotherapy and Speech services are medical services and federal confidentiality regulations apply for participants in these services. Anyone who works, volunteers for, participates in, or provides services to Dream Catchers is bound by this policy. This includes, but is not limited to, full and part time staff, independent contractors, temporary employees, volunteers, and guests. In effect, this policy applies to anyone connected to Dream Catchers who could obtain medical/sensitive information accidentally or purposely. Confidentiality includes photographic/video imaging. I affirm that I understand this policy in its entirety and I agree to comply.

Signature:____ Date:_________________

Applicant (if 18 or older), Parent or Legal Guardian

MEDIA/ VIDEOGRAPHY / IMAGING RELEASE

☐ *I DO*

☐ *I DO NOT*

consent to and authorize the use and reproduction by *Dream Catchers* of any and all photographic, any other audio/visual materials taken of me and/or my child or the participant for whom I am the legal guardian of, and any artwork produced by me and/or my child or the participant for whom I am the legal guardian of or other family members for promotional material, educational activities, and exhibitions or for any other use for the benefit of the program.

Signature: ____ Date: ______________

Applicant (if 18 or older), Parent or Legal Guardian

Registration Forms for the Equine Specialist in Mental Health and Learning Workshop

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Name:______________________________________ DOB:______________________________

Address:____

City/State/Zip:____

Phone #'s: (H):_____________________ (C):______________________ (W):_________________

In the event of an emergency, contact:

Name:______________________________________ Phone:_____________________________

Relationship:____

Physician's Name:______________________________ Physician Phone:______________________

Medical Facility:_______________________________ Facility Phone:_______________________

Heath Insurance Company:________________________ Policy #:_____________________________

In an effort to provide the best care possible please indicate below:

I am allergic to the following medications:____

I have the following ongoing medical conditions (diabetes, seizures, etc):_____________________________

____ ______________________

Signature: Participant/Volunteer/Guest/Staff (Parent / Guardian if under 18) Date

CHECK ONE OF THE OPTIONS BELOW TO INDICATE CONSENT OR NON-CONSENT FOR EMERGENCY MEDICAL TREATMENT

CONSENT FOR EMERGENCY MEDICAL TREATMENT

☐ **I DO** consent for emergency medical treatment in the event emergency medical aid/treatment is required due to illness or injury while being on the premises of or in connection with Dream Catchers.

I authorize Dream Catchers and/or its representatives to:

1. Obtain medical treatment and/or transportation if needed:
2. Release records upon request to the authorized agency or its representative involved in the medial emergency treatment.

NON-CONSENT FOR EMERGENCY MEDICAL TREATMENT

☐ **I DO NOT** give my consent for emergency medical treatment in the case of illness or injury while on the premises of or in connection with Dream Catchers. In the event emergency medical aid/treatment is required due to illness or injury while being on the premises of or in connection with Dream Catchers I wish the following procedure to take place (***LIST PROCEDURE ON LINE BELOW):***

____

Note: Dream Catchers is unable to guarantee that emergency medical treatment will be withheld

Registration Forms for the Equine Specialist in Mental Health and Learning Workshop

Release, Waiver & Indemnity Agreement

I, the undersigned or parent or legal guardian of the undersigned (either as a "Participant, Volunteer, or Staff"), desiring to utilize the premises known as the Cori Sikich Therapeutic Riding Center and the adjoining properties known as 10128 Fire Tower Road and 10102 Fire Tower Road, and any adjoining property owned by Daniel Potter, Karen K. Potter, Neal E. Knemeyer, or NDK Investments, LLC, and Jennifer and Joshua Thibeault, and their heirs, for their properties located at 10046,10058,10070 Fire Tower Road, Toano, VA 23168 collectively known as "the Premises")and the facilities either owned or controlled by Dream Catchers at the Cori Sikich Therapeutic Riding Center ("DCTR"), and to participate in programs offered by DCTR (the Programs), do herby affirm that as a Participant, Volunteer, or Staff is voluntarily entering upon the Premises to participate in the Programs, and I, as the undersigned or parent or legal guardian of the undersigned, do herby willingly enter into this Release, Waiver and Indemnity Agreement.

I recognize that, under Virginia law, an equine activity sponsor or professional is not liable for an injury to or the death of a Participant, Volunteer, or Staff in equine activities resulting exclusively from the inherent risks of equine activities. I fully understand that the activity of mounting, riding, boarding, feeding, or even being near a horse, involves numerous dangers and risks of injury to the Participant, Volunteer, or Staff and I completely release the owner of the Premises, and DCTR and its officers, directors, volunteers, employees, or its agents from any and all liability for any and all injuries from the Participant's, Volunteer's, or Staff's engagement in the Programs offered by DCTR.

I expressly agree that this Release, Waiver, and Indemnity Agreement shall be governed and construed as being sufficient to satisfy the assumption of risk and waiver requirements necessary to relieve equine activity sponsors and equine professionals from liability under the Virginia Equine Activity Liability Act, Section 3.1-796.130, *et.seq*. of the Code of Virginia (the "Act"), and the owners of the Premises, DCTR and its officers, directors, volunteers, employees, and agents are covered as equine activity sponsors and/or equine professionals by the provisions of the Act. This Release, Waiver, and Indemnity Agreement shall be governed and construed by the laws of the Commonwealth of Virginia, regardless of where any injury or loss shall occur. In the event that any portion of this Release, Waiver, and Indemnity Agreement shall be declared unenforceable, such declaration shall not affect the remaining terms of this document, which shall survive intact.

I am also aware and consent to Participant's, Volunteer's, or Staff's inclusion in a study performed by DCTR that, in the interest of improving the quality and effectiveness of the programs offered, will gather data on the program participants. Such data will include, but not limited to, the age, gender, dates of participation, and level of satisfactions of the program participants. Program participants may be selected for the study at random, and DCTR affirms that all program participants not selected for the study will be treated in a manner substantially identical to those program participants. Data will be held strictly confidential and not published in any way or as part of any publication.

I hereby give my permission to participate in the Programs offered by DCTR as a Participant, Volunteer, or Staff, and in consideration, agree individually and as applicable, on behalf of my child or ward, to the terms of the above agreement and release of liability.

____ ______________________________

Printed Name of Applicant, Volunteer, or Staff Member Date

____

Signature of Applicant, Volunteer, or Staff Member

____

Signature of Parent or Guardian of Applicant, Staff or Volunteer if under the age of 18

Registration Forms for the Equine Specialist in Mental Health and Learning Workshop

COVID-19 Assumption of Risk and Waiver of Liability

Coronavirus/COVID-19 Warning and Disclaimer

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person during close contact. Participating in or observing activities at Dream Catchers at the Cori Sikich Therapeutic Riding Center (the “Center”) could increase your risk of contracting COVID-19, and **Dream Catchers cannot guarantee that you will not become infected with COVID-19.**

Acknowledgment of Risk

I, the undersigned, for myself and, if applicable, as parent/guardian on behalf of the minor named below, hereby acknowledge and agree that in consideration for the undersigned participating in or observing activities at the Center: (1) the undersigned is assuming the risks related to COVID-19 inherent to gathering with others and using common facilities and hereby waives the undersigned’s rights to claim liability of Dream Catchers or others resulting from the assumption of such risks; and (2) Dream Catchers is not responsible for sickness or for loss of any kind as a result of COVID-19. I further understand that certain activities at the Center will require additional safety precautions and equipment due to COVID-19, and that, due to physical safety concerns and sudden emergent conditions, certain activities may not permit social distancing of 6 feet per person at all times.

Dream Catchers has taken certain steps to implement recommended guidance and protocols issued by the Centers for Disease Control and Prevention and the Virginia Department of Health for slowing the transmission of COVID-19. The undersigned acknowledges receipt of Dream Catchers’ current policies and requirements for participation in or observation of activities at the Center in response to such guidance and protocols (“Dream Catchers’ COVID-19 policies and requirements”). The undersigned acknowledges and agrees that Dream Catchers may revise its policies and requirements at any time based on updated recommended guidance and protocols issues by the public health agencies.

The undersigned agrees to comply at all times with Dream Catchers’ COVID-19 policies and requirements.
By signing this agreement, **I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 while at the Center and that such exposure or infection may result in personal injury, illness, permanent disability, and/or death**. I understand that the risk of becoming exposed or infected by COVID-19 at the Center may result from the actions, omissions, or negligence of myself or of others, including Dream Catchers. I hereby forever release, waive, discharge, and hold harmless, and agree not to sue or assert any claim against, Dream Catchers (including its directors, staff, employees, volunteers, and agents) for any loss or damages arising from such exposure or infection. I understand that by signing this document, all liability of Dream Catchers (including its directors, staff, employees, volunteers, and agents) to myself for any such loss or damages will be forever extinguished.
I, the undersigned, have read, understand and accept the terms of this Assumption of Risk and Waiver of Liability form. I further acknowledge that no oral representations have been made to me as an inducement to sign this form.

____ __________________________________

Printed Name of Participant, Volunteer, Guest, or Staff Date

____

Signature of Participant, Volunteer, Guest, or Staff

____

Signature of Parent or Guardian of Participant, Staff, Guest, or Volunteer if under the age of 18

Registration Forms for the Equine Specialist in Mental Health and Learning

Workshop ESMHL Workshop Payment Agreement for June 9, 2021 to June 12, 2021

Please check one of the Workshop Options below:

Check Box	Workshop Options	Fee
	BOTH WORKSHOP & HORSEMANSHIP SKILLS TEST	$675.00
	WORKSHOP ONLY	$500.00
	HORSEMANSHIP SKILLS TEST ONLY	$175.00
	AUDIT ONLY	$250.00

I choose to pay in the following way:

☐ By check: Please make check payable to Dream Catchers and mail check and registration forms to:
Dream Catchers
PO BOX 1261
Williamsburg, VA 23187
Attn: Beth Yurkovac, Operations Manager

☐ By Credit Card (please complete the information on the next page)

PATH INTL. ESMHL WORKSHOP AND HORSEMANSHIP SKILLS TEST
EVENT REGISTRATION APPLICATION

Please complete this form and send it to the host site where you are attending the workshop and horsemanship skills test.

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 # ______________
- ❏ I have confirmed that my PATH Intl. membership is current and up-to-date.
- ❏ I plan to participate in the workshop only.
- ❏ I plan to participate in the workshop and skills test.
- ❏ I plan to participate in the skills test only.
- ❏ I do not need an accommodation of any kind to complete the skills test.
- ❏ I need an accommodation to complete the skills test. I have submitted my request to PATH Intl. and am aware that it may take up to 60 days to receive an accommodation.

I have enclosed with my application:

- ❏ Candidate Profile Form
- ❏ Photo and Liability Release Forms
- ❏ Payment and/or payment information

Payment Information:
Cost of workshop: Tuition covers all materials, breakfast and lunches. Please ask the host site for a copy of its 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   Check #: ____________ Check amount: $____________

❏ Credit Card

Credit card information:

Circle One: VISA MasterCard AMEX Discover   Total payment amount: $____________

Credit card number: ______________________________ Exp Date: __________ CVV#: _______

Name as it appears on card: ______________________________

Signature: ______________________________ Date: ______________________

PATH INTL. ESMHL WORKSHOP AND HORSEMANSHIP SKILLS TEST
2020 CANDIDATE PROFILE FORM

Please complete this form and return it to the host site where you are attending the workshop and horsemanship skills test.

Name: ______________________________ Email: ______________________________

Mailing address: ____

City: ____________________________ State: ______ Zip: ____________

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

Are you a PATH Intl. Certified Professional? If yes, what level and/or specialty?:

- ❑ Therapeutic riding instructor, level: ______________________________
- ❑ Driving, level: ______________________________

Equine experience: Please tell us about any certifications you have with other professional equine organizations (such as 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? If yes, describe your role/duties.

Do you have experience working with mental health or special education clients in any setting? Please tell us where and what kind.

Describe any other equine experience you have:

RELEASE OF LIABILITY FORM

I, ______________________________, would like to participate in the PATH Intl.
(Candidate's signature)

Equine Specialist in Mental Health and Learning workshop and Horsemanship Skills Test. 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., its Board of Trustees, employees and faculty/evaluators for any and all injuries and/or losses I may sustain while participating in the PATH Intl. Equine Specialist in Mental Health and Learning workshop and Horsemanship Skills Test.

Signature:______________________________ Date: ______________
(Candidate's signature)

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 recommend 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. Equine Specialist in Mental Health and Learning workshop and Horsemanship Skills Test, I will need to apply for an accommodation as outlined in the accommodation policy.

Signature:______________________________ Date: ______________
(Candidate's signature)

PATH INTL. PHOTO RELEASE FORM

For PATH Intl. Records:

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 taken of me/my son/my daughter/my ward for promotional printed materials, educational activities, the PATH Intl. website, exhibitions or for any other use for the benefit of PATH Intl. and equine-assisted activities.

Candidate's Signature____Date ________________

Name (printed) ____

Name of person(s) in photo____

Address ____

City______________________________________State____________Zip ______________

Phone/email____