High Hopes Advanced Preparatory Workshop

February 6-8, 2017

High Hopes is…

A PATH Intl. Premier Accredited Center

Internationally renowned for training & education

501c3 Non Profit Center

Four Star Charity through Charity Navigator

We offer…

Lectures by experienced professionals

Networking opportunities

A dynamic learning environment

This 3-day workshop will focus on providing a comprehensive review of PATH Intl. Advanced Instructor Criteria and will explore all aspects of the Criteria through classroom discussion, hands on learning, and teaching opportunities with current High Hopes participants. This workshop will include many opportunities for discussion and candidate evaluation.

Who should attend?

- Instructors seeking professional development
- Those planning to attend an Advanced Certification in the next two years
- Anyone wishing to hone their teaching skills

Topics to be covered in the Workshop include:

- Cognitive and Physical disabilities
- Able-Bodied teaching
- Personal riding skills through participation in a lesson
- Group Instruction to individuals with disabilities
- Lesson planning for diverse groups
- Advanced mounting and dismounting techniques
- Lungeing techniques

Prerequisites:

- Participants must be PATH Intl. Registered Instructors with over 75 hours of instruction.
- Participants must be secure riders at walk, trot and canter

Limited Availability to 6 participants

For more information, contact:
Sarah Carlson, Special Programs Manager
at (860) 434-1974 ext. 115 or scarlson@highhopestr.org
Visit us online at *www.highhopestr.org*

To register for a workshop, please complete the information requested below and send it together with the required fee* to:

High Hopes Therapeutic Riding, Inc.
36 Town Woods Road, Old Lyme, CT 06371
www.highhopestr.org
Fax: (860) 434-3723

Upon receipt of this completed form and payment, High Hopes will send you an official letter of welcome and any additional materials necessary. For questions contact Sarah Carlson at (860) 434-1974 ext. 115, or scarlson@highhopestr.org.

Name: ______________________________________ Phone: ________________________________

E-mail: _____________________________________ PATH Member # __________________________

Address: ____

City: ____________________________ State: ______________ Zip: ______________

Organization or Program Affiliation: ____

HEIGHT:________ *WEIGHT:_______ PREFERRED RIDING DISCIPLINE: __ENGLISH __WESTERN

*** Please note High Hopes horses have a weight limit of 180 lbs**

Please register me for the following:

Advanced Prep Workshop ____ $650.00

Registration Deadline: January 3, 2017

Reimbursement policy: Cancellations prior to the registration deadline will receive a full refund minus a $150 service fee. No reimbursements will be granted after the registration deadline.

Riding Instructor Experience

Name ____

Address ____

Phone: Daytime ________________________ Evening ________________________ Cell ________________________

Fax ________________________________ E-mail (required) ____

Are you a licensed therapist? ❑ PT ______ ❑ OT ______ ❑ Other Therapist ______

Is your PATH Intl. Individual Membership current? ❑ Yes ❑ No

If affiliated with a PATH Intl. center, list name: ____

EDUCATION

High School _________________________________ Year ___________ Diploma ___________________________

College or Vocational __________________________ Year ____________ Degree ____________________________

Other Studies/Certificates/License _______________ Year _______________

Work Experience related to disabilities (other than therapeutic riding) ____

____

EQUESTRIAN BACKGROUND

Number of years riding ________ Owning a Horse ________ Number of years giving riding instruction ________

Type of instruction _____________________________________ Pony Club level __________ 4-H level ___________

Your Equestrian Experience: ____

____

EXPERIENCE TEACHING RIDERS/DRIVERS WITH DISABILITIES

Do you work with any of the following disabilities? Check all that apply.

Mental Impairments	❑	Cerebral Palsy	❑
Learning Disabilities	❑	Multiple Sclerosis	❑
Communication Impairments	❑	Muscular Dystrophy	❑
Hearing Impairments	❑	Brain Injury/Head Trauma	❑
Visual Impairments	❑	Spina Bifida	❑
Emotional Impairments	❑	Stroke/CVA	❑
Autism	❑	Post-Polio	❑
Down Syndrome	❑	Other	

ADDITIONAL INFORMATION

Professional organizations of which you are a member ____

Articles/books/lectures you have done ____

Print Name: ___________________________ Signature: ______________________________ Date: ______________

HIGH HOPES THERAPEUTIC RIDING INC
REGISTRATION & RELEASE
VISITOR & SPECIALTY VOLUNTEER FORM
PLEASE COMPLETE ENTIRE FORM

Please Check One: Visitor:___ Brd/Cmt Member:___ Spec Event Volunteer:___ One Day Vol/Group:_______________

Name:_______________________________________ Home #:______________ Cell #:______________DOB: ___________

Address: ____Town:___________________ zip_____________
Email: ____

In case of Emergency, contact: (Parent if minor)____________________________________ Phone:________________________
Please indicate any medical conditions or medications we should be aware of in the event of an emergency: ___________________
____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT*:* In the event emergency medical aid/treatment is required due to illness or injury while being on the property of the agency, I authorize High Hopes to: Secure and retain medical treatment and transportation, if needed and release records upon request to the authorized individual or agency involved in the medical emergency treatment.

Date: _________________ Consent Signature:____

*If volunteer is under 18 years of age, **both** parent & volunteer/visitor signatures are required.*

CONSENT PLAN (*to be invoked in the event that your Emergency Contact cannot be reached*) I give consent for emergency medical treatment/aid (including x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician) in the event of illness or injury while on the property of the agency.

Date: _________________ Consent Signature:____

*If volunteer is under 18 years of age, **both** parent & volunteer/visitor signatures are required.*

***If you choose non-consent for emergency medical treatment/aid in the event of illness or injury while on the property of the agency, please request a Non-Consent Form, which requires notarization.**

PHOTO RELEASE:

_____I hereby consent and authorize _____I do not consent to, nor do I authorize. 1) High Hopes Therapeutic Riding, Inc. to use my(my child's) photograph or image in its print, online and video publications; 2) release High Hopes Therapeutic Riding, Inc., its employees and any outside third parties from all liabilities or claims that I might assert in connection with the above-described activities and 3) waive any right to inspect, approve or receive compensation for any materials or communications, including photographs, videotapes, DVDs, website images or written materials, incorporating photos/images of me(my child).

Date: _________________ Consent Signature:____

*If volunteer is under 18 years of age, **both** parent & volunteer/visitor signatures are required.*

CONFIDENTIALITY POLICY: At High Hopes, we place great importance on protecting the confidential information of our clients, our staff and our volunteers. "Confidential Information" includes, but is not limited to, personally identifiable information such as surnames, telephone numbers, addresses, e-mails, etc., as well as the non-public business records of High Hopes. In particular, medical information about clients, and information about their disabilities or special needs, must be protected as Confidential Information. Volunteers shall never disclose confidential Information to anyone other than High Hopes staff. Volunteers must seek staff permission before taking any pictures or videos. I have read and understand High Hopes Confidentiality Policy and agree to abide by same.

Date: ____________ Signature:____

*If volunteer is under 18 years of age, **both** parent & volunteer/visitor signatures are required.*

LIABILITY RELEASE: I acknowledge the risks and potential for risks of horseback riding and related equine activities including grievous bodily harm. However, I feel that the possible benefits to myself 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 High Hopes Therapeutic Riding Inc., its Board of Trustees, Instructors, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses I may sustain while participating as a High Hopes volunteer from whatever cause, including but not limited to the negligence of these related parties.

The undersigned acknowledges that he/she has read this Volunteer Application in its entirety; that he/she understands the terms of this release and has signed this release voluntarily and with full knowledge of the effects thereof.

Date: _____________ Signature:____

*If volunteer is under 18 years of age, **both** parent & volunteer/visitor signatures are required.*