HighHopes
Therapeutic Riding
HORSES AND HUMANS
IMPROVING LIVES

PATH INT'L EQUINE SPECIALIST MENTAL HEALTH AND LEARNING WORKSHOP &
PRACTICAL HORSEMANSHIP SKILLS TEST
with
Mandy Hogan, PATH Int'l Master Therapeutic Riding Instructor, ESMHL and Co-author of ESMHL Curriculum/Workshop
&
Susanne Haseman, MEd, LCMHC, CEIP-MH, ESMHL and PATH, Int'l Advanced Therapeutic Riding Instructor

Who should attend?

Anyone interested in learning more about Equine Facilitated Learning (EFL) or Equine Facilitated Psychotherapy (EFP).

- Equine Professionals
- Therapeutic Riding Instructors
- Anyone who works with mental health and education professionals and their clients.

Topics to be covered in the Workshop include:

- Therapeutic Relationships
- HIPAA, Confidentiality and Ethical Parameters
- Relationship and Collaboration Exercises
- Equine Behavior and Management
- Session Goals—Rider Skills, Therapy, Education

The Equine Specialist workshop is a three-day workshop offered to equine professionals and therapeutic riding instructors who work or would like to work with students with mental health and/or learning issues.

Workshop—November 17-19, 2017

The workshop is a requirement of the ESMHL certification. It is beneficial to have horsemanship skills and experience when attending the workshop but it is not required.

Horsemanship Skills Test— November 20, 2017

The skills test is held on day 4 following the ESMHL workshop.

Prerequisites

- 21 or older.
- Current PATH Int'l individual member.
- Equestrian skills on the flat in English or Western tack comparable to those described in Pony Club C or CHA Level I. Familiarity with PATH Intl. Standards and PATH Intl. Code of Ethics, and/or a PATH Intl. Certified Therapeutic Riding Instructor.

To register for this workshop and/or test, please complete the information requested on the following pages and send them together with the required fee* to:

High Hopes Therapeutic Riding, Inc.
36 Town Woods Road
Old Lyme, CT 06371
(860) 434-1974
ATT: Patti Coyle
pcoyle@highhopestr.org

*Make checks payable to: High Hopes Therapeutic Riding, Inc.

Registration deadline: October 13, 2017

Additional information is available on the PATH Int'l website www.pathintl.org.

PREMIER ACCREDITED CENTER
PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

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PRACTICAL HORSEMANSHIP SKILLS TEST
Hosted by HIGH HOPES THERAPEUTIC RIDING, Inc.
November 17—20, 2017

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone (Day) _____ Phone (Cell) _____

Email:_____ PATH Int'l membership #_____

Please register me for the following:

*Workshop *ONLY* $475.00
____ November 17-19, 2017

*Workshop *AND Horsemanship Skills Test* $625.00
____ November 17-20, 2017

**Horsemanship* Skills Test *ONLY* $150.00
____ November 20, 2017

The workshop is 3 full days, 8am to 5pm. Cost includes breakfast and lunch each day. On the last day of the workshop a skills test review will be held. The skills test will occur on day 4. No breakfast or lunch provided on this day.

All participants must download a copy of the ESMHL certification booklet and bring it to the workshop and skills test. The booklet is available at http://www.pathintl.org/images/pdf/resources/certifications/PATH-Intl-ESMHL-Certification-Booklet.pdf. A limited number of booklets will also be available at the workshop for an additional $15 fee.

Registration Deadline: October 13, 2017*

**Due to the interest and demand in this ESMHL event, course may fill ahead of deadline*

Cancellation and Refund Policy High Hopes reserves the right to cancel the workshop and/or the skills test on or before October 13, 2017 due to insufficient registrants. In this case all paid registration fees will be refunded in full. 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.

Check all that apply:

- o I am at least 21 years old
- o I am a PATH Intl. Member number _____
- o I have called the PATH Intl. office to pay any membership needed (if applicable)
- o I plan to participate in the workshop only
- o I plan to participate in the workshop and practical testing
- o I plan to participate in the practical testing only
- o I do not need an accommodation of any kind to complete the practical testing

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Please attach another piece of paper or write on the back of this form if necessary to answer the following questions:

- Are you a PATH Intl. Certified Therapeutic Riding Instructor? If yes, what level or specialty: Registered, Advanced, Master, Driving?

- Equine Experience: Please tell us about any Certification you have with an Equine Organization (examples would be Pony Club, CHA, USDF, USEA, ARICP, Eagala, etc…)

  Organization: _____Level: _____

  Organization: _____Level: _____

  Organization: _____Level: _____

- Do you have experience working with Mental Health or Special Education clients in any setting? If yes, please tell us where and what kind:

- Describe other equine experience you have:

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.*