Professional Association of Therapeutic Horsemanship International
PREMIER ACCREDITED CENTER CHANGE NOTIFICATION FORM

A Professional Association of Therapeutic Horsemanship International Premier Accredited Center may be revisited at any time as determined by the PATH Intl. Accreditation Subcommittee. The Accreditation Subcommittee will review this form and any necessary attachments. If the need for a revisit is deemed necessary, the center will be advised of any revisiting fees and requirements. Failure to agree to a revisit will result in cancellation of accreditation status.

Any changes to your center's information must be submitted to PATH Intl. within 30 days. All changes must be made using this form. Changes received via telephone or email will not be accepted.

_____ _____ _____

Name of PATH Intl. Premier Accredited Center | *Center Membership Number* | *Date of Last Accreditation Site Visit*

_____

Address | *City* | *State* | *Zip*

Changes have been made in the following areas since our last accreditation visit:

1. Change in center name, contact information or contact person: ❑ Yes ❑ No
   If yes, attach a sheet detailing new information (be specific): list both old and new information.

2. Change in location of program activities: ❑ Yes ❑ No
   If yes, check the appropriate box and attach a sheet detailing new information (be specific) and include a PATH Intl. Center Accreditation Self-Study form:
   - ❑ This location is in addition to the location for program activities that was visited during our accreditation visit.
   - ❑ This location replaces the location for program activities that was visited during our accreditation visit.
   - ❑ Removing one or more locations that were visited during our accreditation visit.

3. Change in personnel: ❑ Yes ❑ No
   If yes, check the appropriate box and attach a sheet detailing new information (be specific):
   - ❑ Add instructor(s) – (note their level of PATH Intl. certification as well)
   - ❑ Remove instructor(s)
   - ❑ Add instructor who replaces another instructor
   - ❑ Add or remove executive director/program director/development director

4. Change in program activities: ❑ Yes ❑ No

If yes, check the appropriate box	Add	Delete:	Name and Credentials	Date Added/Removed	Self-Study
Driving	❑	❑	_____	_____	❑
Therapy Utilizing Equine Movement*	❑	❑	_____	_____	❑
Equine-Assisted Psychotherapy/Counseling*	❑	❑	_____	_____	❑
Interactive Vaulting	❑	❑	_____	_____	❑
Therapeutic Riding	❑	❑	_____	_____	❑

*Include credentialing documentation of therapist when adding therapy utilizing equine movement or equine-assisted psychotherapy/equine-assisted counseling

Only persons granted authority by the center to make changes to the center's information can do so through the PATH Intl. office. If personnel granted authority is/are no longer affiliated with the center, an explanation of change in personnel and name of new contact person must be drafted on the center's letterhead and must accompany this Change Notification form.

By signing this form, I verify that the information provided is accurate to the best of my knowledge and that the above listed PATH Intl. Premier Accredited Center is in full compliance with all mandatory and applicable standards in accordance with current PATH Intl. accreditation and center membership requirements.

_____

Signature (must be an authorized individual for the center) | *Printed Name* | *Date*

Complete and mail to: PATH Intl. • PO Box 33150 • Denver, CO 80233 • or fax to: (303) 252-4610

Professional Association of Therapeutic Horsemanship International
CENTER MEMBER CHANGE NOTIFICATION FORM

Any changes to your center's information must be submitted to Professional Association of Therapeutic Horsemanship International within 30 days. All changes must be made using this form. Changes received via telephone or email will not be accepted.

_____ _____

Name of PATH Intl. Center *Center Membership Number*

_____

Address *City* *State* *Zip*

The above listed PATH Intl. Center has made changes in the following areas:

1. Change in center name, contact information or contact person: ❑ Yes ❑ No
   If yes, attach a sheet detailing new information (be specific): list both old and new information.

2. Change in location of program activities: ❑ Yes ❑ No
   If yes, check the appropriate box and attach a sheet detailing new information (be specific) and include a Self-Study form:
   - ❑ This location is in addition to the location for program activities previously listed with PATH Intl.
   - ❑ This location replaces the location for program activities previously listed with PATH Intl.
   - ❑ Removing one or more locations.

3. Change in personnel: ❑ Yes ❑ No
   If yes, check the appropriate box and attach a sheet detailing new information (be specific):
   - ❑ Add instructor(s) - (note their level of PATH Intl. certification as well)
   - ❑ Remove instructor(s)
   - ❑ Add instructor who replaces another instructor
   - ❑ Add or remove executive director/program director/development director

4. Change in program activities: ❑ Yes ❑ No

If yes, check the appropriate box	Add	Delete:	Name and Credentials	Date Added/Removed	Self-Study
Driving	❑	❑	_____	_____	❑
Therapy Utilizing Equine Movement*	❑	❑	_____	_____	❑
Equine-Assisted Psychotherapy/Counseling*	❑	❑	_____	_____	❑
Interactive Vaulting	❑	❑	_____	_____	❑
Therapeutic Riding	❑	❑	_____	_____	❑

*Include credentialing documentation of therapist when adding therapy utilizing equine movement or equine-assisted psychotherapy/equine-assisted counseling

Notes (you may also use the back of this form or an additional sheet for notes):

By signing this form, I verify that the information provided is accurate to the best of my knowledge and that the center is in full compliance with all mandatory and applicable standards in accordance with current PATH Intl. center membership requirements.

_____

Signature (must be an authorized individual for the center) *Printed Name* *Date*

Complete and mail or fax to: PATH Intl., PO Box 33150, Denver, CO 80233, fax: (303) 252-4610

Professional Association of Therapeutic Horsemanship International

MEMBERSHIP FIELD TEST STANDARDS FEEDBACK FORM

This form is **optional** and intended for additional feedback on standards or the accreditation process.

Thank you for taking the time to complete this form. The membership's input on all standards is valued and increases the effectiveness of the accreditation process. As the standards process is intended to be industry- and peer-driven, your suggestions and/or comments are welcomed by the PATH Intl. Accreditation Subcommittee. Please attach an extra sheet if needed.

Center Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Day Phone: (_____) _____ Evening Phone: (_____) _____

Fax Number: (_____) _____ Email Address: _____

Standard	Comments

Please include your credentials, professional background and/or current experience relevant to the standard (e.g., currently presenting a program affected by the standard in field test.) Please attach an extra sheet if needed.

Signature _____ Date _____

Please return this form to: PATH Intl., PO Box 33150, Denver, CO 80233

Consult a lawyer to ensure this form meets your state's regulations. Take this form to your local emergency room to ensure that all pertinent information is present.

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Participant's Application & Health History

GENERAL INFORMATION

Participant: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M F

Address: _____

Phone: _____ Email: _____ Alternative #: _____

Employer/School: _____

Address: _____

Phone: _____

Parent/Legal Guardian: _____

Caregivers: _____

Address (if different from above): _____

Phone: _____

Referral Source: _____

Phone: _____

How did you hear about the program? _____

HEALTH HISTORY

Diagnosis: _____ Date of Onset: _____

Please indicate current or past special needs in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

MEDICATIONS (include prescription and over-the-counter, name, dose and frequency) _____

_____

_____

_____

_____

_____

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):

PHYSICAL FUNCTION (e.g., mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

_____

_____

_____

_____

_____

_____

PSYCHOSOCIAL FUNCTION (e.g., work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)

_____

_____

_____

_____

_____

_____

GOALS (i.e., why are you applying for participation? What would you like to accomplish?

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____

PHOTO RELEASE

I ❑ DO

❑ DO NOT

consent to and authorize the use and reproduction by _____
(center)

of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____

Client, Parent or Legal Guardian

Signed in the presence of center staff

Participant's Consent for Release of Information

I hereby authorize: _____
(person or facility)

to release information from the records of: _____ DOB: _____
(participant's name)

The information is to be released to: _____
(center or therapist's name)

for the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below:

- ❑ Medical history
- ❑ Physical therapy evaluation, assessment and program plan
- ❑ Speech therapy evaluation, assessment and program plan
- ❑ Mental health diagnosis and treatment plan
- ❑ Individual Habilitation Plan (IHP)
- ❑ Classroom Individual Education Plan (IEP)
- ❑ Psychosocial evaluation, assessment and program plan
- ❑ Cognitive-behavioral management plan
- ❑ Other: _____

This release is valid for one year and can be revoked, in writing, at my request.

Signature: _____ Date: _____

Print Name: _____

Relation to Participant: _____

Please send materials to: _____

_____

_____

_____

This is an initial letter to your participant's physician. Attach the Participant's Medical History & Physician's Statement.

Date: _____

Dear Health Care Provider:

Your patient _____

(participant's name)

is interested in participating in supervised equine activities.

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

Atlantoaxial Instability - include neurologic symptoms

Coxarthrosis

Cranial Defects

Heterotopic Ossification/Myositis Ossificans

Joint subluxation/dislocation

Osteoporosis

Pathologic Fractures

Spinal Joint Fusion/Fixation

Spinal Joint Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt

Seizure

Spina Bifida/Chiari II Malformation/Tethered Cord/Hydromyelia

Other

Age - under 4 years

Indwelling Catheters/Medical Equipment

Medications - e.g., Photosensitivity

Poor Endurance

Skin Breakdown

Medical/Psychological

Allergies

Animal Abuse

Cardiac Condition

Physical/Sexual/Emotional Abuse

Blood Pressure Control

Dangerous to Self or Others

Exacerbations of Medical Conditions (e.g., RA, MS)

Fire Setting

Hemophilia

Medical Instability

Migraines

PVD

Respiratory Compromise

Recent Surgeries

Substance Abuse

Thought Control Disorders

Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine-assisted services, please feel free to contact the center at the address/phone indicated above.

Sincerely,

Name *Center Name* *Phone Number*

This is an update form for your participant's physician. Attach a copy of the previous Participant's Medical History & Physician's Statement.

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Date: _____

Dear Health Care Provider:

Your patient _____
(participant's name)

has been participating in supervised equine activities at _____
(center)

and is due for an update of ~~his/her~~ medical status. Please review the previous medical history and provide an update of the information in the space below. Address occurrences over the past year including surgeries, illnesses, hospitalizations, changes in medications, treatment, weight or behavior. Please indicate current height/weight. For your reference, potential precautions/contraindications are listed on the reverse. If this person has Down syndrome or any other condition that predisposes ~~him/her~~ to Atlantoaxial Instability, please include results of ~~his/her~~ neurologic exam.

Diagnosis: _____

Height: _____ Weight: _____

Update Status: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted services. I understand that the PATH Intl. Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl. Center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA ~~Other~~ _____

Signature: _____ Date: _____

Address: _____

Phone: (_____) _____ License/UPIN Number: _____

Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled: Y N Date of Last Seizure: _____

Shunt Present: Y N Date of last revision: _____

Special Precautions/Needs: _____

_____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices: _____

For those with Down syndrome: Neurologic Symptoms of Atlantoaxial Instability: ❑ Present ❑ Absent

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted services. I understand that the PATH Intl. Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl. Center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA ~~Other~~ _____

Signature: _____ Date: _____

Address: _____

Phone: (_____) _____ License/UPIN Number: _____

PATH
INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Participant's Profile

Name: _____ Date: _____

Disability: _____

Ambulatory Status: _____

Adapted Equipment Required: _____

Mounting/Dismounting (method, number of volunteers) _____

_____

Helpers required (indicate gait* assistance needed; update as needed):

Type of Assistance	Date	Gaits	Date	Gaits	Date	Gaits
Leader and two sidewalkers						
Leader and one sidewalker						
Leader only						
Sidewalker						
Independent						

Riding Position (describe): _____

_____

_____

Participant Skills (indicate gait*/task is completed; update as needed):

Task	Date	Gaits	Date	Gaits	Date	Gaits
Holds reins						
Holds handhold						
Able to control horse						
Able to halt from the...						
Able to circle at the...						
Rides without stirrups						
Able to maintain half seat						
Able to post at the...						
Knows diagonal or lead						
Able to steer over cavalletti						
Able to jump a crossbar						

Participant can walk _____ sitting trot _____ posting trot _____ canter _____

Horse recommendations _____

_____

(write any additional comments on the reverse side)

*Gait Key: W - walk; ST - sitting trot; PT - posting trot; C - canter

PATH
INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Volunteer/Staff Information Form and Health History

General Information

Name: _____ Date: _____

Address: _____

Date of Birth: _____ Phone: (H) _____ (W) _____

Employer/School: _____

Address: _____

Parent/Legal Guardian/Caregiver Name/Address/Phone Number: _____

_____

How did you learn about the program? _____

Recent medical tests: _____ Last Tetanus Shot: _____ Tuberculosis Test + — Date: _____

(Consult your physician or local health department if you are not up to date with these shots/tests)

Health History

Please describe your current health status, particularly regarding the physical/emotional demands of working in an equine-assisted program. Address fitness, cardiac, respiratory, bone or joint function, recent hospitalizations/surgeries or lifestyle changes.

_____

_____

_____

_____

_____

_____

_____

Allergies: _____

_____

Medications: _____

_____

_____

Check areas in which you are interested:

Program	Special Events	Administration	
❑ Horse Handling	❑ Horse Show	❑ Public Relations	❑ Photography/Video
❑ Sidewalking With a Student	❑ Fundraising	❑ Grant Writing	❑ Budget & Finance
❑ Stable Management	❑ Special Olympics	❑ Newsletter	❑ Future Planning
❑ Facility Repairs	❑ Trail Rides	❑ Volunteer Recruitment	

I understand that the information provided above is accurate to the best of my knowledge. I know of no reason why I should not participate in this center's program.

Signature: _____ Date: _____

(volunteer/staff/caregiver; signed in presence of center staff)

PATH
INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Volunteer/Staff Information Form and Health History

Page 2

Name: _____

Address: _____

Phone: _____ Date of Birth: _____

Photo Release

I ❑ DO

❑ DO NOT

consent to and authorize the use and reproduction by _____
(PATH Intl. Center)

of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____

Background Information

Have you ever been charged with or convicted of a crime? Y N Please explain_____

_____

_____

I, _____(volunteer/staff), authorize _____ to receive information from any law enforcement agency, including police departments and sheriff's departments, of this state or any other state or federal government, to the extent permitted by state and federal law, pertaining to any convictions I may have had for violations of state or federal criminal laws, including but not limited to convictions for crimes committed upon children or animals.

I understand that such access is for the purpose of considering my application as an employee/volunteer, and I expressly DO NOT authorize the PATH Intl. Center, its directors, officers, employees or other volunteers to disseminate this information in any way to any other individual, group, agency, organization or corporation.

Signature: _____ Date: _____
(volunteer/staff)

CURRENT DRIVER'S LICENSE Y N LICENSE NUMBER_____ STATE _____

Confidentiality Agreement

I understand that all information (written and verbal) about participants at this PATH Intl. Center is confidential and will not be shared with anyone without the expressed written consent of the participant and ~~his/her~~ parent/guardian in the case of a minor.

Signature: _____ Date: _____
(volunteer/staff)

PATH
INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Volunteer Job Description Worksheet

Job Title: _____

Supervised by: _____

General Description of Duties (indicate major functions): _____

_____

_____

_____

_____

Specific Job Responsibilities (list major tasks and standards of performance):

_____

_____

_____

_____

Conditions of Assignment (location, time required, degree of supervision and support, etc.):

_____

_____

_____

_____

Qualifications, Training and Preparation for Assignment (list knowledge, skills and attitudes needed for job):

_____

_____

_____

_____

_____

_____

Release of Liability

It is mandatory that PATH Intl. Centers have a Release of Liability form signed by all participants/volunteers at the center. PATH Intl. no longer provides a generic liability release form. There is no sample form that would be adequate or accurate for all 50 states. The language in the various laws are different in each state. As of February 2002, forty-four (44) states have enacted equine/farm liability acts and legislation. In general, the act states that the participant and parents, legal guardians, spouses, children waive and release claims from damages or injuries suffered while engaged in horseback riding and other equine events. You must contact a lawyer in your state who is familiar with the laws in your state and ask the lawyer to draw up a release that meets the requirements of your state act. Or get together with other centers in your state that provide similar services to have one lawyer consult for all the programs. Then include the release language here with appropriate required signatures. Signatures should be completed in the presence of center staff and so indicated on the form. Your state may also require signature by a notary public.

Liability releases should specifically reflect the type of activities the center provides. There are provisions in many states allowing some liabilities to override releases. **There is never a guarantee that the courts will enforce the one liability release you use.**

Elements of a Confidentiality Policy

By Marilyn Barker, MD,
PATH Intl. Medical Committee
(reprinted from the March/April 1995 issue of NARHA News)

In the September/October 1994 issue of NARHA News, I discussed a number of concerns about a therapeutic riding center's legal and ethical obligations to maintain confidentiality of the sensitive information it might receive about a rider. To protect your center legally as well as to better serve your riders, I suggest developing a confidentiality policy that is distributed to all staff and volunteers. When writing the policy, include the following elements:

I. General Principles
Riders and their families have a right to privacy that gives them control over the dissemination of their medical or other sensitive information. A sample statement in your policy could read: The therapeutic riding center shall preserve the right of confidentiality for all individuals in its program.

II. Information Covered by the Confidentiality Policy
It is important to specify exactly what kind of information is covered by the policy, such as medical, financial and other sensitive information. You must maintain the confidentiality of such information regardless of how it is obtained. Disclosures can occur because a chart, record or computer screen is left unattended. Someone may overhear a discussion or a third party may give information. This kind of information is protected and employees who receive this information must not disclose it to anyone else without proper authorization. For example, the wording for your policy might be: *The staff shall keep confidential all medical, social, referral, personal and financial information regarding a person and his/her family.*

III. Persons Subject to the Confidentiality Policy
Anyone who works or volunteers for or provides services to the therapeutic riding center should be bound by the policy. This includes but is not limited to:

- full- and part-time staff
- independent contractors
- temporary employees
- volunteers
- board members

The policy should also apply to anyone connected with your center who could obtain this information either accidentally or on purpose.

IV. Competency and Informed Consent Disclosure
A rider may not be competent to give consent for disclosure of medical or sensitive information or both (including photographs and videotapes) because of age or mental capacity. As a general rule, infants and children under age 18 do not have legal authority to consent to disclosure. Only parents, legal representatives or others defined by state statute generally have this authority.

Adults with developmental disabilities are presumed legally competent to give or deny consent to disclosure unless they have been adjudicated incompetent to make this kind of health care decision. If a substitute decision-maker has been appointed, you must obtain specific and informed written consent from that individual.

V. Intra-Agency Access to and Disclosure of Medical and/or Sensitive Information
The extent of access allowed under this standard will vary depending on the type of agency and the type of services provided. For example, the number of staff members requiring medical or sensitive information or both at a health care facility is likely to be higher than at a therapeutic riding center. You should *not* permit access to or disclosure of such information without a rider's consent based on a *perceived* need to protect staff or anyone else from possible exposure through casual contact.

Casual contact poses no risk of transmission of diseases such as HIV. The most effective method of protection for situations in which staff may be exposed to the blood of a rider is the use of infection control procedures. These procedures should be used with all riders under the assumption that all riders may have HIV, hepatitis or other bloodborne diseases. Knowledge that a particular rider has HIV infection does not protect staff members from transmissions. Using universal precautions does. (See your May/June 1994 *NARHA News* for suggested universal precautions for therapeutic riding centers.)

VI. Extra-Agency Disclosure of Medical and/or Sensitive Information
Disclose outside information to outside agencies or individuals only with the specific written consent of the rider.

VII. Penalties for Unauthorized Disclosures

Write your confidentiality policy to emphasize the personal and professional penalties that can result from breaching confidentiality. Outline internal penalties, such as reprimand, loss of certain job responsibilities and termination.

Have your director of personnel or volunteer coordinator ensure that all staff and volunteers receive a copy of your center's confidentiality policy. Then, have each sign a confidentiality statement that pledges to protect the confidentiality of all information regarding individuals who participate in the center's program. The statement may be as simple as: *I understand and will observe the confidentiality policy of (insert your center's name).* Include a line for a signature and date and a line for a witness signature and date.

Writing a comprehensive confidentiality policy is not hard if you consider all of the above elements. The benefit is that you will know that all staff and volunteers understand the importance of your riders' confidentiality. This understanding builds trust and professionalism.

An occurrence is any unusual event. It may or may not result in an injury to a participant, staff, volunteer or horse. Any occurrence that results in medical treatment should be phoned in to the center's insurance company within 24 hours, whether or not a claim is made. Forms should be filled out the same day, including a narrative of what happened, with signed statements/ reports from any witnesses or participants in the occurrence. Written forms should be sent to the insurance company, with a copy saved in the center's files.

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Center Occurrence Report

Name of involved: _____ Date: _____ Time: _____

Address: _____

Phone: (H)_____ (W)_____ Email: _____

Information About the Occurrence

Location: _____

Situation: _____

Witness: _____

Address: _____ Phone: _____

Witness: _____

Address: _____ Phone: _____

Witness: _____

Address: _____ Phone: _____

(Please use additional forms for signed statements from witnesses/additional parties involved)

Description of occurrence: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Environmental factors: _____

_____

_____

What injuries were incurred? _____

_____

_____

_____

(over)

What treatment was given for injuries? _____

_____

Who was contacted (e.g., family, doctor, vet)? Indicate time/date _____

_____

_____

Follow-up calls/contacts _____

_____

_____

What will be done to prevent this type of occurrence in the future? (This section does not need to be completed prior to sending to the insurance company) _____

_____

_____

_____

_____

_____

_____

In your opinion, will a claim be filed? Y N

Signature of person filling out form: _____ Date: _____

Title: _____ Center: _____

Signature of center director: _____ Date: _____

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Horse Profile

Name: _____ Age: _____

Height: _____ Weight: _____

Breed: _____ Sex: _____ Markings: _____

Personality

Likes: _____

_____

_____

_____

Dislikes: _____

_____

_____

_____

Body Language: Do's and Don'ts: _____

_____

_____

_____

Grooming Likes and Dislikes: _____

_____

_____

Tack

English: Saddle(s)_____ Pads: _____

Bridle: _____ Clip-Ons: _____ Girths: _____

Western: Saddle(s)_____ Pads: _____

Bridle: _____ Clip-Ons: _____ Girths: _____

Bareback: _____ Jumps: _____

Vaulting: _____ Surcingle: _____

Lunges: _____

Mounting Procedure: _____

_____

Stall Etiquette: _____

_____

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Horse First Aid Checklist

The Horse First Aid supplies are in (a) clearly marked container(s) in a designated location, accessible to all center personnel and participants at each activity site and must contain, but are not limited to, the following items. This form or this information must be placed within the Horse First Aid container.

EMERGENCY NUMBERS:

Veterinarian:	Dr. Rogers	(333) 333-3333
Personnel:	Marie Marson—Barn Manager	(333) 555-5555
	Tom Tomson—Equine Coordinator	(333) 444-4444
	Chris Christianson—Program Director	(333) 545-5454
	Lucy Lucent—Head Instructor	(333) 454-4545
Farrier:	Bob Roberts	(333) 222-2222
Horse Owners:	Lucky—Cindy and Bill Johnson	(333) 232-2323
	_____	_____
	_____	_____
	_____	_____

ITEM	Jan	Feb	Mar	April	May	June	July	Aug	Sep	Oct	Nov	Dec
horse thermometer (with string + clip attached)												
topical antibiotic												
antiseptic cleaner +												
surgical scrub												
cotton roll												
cling wrap												
gauze pads, in assorted sizes												
sharp scissors												
cup or container												
latex gloves												
saline solution												
stethoscope												
clippers												
INITIAL WHEN CHECKLIST COMPLETE:												

PATH
INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Human First Aid Checklist

The Human First Aid Kit is in (a) clearly marked container(s) in a designated location, accessible to all center personnel and participants at each activity site and may contain, but is not limited to, the following items:

ITEM	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
sterile gauze pads												
self-adhering roller bandages												
occlusive dressing												
adhesive tape												
antiseptic spray												
safety pins												
bandage scissors												
adhesive strip bandages												
disposable gloves												
disinfectant cleaner												
plastic garbage bags												
CPR mask												
linens, pillows, blankets												
emesis bags/basins												
tissues												
towels												
disposable drinking cups												
drinking water												
wet wipes												
warning/signaling devices												
fire extinguisher (close by)												
telephone, or other device (close by)												
emergency guide												
INITIAL WHEN CHECKLIST COMPLETE:												

Making the Call

- ❑ Stay calm
- ❑ Be accurate
- ❑ Location of emergency
- ❑ Telephone number of the telephone being used
- ❑ The caller's name
- ❑ What happened
- ❑ The number of victims
- ❑ The victim's condition
- ❑ The help being given

Remember

DO NOT hang up first - dispatcher may need more information

Emergency Information

Hang this card near the telephone

This Phone Number Is _____

This Address Is _____

Directions Are _____

_____

_____

Police _____

Fire _____

Doctor _____

Ambulance _____

Veterinary _____

Other _____

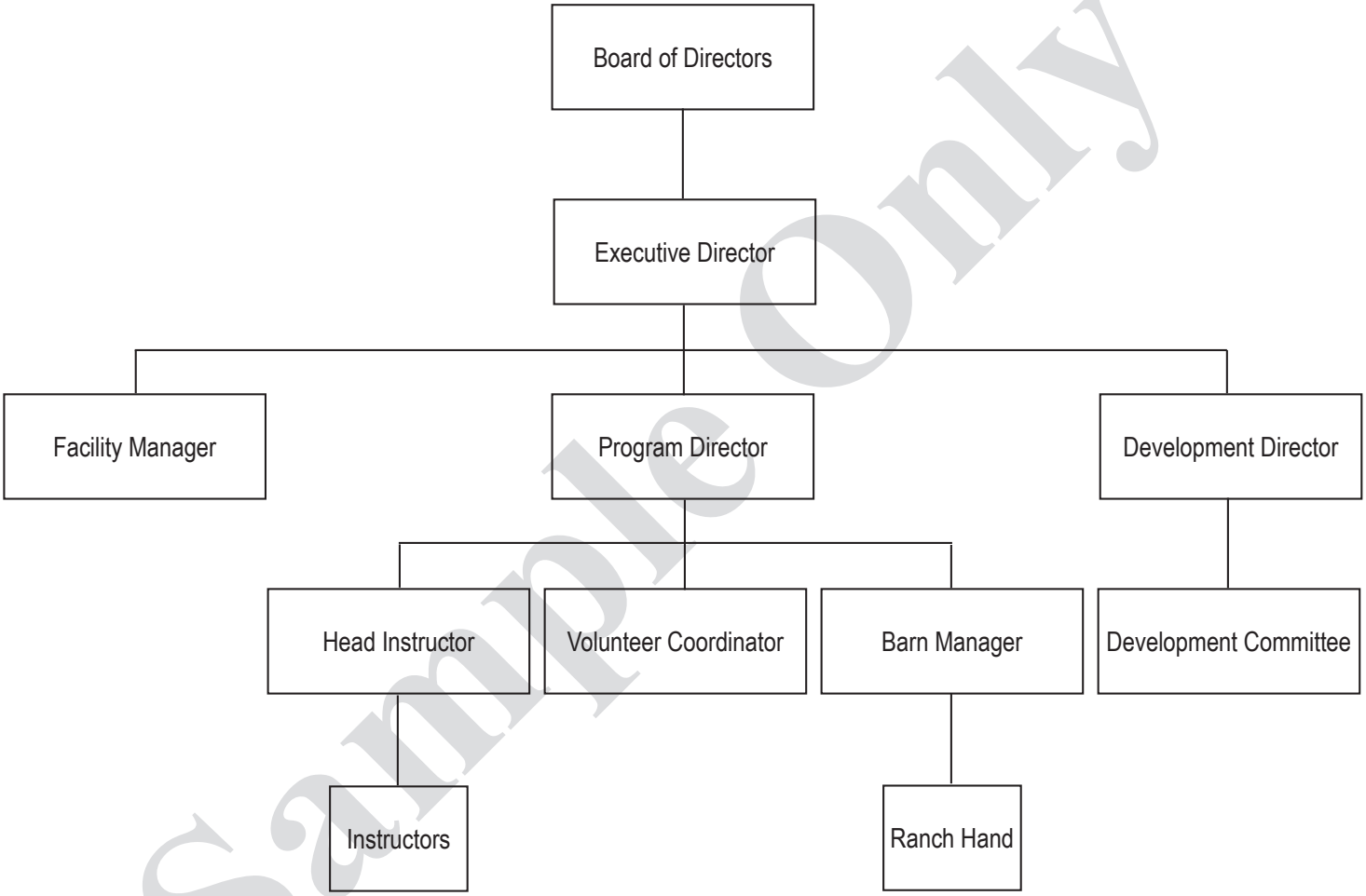
_____

_____

Prepared by:

For:

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International


Board of Directors
Executive Director
Facility Manager
Program Director
Development Director
Head Instructor
Volunteer Coordinator
Barn Manager
Development Committee
Instructors
Ranch Hand