



# 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	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>
Therapy Utilizing Equine Movement*	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>
Equine-Assisted Psychotherapy/Counseling*	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>
Interactive Vaulting	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>
Therapeutic Riding	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>

\*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