Therapeutic Riding & Equine Assisted Therapy Questionnaire

Name of Applicant ____

Agency ____

Email ______________________ Website ______________________

General Questions

		Yes	No
1.	Operating Name for Therapeutic Riding Operations ______________________		
2.	Please select the organization(s) with which you hold accreditations/certifications/licenses: ☐ PATH ☐ EAGALA ☐ Other ______________________ *Note: Ineligible for the program if you are not PATH certified.*		
3.	Do you abide by all your accrediting/certifying/licensing organization's safety guidelines?	☐	☐
4.	How many years have you managed or provided a therapeutic riding program? ______________		
5.	Do you hold and maintain Adult and Child CPR and basic First Aid certifications?	☐	☐
6.	Do you obtain medical permission forms and keep them on record for all clients?	☐	☐
7.	Do you obtain signed Release/Hold Harmless forms and keep them on record for all clients?	☐	☐
8.	Who is involved in the therapy? ☐ Employees ☐ Officers ☐ Volunteers ☐ Independent Contractors ☐ Guardians If Volunteers, How many? ______________		
9.	Activities Offered: ☐ Equine Assisted Therapy *(No Riding)* ☐ Hippotherapy ☐ Therapeutic Driving ☐ Therapeutic Vaulting ☐ Recreational Riding for Riders with Disabilities ☐ Competitions for Riders with Disabilities ☐ Therapeutic Riding		
10.	What is the average number of therapy clients treated weekly? ______________ What is the maximum number of clients in a single session? ______________		
11.	Who provides the horses used in therapy session? ☐ Owned by you ☐ Leased from Others		
12.	How are horses evaluated for suitability for use in the therapy program?		
13.	What facilities are used for the therapeutic equine operations? ☐ Enclosed Indoor Arena ☐ Fenced Outdoor Arena ☐ Trails ☐ Other, please describe: ______________________		
14.	What safety equipment/perimeters are required while mounted?		

General Questions	Yes	No
15. Do you have an "at-risk" type program? **If yes**, describe the types of at-risk patients you accept *(i.e. broken homes, domestic violence, gang-related violence, etc)*.	☐	☐
16. Do you provide equine therapy to anyone who could be considered dangerous to themselves or others? **If yes**, please describe:	☐	☐
17. What fundraising activities do you employ?		
18. What non-equine activities are offered to your equine-therapy clients?		
19. Do you bring any of your animals in any structures not intended for such animals? *(i.e. elevators, nursing homes, etc.)*	☐	☐
20. Is Abuse & Molestation Liability Coverage desired? **If yes**, please complete the separate Abuse & Molestation Liability Questionnaire.	☐	☐

The undersigned Authorized Representative of the Applicant declares that, to the best of his/her knowledge and belief, the statements set forth in this supplemental application and its attachments and other materials submitted to the Company are true and complete and me be relied upon.

Signature of Applicant's Authorized Representative ______________________________

Name ***(Printed)*** ______________________________

Title ______________________________ **Date** ______________________________