Reins of Life Therapeutic Riding Center

PATH INT'L EQUINE SPECIALIST IN MENTAL HEALTH & LEARNING WORKSHOP and Skills Test
March 31– April 3, 2023

Event Application

To register for this workshop please, please complete the following forms and send with the required fees to the address below.

Name:_____ **PATH Member ID:**_____
Address:_____
Street City State ZIP
Phone:_____ **Email:**_____

Please complete the following forms:
- Event Registration Form
- PATH, Int'l ESMHL Profile Form
- PATH, Int'l ESMHL Photo Release Form
- PATH, Int'l ESMHL Application
- PATH, Int'l ESMHL Liability Release Form

Fees (covers materials, breakfasts and lunches):

Workshop only	____$525.00
Practical Test only	____$150.00
Workshop & Practical Test	____$650.00
Audit	____$200.00

Cancellation and Refund Policy:
Cancellations prior to the registration deadline of **February 28, 2023** will receive full refund minus $50 service fee. Cancellations after deadline will receive 50% refund. No refund will be granted after March 5th.

METHOD OF PAYMENT:
Check enclosed (make payable to Reins of Life) _____
Credit Card: _____ Visa _____ MC _____Discover No:_____
Exp. Date: _____ CVS (on back) :_____ **$Amt.:**_____ **Phone:** _____
Name on Card:_____ **Email:** _____
(Please Print)
Billing Address:_____
Street City State ZIP
or Call 574-232-0853 with payment information.

Email forms to: aly.olson@reinsoflife.org
Or send forms to:
Reins of Life, Inc
Attn: Aly Olson
55200 Quince Road South Bend, IN 46619

Reins of Life, Inc.

55200 Quince Road
South Bend, IN 46619
Phone: 574-232-0853

9375 W. 300 N.
Michigan City, IN 46360
Phone: 219-874-7519

Fax: 574/232-1104
Website: www.reinsoflife.org

EVENT REGISTRATION FORM

Please (x) appropriate workshop/certification

____ ESMHL **workshop**
____ ESMHL **skills test**
____ ESMHL **audit**

Name: _____Date of Birth: _____

Address: _____

City_____ State_____ Zip: _____

(OSWC participants only) Height _____ ft ____ in Weight_____ lbs

Home phone: _____ Cell/Other: _____

Work: _____

Email: _____

Person(s) to be contacted in case of an emergency:

1. Contact _____ Relation _____ Phone: _____
2. Contact _____ Relation _____ Phone: _____

Physician's Name: _____

Preferred Medical Facility: _____

Health Insurance Company: _____ Policy # _____

Participant Confidentiality Statement

I understand that any and all activity and information that may be disclosed to me during my activities as a participant are deemed confidential and are not to be discussed with anyone other than Reins of Life staff.

Signed _____ Date _____

WARNING

Under Indiana law, an equine professional is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities.

PARTICIPANT REGISTRATION *(cont.)*

Participant's Authorization for Emergency Medical Treatment

In the event emergency medical aid/treatment is required due to illness or injury while participating at Reins of Life, I authorize Reins of Life to secure and retain medical treatment and transportation if needed.

Signed _____ Date _____

Consent Plan

This authorization includes X-ray, surgery, hospitalization, medication and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the contact persons above are unable to be reached.

Consent Signature _____ Date _____

Print Name _____

OR

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury while participating at Reins of Life. In the event emergency treatment/aid is required, I wish the following procedure to be followed:

_____

_____

_____

Non-Consent Signature _____Date_____

Print Name _____

Participant Liability Release

As a participant with Reins of Life, I acknowledge the risks and potential for the risks of a horseback riding program. However, I feel the possible benefits to myself and the clients I work with are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damage against Reins of Life, Inc., its Board of Directors, Instructors, Therapists, Volunteers and/or Employees, Operating Site for any and all injuries and/or losses I may sustain while participating in Reins of Life, Inc.

Signed _____ Date _____

Photo/Media Release/Website

I hereby consent to and authorize the use and reproduction by Reins of Life, Inc. of any and all photographs and any other audiovisual material taken of me/my son/my daughter for promotional printed material, educational activities or for any other use for the benefit of the program. I waive any current and future claims against Reins of Life, financial & otherwise, and release Reins of Life for use of any previously stated materials.

Yes	No			
☐	☐	Photo Release	Signature: _____	Date: _____
☐	☐	Video Release	Signature: _____	Date: _____
☐	☐	Media Release	Signature: _____	Date: _____
☐	☐	Social Media Release	Signature: _____	Date: _____

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