RIDER ELIGIBILITY FORM

Honoring our service men and women and the horses that are helping them heal.

Rider Information

Rider Name:	
Address:	City/State/Zip:
Phone:	Email:
Branch of Service:	Time in Service:

PATH Intl. Equine Services for Heroes Information

Therapeutic Riding Facility:	
Address:	City/State/Zip:
Phone:	Email:
Website:	Contact:

*For Veterans who **do not** participate in Therapeutic Riding programs, please attach the Department of Veteran Affairs letter recording the dates of service, the Service-connected Disability Rating, and the date it was awarded. Please black out any personal information such as SSN and monetary amounts.*

Adaptive Equipment

Please indicate which adaptive equipment is needed:

- ☐ Audio Communication
- ☐ Boot Adaptations
- ☐ Hand Hold (flexible and/or rigid)
- ☐ Laces to tie stirrups/leathers to girth or cinch
- ☐ Loop Reins
- ☐ Rein Handle Tethers
- ☐ Saddle Blocks/Wedges/Cushions
- ☐ Seat Savers
- ☐ Whips
- ☐ Bareback Pads
- ☐ Dowel Reins
- ☐ Helmets
- ☐ Ladder Reins
- ☐ Rein Handles
- ☐ Rubber Bands
- ☐ Safety Stirrups
- ☐ Surcingle
- ☐ Other _____

(Subject to approval)

Instructor Statement

This applicant will be using the above designated equipment while competing in the:

☐ Independent ☐ Supported

I verify that the above information is accurate:

Name:_____ Date: _____

Signature:_____ Certification Number: _____