AHCB
American Hippotherapy Certification Board

Hippotherapy Certification Examination
Attestation Statement

CANDIDATE FULL NAME:	CANDIDATE EMAIL:
CANDIDATE ADDRESS:	CANDIDATE PHONE:

VERIFICATION OF HIPPOTHERAPY EXPERIENCE BY OPERATING CENTER DIRECTOR OR EQUIVALENT

I certify that the candidate named above has a minimum of 25 hours of direct patient treatment using hippotherapy in addition to completing AHA Inc. Level/Part I and II courses or equivalent graduate level courses.

OPERATING CENTER DIRECTOR SIGNATURE	DATE:
PRINT NAME:	EMAIL:
OPERATING CENTER NAME WHERE CANDIDATE HAS INCORPORATED HIPPOTHERAPY:	PHONE:

VERIFICATION OF HORSE EXPERIENCE BY RIDING INSTRUCTOR WITH CREDENTIALS ACCEPTABLE TO AHCB*

I certify that the candidate named above conducts the following activities safely and independently:

a. groom and tack up a horse
b. mount and dismount
c. ride safely with control at a walk or trot
d. work with horses in a comfortable and confident manner

CREDENTIALED INSTRUCTOR/JUDGE SIGNATURE	DATE:
PRINT NAME:	EMAIL:
INSTRUCTOR/JUDGE CREDENTIALS:	PHONE:

*Examples of acceptable credentials: USPC, USDF, PATH International, CHA, BHSAI