Hippotherapy Clinical Specialist® 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 100 hours of direct patient treatment using hippotherapy within the last three (3) years.

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, trot, and canter (lope)

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