



# SHADOW EXPERIENCE APPLICATION

*Thank you for your interest in the Park Equine Hospital Shadow program!  
Please email a PDF of **this form and a letter of intent** to:  
applications@parkequinehospital.com*

## IDENTIFICATION INFORMATION

Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City, State, & Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_\_ Check One:      MALE      FEMALE

Current School/University: \_\_\_\_\_

Current Level of Education: \_\_\_\_\_

Have you been injured, or do you have any injuries (hip, back, knee, wrist, etc.) that would hinder your participation in this program? Do you have any allergies (hay, straw, animals, dust, etc.)? If so, please describe:

\_\_\_\_\_  
\_\_\_\_\_

Please specify dates of availability (you may list multiple blocks of time for us to choose from):

\_\_\_\_\_  
\_\_\_\_\_

## **AUTHORIZATION AND SIGNATURE**

I certify that all the information provided on and with this application is complete and accurate to the best of my knowledge. I understand that all information will be available to the Review & Selection Committee. I grant permission to Park Equine Hospital to verify all information pertinent to my application.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature (*if under 18 years of age*): \_\_\_\_\_ Date: \_\_\_\_\_