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): _____

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: _____

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