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: _____

Please explain what your current horse experience level is in detail:

_____

_____

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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