



## Hippotherapy Clinical Specialist® 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.

Operating center director signature:	Date:
Print name:	Email:
Operating center name where candidate has incorporated hippotherapy (Use more than one form if necessary):	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 | c. Ride safely with control at a walk, trot and canter  |
| b. Mount and dismount        | d. Work with horses in a comfortable & confident manner |

Credentialed instructor/judge signature:	Date:
Print name:	Email:
Instructor/judge credentials:	Phone:

**\*Examples of organizations whose credentials are acceptable include: USPC, USDF, PATH Int'l/CTRI, CHA, BHSAI, etc. If other, or you have a question regarding acceptable credentials, please ask prior to submitting the application to avoid delays.**