




Free S.P.I.R.I.T. Riders, Inc.
Special People in Riding Therapy
Rider Registration

Name _____	Birthdate _____
Address _____	Home Phone _____
City, State, Zip _____	Work Phone _____
E-Mail _____	Your Employer _____
Name of Spouse _____	Spouse Employer _____

IF UNDER 18 YEARS OF AGE, COMPLETE THE FOLLOWING:

Name of School _____	Employer _____
Name of Parent/Guardian _____	Work Phone _____
Address _____	Work Phone _____
City, State, Zip _____	Work Phone _____
Spouse Employer _____	Work Phone _____

EMERGENCY CONTACT

Name _____	Phone _____
Relationship _____	Cell _____

Physician Name _____	Phone _____
Address _____	
ARE YOU CURRENTLY ENROLLED IN:	DO YOU RECEIVE FUNDING THRU ANY OF THE FOLLOWING:
Physical Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No	County Family Support Program (FSP) <input type="checkbox"/> Yes <input type="checkbox"/> No
Occupational Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Community Options Program (COP) <input type="checkbox"/> Yes <input type="checkbox"/> No
Speech Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Community Integration Program (CIP) <input type="checkbox"/> Yes <input type="checkbox"/> No
Explain therapy involvement _____	Care Management Organization (CMO) <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	If yes, Case Manager (<i>only if FSR services are funded through your county</i>)
_____	Name _____
_____	Address _____
_____	Phone _____

HOW DID YOU HEAR ABOUT FREE S.P.I.R.I.T RIDERS INC. ?
 Newspaper Radio/ TV Poster Friend Volunteer Another Organization Other _____

HAVE YOU RIDDEN A HORSE BEFORE? YES NO

ARE YOU WILLING TO ATTEND EVERY CLASS? YES NO

IS THERE A PARENT, GUARDIAN, SIBLING, OR OTHER PERSON INTERESTED IN HELPING DURING RIDER'S CLASS TIME? IF SO, NAME: _____

WHAT DO YOU HOPE TO GAIN FROM THIS PROGRAM?

