Heroes Equine Learning Program

Retreat Application

Attendee Information

Last Name:	First Name/M.I.:

Street Address:	Apt./Unit#:

City:	Postal Code:

Mailing Address if Different:

Phone:	Email:

Birth Date:

Branch of Service:	Rank:	Active service/ End Date:

Type of Discharge:

Active Duty:	Retired:	Medically Retired:

Medical

Dietary Constraints:	Allergies:

Illness/Injury Date (can be estimated):

Medical Conditions:	Medications:

Amputee:	Vision/Hearing Loss:

Traumatic Brain Injury:

Post Traumatic Stress:

Burn:

Other:

Heroes Equine Learning Program

Retreat Application

Participants Name:

Other Contact Information:

Commander or Supervisor's Name (if still active):	
Phone:	Email:

Case Manager (if applicable):	
Phone:	Email:

Additional information retreat staff should know about:

Referral Process:

A referral from a physician, medical doctor, psychiatrist, or psychologist must be attached to the Retreat Application form. This referral must state the participant experiences only mild to moderate post-traumatic stress symptoms and characteristics.

Fees and Payments: Applying for (choose one):
4-Day Retreat including 4 night accommodations and 3 days of meals
Applicant Registration Fee (choose one):
Refund Policy: Refunds less $50 administrative fee per applicant up to third days prior to retreat.

Name as it appears on card: _____Visa _____ MasterCard Total fee charged on card will be reflective of registration *Fees will only be charged after application has been approved and you are notified by email	
Credit Card Number:	
Expiration Date:	Security Number:
You agree to the fees, terms, and conditions above: Card Holder's Signature:	Date:

Disclaimer and Signature:

I certify my answers are true and completed to the best of my knowledge: Signature:	Date:

Heroes Equine Learning Program

Retreat Application

Only Complete the Following Pages if Applying to Part 2 or Part 3

Participants Name:

Co-Attendee:

Last Name:	First Name/M.I.:
Street Address:	Apt./Unit#:
City:	Postal Code:
Mailing Address if Different:	
Phone:	Email:
Birth Date:	
Relationship to Applicant:	

Medical

Dietary Constraints:	Allergies:
Medical Conditions:	Medications:
Other:	

Disclaimer and Signature (signed by Co-Attendee):

I certify my answers are true and completed to the best of my knowledge:	
Signature:	Date:

Heroes Equine Learning Program

Retreat Application

Only Complete the Following Pages if Applying to Part 3

Participants Name:

Co-Attendee:

Last Name:	First Name/M.I.:
Street Address:	Apt./Unit#:
City:	Postal Code:
Mailing Address if Different:	
Phone:	Email:
Birth Date:	
Relationship to Applicant:	

Medical

Dietary Constraints:	Allergies:
Medical Conditions:	Medications:
Other:	

Disclaimer and Signature (signed by Co-Attendee):

I certify my answers are true and completed to the best of my knowledge:	
Signature:	Date:

Heroes Equine Learning Program

Retreat Application

Only Complete the Following Pages if Applying to Part 3

Participants Name:

Co-Attendee:

Last Name:	First Name/M.I.:
Street Address:	Apt./Unit#:
City:	Postal Code:
Mailing Address if Different:	
Phone:	Email:
Birth Date:	
Relationship to Applicant:	

Medical

Dietary Constraints:	Allergies:
Medical Conditions:	Medications:
Other:	

Disclaimer and Signature (signed by Co-Attendee):

I certify my answers are true and completed to the best of my knowledge:	
Signature:	Date:

Please **print** this form (including all required pages based on the Part you are applying to), sign, scan, and email to:

info@help-ptsd.com or mail to P.O. Box #72, 2343 Perkins Drive, North Gower, ON, K0A 2T0