



## PARTICIPANT APPLICATION

### **Dear Applicant:**

We are excited that you are interested in the programs at EQUI-VETS Service Program. EQUI-VETS Service Program is a program offered at EQUI-KIDS Therapeutic Riding Program, which is accredited as a premier center by the Professional Association of Therapeutic Horsemanship International (PATH Intl.) and has been providing services since 1989 to individuals with physical, cognitive, and emotional needs. Equine-assisted activities are conducted Monday – Saturday and are scheduled in five (5) sessions each year. Participants are appropriately assigned to lessons based on their skills and needs and we are unable to guarantee a specific day for participation.

### **EQUI-VETS Service Program Applicant Eligibility Guidelines**

- EQUI-VETS Service Program is based on an individual's ability to participate safely and effectively and be compliant with the PATH Intl. standards. Enrollment is offered when the necessary resources are available including: an appropriate horse, volunteers, and a class suitable to the participant's needs.
- Forms: Registration forms must be renewed annually by all participants who are actively participating in EQUI-VETS programs.

To apply please take the following steps:

- Fully complete the attached Application and Physician Release
- Mail, fax, or email the completed forms to EQUI-VETS Service Program. We will contact you to schedule an appointment for an assessment after processing your application. The assessment will take up to 1 hour. Following the assessment, you will be placed in a class if a suitable opening is available and EQUI-VETS Service Program can meet the needs of the applicant.
- Please contact our Programs Office at 757-721-7350 or email [kathy.chitwood@equikids.org](mailto:kathy.chitwood@equikids.org) if you have any questions.



PARTICIPANT APPLICATION

**General Information**

***(This section is to be completed by Applicant/Parent/Guardian)***

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Sex:  M  F  Other Preference: \_\_\_\_\_

Email Address: \_\_\_\_\_

Please answer the following questions in order to help us determine a day and time that best suits your needs:

I prefer the: \_\_\_\_\_ Morning \_\_\_\_\_ Afternoon

My preferred day of the week is:  Monday  Tuesday  Wednesday  Thursday  Friday  Saturday

Please let us know any other scheduling preferences or needs you may have: \_\_\_\_\_

How did you hear about our program? \_\_\_\_\_



## PARTICIPANT APPLICATION

### Participant Health History

Please indicate current or past special needs in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			
Fear/Aversion to animals			

**Medication** (include prescription, over-the-counter, name, dose and frequency, side effect encountered):

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**Describe your abilities/difficulties in the following areas (including assistance required or equipment needed):**

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**Physical Function** (mobility skills such as transfers, walking, wheelchair use, driving/bus riding):

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**Psycho/Social Function** (work/school including grade completed, leisure interests, relationship-family structure, support system, companion animals, fears/concerns, etc.):

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Printed Name of Participant, Volunteer, or Staff Member

Date

Signature of Participant/Volunteer/Guest/Staff (Parent / Guardian if under 18)



## PARTICIPANT APPLICATION

### **Participant Goals and Expectations**

Participant Name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

# of Years Riding/Involved in Program: \_\_\_\_\_

Age of Participant: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Email: \_\_\_\_\_

To better serve you, we would like to have your input regarding the EQUI-VETS service program. Please take a few moments and let us know what you would like to see accomplished in the upcoming year; either for yourself or for your child.

1. What specific goals would you like to obtain this year?
  
  
  
  
  
  
  
  
  
  
2. Do you feel that you are riding/involved at the proper skills level? If not, what do you feel would be more appropriate and how can we develop this?
  
  
  
  
  
  
  
  
  
  
3. What changes, if any, in your medication could affect your abilities during your sessions?

Additional comments/concerns:



## PARTICIPANT APPLICATION

### Lesson and Camp Policy and Procedures

1. The purpose of therapeutic riding lessons shall be to foster positive self-awareness by all participants, increase muscle strength and coordination, and allow for outdoor recreational opportunities for special needs individuals. A "special needs individual" shall be any person, adult or child, who may have any type of disabling condition, including but not limited to, Down syndrome, spina bifida, cerebral palsy, autism, learning disabilities, amputation, emotional and/or behavioral disorders.
2. Every attempt will be made, each session, to provide therapeutic riding lessons to new participants depending upon the availability of the class, disability of the participant and/or competence of the therapeutic riding instructor in that particular field of teaching. A waiting list has been compiled and is updated on a regular basis to incorporate new participants.
3. It is our policy that once a session begins, classes are closed and shall remain so until the next series of lessons is open for registration. To incorporate new participants at various stages during these lessons not only detracts from the progress in that particular class, it does not allow for proper interaction between the new participant and the instructor. New participant orientation will be scheduled prior to every session to introduce new participants to the facility, instructors and horses; however, should there be a scheduling conflict the participant will be introduced to the program on the first lesson.
4. The EQUI-VETS program is funded entirely by grants and donations. There is no fee to the participant.
5. EQUI-KIDS offers scholarships to a limited number of participants each year who could not otherwise afford to participate in the program. Scholarship information, including the Scholarship Policy and Application is available through the Program Director.
6. Camp fees are due and payable **PRIOR TO** camp to hold the participant's enrollment in summer camp. Camp fees are **NON-REFUNDABLE**.
7. Participants are encouraged to be ready for their lessons and arrive on time. Participants who are ten or more minutes late will not be permitted to take part in the lesson. If you are unable to attend a class, please contact our office or the instructor prior to your lesson day at the number below. Participants who accumulate three (3) unexcused absences in a lesson session will be removed from the program and fees are non-refundable. **EQUI-KIDS Office: 757-721-7350**
8. Lessons will be held rain or shine. For severe weather conditions, such as hurricanes, severe lightning, snow or tornados, participants will be contacted and make-up lessons will be scheduled. It is EQUI-KIDS policy that make-up lessons may only be scheduled due to severe weather conditions, facility disruptions, or other unforeseen events. Make-up lessons will not be provided for missed lessons.
9. Children not enrolled in the program must be accompanied by an adult at all times.
10. Any participant not participating in the riding program for two consecutive sessions will be automatically removed from the active participant roster and they must reapply to participate in future sessions.
11. Due to the nature of therapeutic riding, EQUI-KIDS rider weight limit is 200 lbs., unless otherwise determined acceptable by the Program Director. The limitation has been established to ensure the soundness and well-being of all program horses and ponies. Special considerations will be reviewed on a case-by-case basis and applicants/participants are encouraged to discuss these considerations with the Program Director.

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Printed Name of Participant, Volunteer, or Staff Member

Date

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Signature of Participant/Volunteer/Guest/Staff (Parent / Guardian if under 18)



## PARTICIPANT APPLICATION

### **Release, Waiver & Indemnity Agreement**

I, the undersigned or parent or legal guardian of the undersigned (either as a "Participant, Volunteer, or Staff"), desiring to utilize the premises known as the EQUI-KIDS Therapeutic Riding Program at 2626 Heritage Park Drive, Virginia Beach, VA 23456 known as "the Premises") and the facilities either owned or controlled by EQUI-KIDS Therapeutic Riding Program, and to participate in programs offered by EQUI-KIDS Therapeutic Riding Program (the Programs), do hereby affirm that as a Participant, Volunteer, or Staff is voluntarily entering upon the Premises to participate in the Programs, and I, as the undersigned or parent or legal guardian of the undersigned, do hereby willingly enter into this Release, Waiver and Indemnity Agreement. I recognize that, under Virginia law, an equine activity sponsor or professional is not liable for an injury to or the death of a Participant, Volunteer, or Staff in equine activities resulting exclusively from the inherent risks of equine activities. I fully understand that the activity of mounting, riding, boarding, feeding, or even being near a horse, involves numerous dangers and risks of injury to the Participant, Volunteer, or Staff and I completely release the owner of the Premises, and EQUI-KIDS and its officers, directors, volunteers, employees, or its agents from any and all liability for any and all injuries from the Participant's, Volunteer's, or Staff's engagement in the Programs offered by EQUI-KIDS Therapeutic Riding Program. I expressly agree that this Release, Waiver, and Indemnity Agreement shall be governed and construed as being sufficient to satisfy the assumption of risk and waiver requirements necessary to relieve equine activity sponsors and equine professionals from liability under the Virginia Equine Activity Liability Act, Section 3.1-796.130, *et.seq.* of the Code of Virginia (the "Act"), and the owners of the Premises, EQUI-KIDS Therapeutic Riding Program and its officers, directors, volunteers, employees, and agents are covered as equine activity sponsors and/or equine professionals by the provisions of the Act. This Release, Waiver, and Indemnity Agreement shall be governed and construed by the laws of the Commonwealth of Virginia, regardless of where any injury or loss shall occur. In the event that any portion of this Release, Waiver, and Indemnity Agreement shall be declared unenforceable, such declaration shall not affect the remaining terms of this document, which shall survive intact. I hereby give my permission to participate in the Programs offered by EQUI-KIDS Therapeutic Riding Program as a Participant, Volunteer, or Staff, and in consideration, agree individually and as applicable, on behalf of my child or ward, to the terms of the above agreement and release of liability.

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Printed Name of Participant, Volunteer, Guest, or Staff

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Date

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Signature of Participant/Volunteer/Guest/Staff (Parent / Guardian if under 18)



## PARTICIPANT APPLICATION

### **Confidentiality Policy**

Maintaining the confidentiality of our participants' medical and sensitive information is of utmost importance to the staff at EQUI-KIDS Therapeutic Riding Program. Participants and their families have a right to privacy that gives them control over the dissemination of their medical or other sensitive information. EQUI-KIDS Therapeutic Riding Program staff and volunteers will preserve this right of confidentiality for all individuals in its program. EQUI-KIDS Therapeutic Riding Program staff, volunteers, and workshop participants will keep confidential all medical, social, referral, personal, and financial information regarding a person and his/her family. All participants, their families, volunteers, employees, and guests have a right to confidentiality. Equine Facilitated Psychotherapy is a medical service and federal confidentiality regulations apply for participants in these services. Anyone who works, volunteers for, participates in, or provides services to EQUI-KIDS Therapeutic Riding Program is bound by this policy. This includes, but is not limited to, full and part time staff, independent contractors, temporary employees, volunteers, and guests. In effect, this policy applies to anyone connected to EQUI-KIDS Therapeutic Riding Program who could obtain medical/sensitive information accidentally or purposely. Confidentiality includes photographic/video imaging. I affirm that I understand this policy in its entirety and I agree to comply.

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Printed Name of Participant, Volunteer, or Staff Member

Date

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Signature of Participant/Volunteer/Guest/Staff (Parent / Guardian if under 18)

### **Media Consent**

*Please select an option below to advise us of your media consent preferences.*

**I DO CONSENT** for valuable consideration given and which is hereby acknowledged, the undersigned hereby grants to the **EQUI-KIDS THERAPEUTIC RIDING PROGRAM**, permission to take or have taken still and/or moving photographs and films, including, but not limited to, television, pictures of myself or my (son/daughter/ward) and consents and authorizes the **EQUI-KIDS THERAPEUTIC RIDING PROGRAM**, and its advertising agencies, news media and any other persons interested in the **EQUI-KIDS THERAPEUTIC RIDING PROGRAM**, and its work, to use and reproduce the photographs, films and pictures and to circulate and publicize the same by all means including without limiting the generality of the foregoing, newspapers, television media, brochures, pamphlets, instructional, clinical and/or research material and books. With respect to the foregoing matters, no inducements or promises have been made to me /us to secure our/my signature(s) to this release other than the intention of the **EQUI-KIDS THERAPEUTIC RIDING PROGRAM**, to use or cause to be used such photographs, film and pictures for the primary purpose of promoting and aiding the program and its mission.

**I DO NOT CONSENT** for reasons that I am not obligated to disclose, for photographs, either still or moving, or any television or news media, to be taken of myself, or my son/daughter/ward, by the **EQUI-KIDS THERAPEUTIC RIDING PROGRAM** or any persons working on behalf of said program. I understand that a **RED MARK** will be placed on the record kept in the administrative offices of the program, which will designate that photographs are not allowed of myself or said person.

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Printed Name of Participant, Volunteer, or Staff Member

Date

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Signature of Participant/Volunteer/Guest/Staff (Parent / Guardian if under 18)



PARTICIPANT APPLICATION  
**Medical Treatment Authorization**

Applicant: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #'s: (H): \_\_\_\_\_ (C): \_\_\_\_\_ (W): \_\_\_\_\_

**In the event of an emergency, contact:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician Phone: \_\_\_\_\_

Medical Facility: \_\_\_\_\_ Facility Phone: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

In an effort to provide the best care possible please indicate below:

I am allergic to the following medications: \_\_\_\_\_

I have the following ongoing medical conditions (diabetes, seizures, etc): \_\_\_\_\_

**CHECK ONE OF THE OPTIONS BELOW TO INDICATE CONSENT OR NON-CONSENT FOR EMERGENCY MEDICAL TREATMENT**

**CONSENT FOR EMERGENCY MEDICAL TREATMENT**

**I DO** consent for emergency medical treatment in the event emergency medical aid/treatment is required due to illness or injury while being on the premises of or in connection with EQUI-KIDS Therapeutic Riding Program. I authorize EQUI-KIDS and/or its representatives to: 1) Obtain medical treatment and/or transportation if needed and 2) Release records upon request to the authorized agency or its representative involved in the medical emergency treatment.

**NON-CONSENT FOR EMERGENCY MEDICAL TREATMENT**

**I DO NOT** give my consent for emergency medical treatment in the case of illness or injury while on the premises of or in connection with EQUI-KIDS Therapeutic Riding Program. In the event emergency medical aid/treatment is required due to illness or injury while being on the premises of or in connection with EQUI-KIDS, I wish the following procedure to take place (**LIST PROCEDURE ON LINE**): \_\_\_\_\_

***\*\*Note: EQUI-KIDS is unable to guarantee that emergency medical treatment will be withheld\*\****

\_\_\_\_\_  
Signature of Participant/Volunteer/Guest/Staff (Parent / Guardian if under 18) \_\_\_\_\_ Date \_\_\_\_\_



## PARTICIPANT APPLICATION

### **COVID Policies and Requirements**

Face-to-face services and experiences increase the risk of contracting and passing on the Covid-19/ Coronavirus/Infectious Diseases. Interactions include, but are not limited to; the receiving of services, providing services, attending an event, or volunteering within the Center. I am aware of the options that may be available for remote services including telephonic and video telehealth, as allowed by insurances and State Licensing Board recommendations, during this Pandemic outbreak or other infectious diseases outbreak.

I agree and will follow all guidelines for personal hygiene, personal safety, and public safety as recommended by the EQUI-KIDS Therapeutic Riding Program; as well as my individual provider/practitioner. This may include, but is not limited to, waiting in my vehicle and/or home until I am asked to enter the building/farm; maintaining social distance; washing my hands prior to and following each session or activity; use of hand sanitizer upon request; wiping down surfaces with disinfecting wipes and/or wearing a protective medical mask and/or gloves.

I agree to stay home and/or cancel my services should I have personally exhibited or have been in contact with someone who has presented with illness within the previous 24 hours to 2 weeks. Symptoms including; cough, sneezing, fever, chest congestion, or additional signs of the potential spread of any virus or bacterial disease. In addition, I will follow the recommendations of my provider once I have notified them of these risks in regard to my future services or attendance during this pandemic or any infectious diseases outbreak.

EQUI-KIDS Therapeutic Riding Program will engage in regular cleaning and sanitizing of the facility and frequently touched areas such as offices, doors and door handles, countertops, chairs, and tables as recommended by the CDC for the safety of clients, employees, volunteers, and horses. Equipment used for participant services such as horse tack, grooming supplies, and frequently touched areas in-between clients will be cleaned between clients as recommended by the CDC for the safety of clients, employees, volunteers, and horses.

I affirm that I understand this policy in its entirety and I agree to comply.

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Printed Name of Participant, Volunteer, or Staff Member

Date

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Signature of Participant/Volunteer/Guest/Staff (Parent / Guardian if under 18)



## PARTICIPANT APPLICATION

### **COVID-19 Assumption of Risk and Waiver of Liability**

#### **Coronavirus/COVID-19 Warning and Disclaimer**

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person during close contact. Participating in or observing activities at EQUI-KIDS Therapeutic Riding Program (the “Center”) could increase your risk of contracting COVID-19, and EQUI-KIDS cannot guarantee that you will not become infected with COVID-19.

#### **Acknowledgment of Risk**

I, the undersigned, for myself and, if applicable, as parent/guardian on behalf of the minor named below, hereby acknowledge and agree that in consideration for the undersigned participating in or observing activities at the Center: (1) the undersigned is assuming the risks related to COVID-19 inherent to gathering with others and using common facilities and hereby waives the undersigned’s rights to claim liability of EQUI-KIDS or others resulting from the assumption of such risks; and (2) EQUI-KIDS is not responsible for sickness or for loss of any kind as a result of COVID-19. I further understand that certain activities at the Center will require additional safety precautions and equipment due to COVID-19, and that, due to physical safety concerns and sudden emergent conditions, certain activities may not permit social distancing of six feet per person at all times.

EQUI-KIDS has taken certain steps to implement recommended guidance and protocols issued by the Centers for Disease Control and Prevention and the Virginia Department of Health for slowing the transmission of COVID-19. The undersigned acknowledges receipt of EQUI-KIDS’ current policies and requirements for participation in or observation of activities at the Center in response to such guidance and protocols (“EQUI-KIDS’ COVID-19 policies and requirements”). The undersigned acknowledges and agrees that EQUI-KIDS may revise its policies and requirements at any time based on updated recommended guidance and protocols issued by the public health agencies. **The undersigned agrees to comply at all times with EQUI-KIDS’ COVID-19 policies and requirements.**

By signing this agreement, **I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 while at the Center and that such exposure or infection may result in personal injury, illness, permanent disability, and/or death.** I understand that the risk of becoming exposed or infected by COVID-19 at the Center may result from the actions, omissions, or negligence of myself or of others, including EQUI-KIDS. I hereby forever release, waive, discharge, and hold harmless, and agree not to sue or assert any claim against, EQUI-KIDS (including its directors, staff, employees, volunteers, and agents) for any loss or damages arising from such exposure or infection. I understand that by signing this document, all liability of EQUI-KIDS (including its directors, staff, employees, volunteers, and agents) to myself for any such loss or damages will be forever extinguished.

I, the undersigned, have read, understand and accept the terms of this Assumption of Risk and Waiver of Liability form. I further acknowledge that no oral representations have been made to me as an inducement to sign this form.

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Printed Name of Participant, Volunteer, Guest, or Staff

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Date

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Signature of Participant/Volunteer/Guest/Staff (Parent / Guardian if under 18)



## PARTICIPANT APPLICATION

Dear Healthcare Provider:

Your patient, \_\_\_\_\_, is interested in participating in supervised equine activities. In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

### **ORTHOPEDIC**

Atlantoaxial Instability - include neurologic symptoms  
Coxarthrosis  
Cranial Defects  
Heterotopic Ossification Myositis Ossificans  
Joint Subluxation/Dislocation  
Osteoporosis  
Pathologic Fractures  
Spinal Joint Fusion/Fixation  
Spinal Joint Instability/Abnormalities

### **NEUROLOGIC**

Hydrocephalus/shunt  
Seizure  
Spina bifida/Chiari II Malformation/Tethered Cord  
Hydromyelia

### **OTHER**

Age – Under 4 Years  
Indwelling Catheters/Medical Equipment  
Medication – i.e. Photosensitivity  
Poor Endurance  
Skin Breakdown

### **MEDICAL/PSYCHOLOGICAL**

Allergies  
Animal Abuse  
Cardiac Condition  
Physical/Sexual/Emotional Abuse  
Blood Pressure Control  
Dangerous to Self or Others  
Exacerbations of Medical Conditions (i.e. RA, MS)  
Fire Settings  
Hemophilia  
Medical Instability  
Migraines  
PVD  
Respiratory Compromise  
Recent Surgeries  
Substance Abuse  
Thought Control Disorders  
Weight Control Disorders

Thank you very much for your assistance. Should you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact the center at the address/phone indicated below.

Sincerely,

Kathy Chitwood, RN,BC

Program Director

EQUI-KIDS Therapeutic Riding Program

2626 Heritage Park Drive

Virginia Beach, VA 23456

Email: [kathy.chitwood@equikids.org](mailto:kathy.chitwood@equikids.org)

Phone: 757-721-7350

Fax: 757-721-7354



PARTICIPANT APPLICATION

**Participant's Medical History and Physician's Statement**

Participant Name \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Past/Prospective Surgeries: \_\_\_\_\_

**PLEASE LIST ALL CURRENT MEDICATIONS (Additional medications can be listed on separate paper)**

\_\_\_\_\_ Taken For \_\_\_\_\_

\_\_\_\_\_ Taken For \_\_\_\_\_

\_\_\_\_\_ Taken For \_\_\_\_\_

Does the participant have seizures?  Y  N Are seizures controlled?  Y  N

Date of last seizure: \_\_\_\_\_ Seizure type: \_\_\_\_\_

Shunt Present:  Y  N Date of last revision: \_\_\_\_\_

Special Precautions/Needs: \_\_\_\_\_

Ambulatory:  Y  N Uses:  Crutches  Braces  Cane  Walker  Wheelchair

Other assistive devices: \_\_\_\_\_

Neurologic Symptoms of Atlantoaxial Instability:  Absent  Present

***Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.***

			Comments
Auditory:	Y	N	_____
Visual:	Y	N	_____
Tactile Sensation:	Y	N	_____
Speech:	Y	N	_____



## PARTICIPANT APPLICATION

			Comments
Cardiac:	Y	N	_____
Circulatory:	Y	N	_____
Integumentary/Skin:	Y	N	_____
Immunity:	Y	N	_____
Pulmonary:	Y	N	_____
Neurologic:	Y	N	_____
Muscular:	Y	N	_____
Balance:	Y	N	_____
Orthopedic:	Y	N	_____
Allergies:	Y	N	_____
Learning Disability:	Y	N	_____
Cognitive:	Y	N	_____
Pain:	Y	N	_____
Emotional/Psychological:	Y	N	_____
Other:	_____		

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities and/or therapies. I understand that EQUI-KIDS Therapeutic Riding Program will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to EQUI-KIDS for ongoing evaluation to determine eligibility for participation.

Name/Title: \_\_\_\_\_

MD  DO  NP  PA  Other \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone:(\_\_\_\_) \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_