USHJA DIRECTORY OF CLINICS INFORMATION FORM

DATE OF CLINIC: _____ ☐ **Riding Clinic** ☐ **Non-Riding Clinic**

CLINIC ORGANIZER

Name: _____ USHJA #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Zone: _____ Email: _____

**Phone number, email, and website will be listed on the USHJA DOC.*

Website URL containing clinic information: _____

HOST FACILITY

Name: _____ Owner: _____

Address: _____

City: _____ State: _____ Zip: _____

CLINICIAN

Name: _____ USHJA #: _____

City: _____ State: _____

Phone: _____ Email: _____

Visit the USHJA Credential Directory for clinicians who are USHJA Credentialed Instructors or TCP Certified Trainers.

ADDITIONAL INFORMATION ABOUT YOUR CLINIC

Please include all information you would like to have published on the USHJA DOC website regarding your clinic (i.e. height sections that will be offered, fees assessed, auditor details, etc.).

INSURANCE

☐ I carry liability insurance.

☐ I acknowledge that the clinic will not be included in the USHJA Directory of Clinics unless USHJA receives this application and service fee (if applicable) a minimum of 30 days before the clinic.

ACKNOWLEDGMENTS

☐ I acknowledge that I may not advertise my clinic as part of the USHJA Directory of Clinics until I have submitted the documentation listed below to USHJA and received permission to do so from USHJA

To be included in the USHJA Directory of Clinics, this form must be submitted to the Education Department a minimum of 30 days before your clinic.

Clinic Organizer Signature: _____ Date: _____

PAYMENT

Directory Listing Service Fee:

☐ $50 – Riding clinic with a host or clinician who ***is not*** an Olympian, Credentialed Instructor, or TCP Certified Trainer. Visit the USHJA Credential Directory for eligible clinicians

☐ No Fee – Riding clinic with a host or clinician who ***is*** an Olympian, Credentialed Instructor or TCP Certified

☐ No Fee – Non-riding educational clinic

☐ No Fee – Clinic hosted by a current USHJA Affiliate Association or Recognized Riding Academy

Date of Clinic: _____ **Clinician:** _____

Clinic Organizer: _____ **USHJA #:** _____

☐ Visa ☐ MasterCard ☐ American Express ☐ Check # _____

Card Number: _____ Exp Date: _____

Name as it appears on Card: _____

Signature: _____ Billing Zip Code: _____

Please be advised: *The typing of your name above shall be considered to be an electronic signature and shall be considered to have the same legal effect and validity as your handwritten signature. Therefore, in so typing your name in the fields above, you are confirming this verification statement and the truth of the contents of the document.*

Submit applications containing credit card payment via fax or mail. Do not email credit card information as it is not a secure method for transmitting sensitive data. *The USHJA Directory of Clinics fee is non-refundable.*

Mail: 3870 Cigar Lane, Lexington, KY 40511
Fax: 859.258.9033
Email: **education@ushja.org**

Thank you for your support of USHJA programs!