

**Western Chapter NYS Horse Council  
Therapeutic Riding Scholarship Application**

Name of Applicant: \_\_\_\_\_

Age \_\_\_\_\_

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

Therapeutic riding organization to which you are applying \*: \_\_\_\_\_

Address \_\_\_\_\_

Town \_\_\_\_\_ State NY ZIP \_\_\_\_\_ Phone # \_\_\_\_\_

Describe the need for financial assistance:

Amount requested \_\_\_\_\_ Length of one session \_\_\_\_\_ weeks

Has this candidate had any other therapeutic riding experiences? Y N

If so, where? \_\_\_\_\_

**Required Signatures**

1. Signature/ legal guardian if participant is under18 \_\_\_\_\_

Please print name \_\_\_\_\_

2. Therapeutic organization representative \_\_\_\_\_

Please print name \_\_\_\_\_

3. Signature of physician granting permission \_\_\_\_\_

Please print name \_\_\_\_\_

Office Phone # \_\_\_\_\_

Mail completed application to:

**Western Chapter, NYS Horse Council  
P.O. Box 796  
Orchard Park, NY 14127**

**\* THERAPEUTIC RIDING CENTER MUST BE MEMBER OF WESTERN CHAPTER TO BE ELIGIBLE**  
*For any further questions or concerns, please contact Susan at 716-941-9120.*