

**Cedar Ridge Farm
Clinic Participation Form**

CLINIC: _____ **Dates:** _____

PARTICIPANT INFORMATION:

Name: _____

Address: _____

Phone: _____ **Email:** _____

RIDER EXPERIENCE:

Years of riding: _____ **Competition:** _____

Current level: _____ **Beginner** _____ **Adv.Beginner** _____ **Intermediate**
_____ **Intermediate/Adv.** _____ **Advanced**

Professional _____ **Amateur** _____

HORSE EXPERIENCE:

Horse name: _____ **Age:** _____ **Breed:** _____

Experience: _____

STABLING REQUIRED? _____ **YES** _____ **NO** _____ **# NIGHTS**

CLINIC FEE: _____ **STABLING FEE:** _____ **TOTAL:** _____

All fees must be paid in advance and are non-refundable except for cancellation by organizer or clinician. Please mail completed form and payment to:

**Cedar Ridge Farm
7804 Jefferson River Road, Athens, GA 30607**

Sessions/schedule/details will be posted on website:
www.cedar-ridge-farm.com