



Winter Therapeutic Horticulture Program Request Form

- Completion of this form does not guarantee a program. We will contact you to confirm your request.
- Please ensure that at least one of your staff members will be present at all times during the program.
- You will provide a quiet space that's big enough for the group and has tables, chairs and access to water.
- **Refer to our [website](#) for price information.**
- Cancellations, made by the Gardens or by facilities, greater than one business week prior to the program will receive a full refund.
- Cancellations with less than one business week notice (weather cancellations excepted) are not refundable. If cancellation is made by the Gardens, we'll seek to re-schedule your program.
- **Think green—if possible, please fill out and save this form, and email back to us as an attachment instead of printing and faxing a hard copy.**

Step 1: Facility Information

Facility Name: _____

Facility Address: _____

City: _____ State: _____ Zip: _____

Contact Person and Position _____

Facility Phone: _____ Contact Person Phone: _____

Facility/Contact Person Email: _____

Is your facility a profit or non-profit organization? Profit Non-profit

Step 2: Population Information

This information will help us determine which activities are best suited for your participants.

1. Describe the people who will be attending the program.

2. Do the participants function on similar levels?

3. Are there any safety concerns we should be aware of?

Step 3: Program Information

1. What program are you choosing?

- Winter Green Cool Season Gardening (available in Feb. and Mar.)

If you are choosing Winter Green, fill out questions 2 and 3:

2. Visit day and time – Rank your 1st and 2nd choice. We will do our best to match your requests. Programs may be scheduled between 10 a.m. - 3 p.m. from Nov. 1, 2011 to Mar. 29, 2012 on Tuesday, Wednesday and Thursday.

1. _____ 2. _____

3. What activity will best serve your clients? Rank your 1st and 2nd choice

- _____ Dried Flower Arranging _____ Plant Propagation _____ Terrariums
_____ Making a Topiary _____ Pretty Pots

If you are choosing Cool Season Gardening, fill out questions 4 and 5:

4. Number of sessions: Three Six

5. Visit days and times – Provide your preferred dates and times. We will do our best to match your requests.

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

6. How many people will be participating in the program? _____ (Maximum 12 per session)

7. Where will the program take place at your facility?

8. What are the goals that you hope the program will help you achieve?

Step 4: Other Information

1. Are we allowed to take photos of residents during the program? Yes No

(These photos may be used and/or published in any and all media, advertising, or any other purpose whatsoever deemed appropriate by Denver Botanic Gardens.)

2. How did you hear about our Therapeutic Horticulture program?

Signature of Contact Person* _____ **Date:** _____

(*By typing your name on this line, it denotes an authorized signature.)

PLEASE RETURN this document to the Adult Program Coordinator.

Denver Botanic Gardens • 909 York St. • Denver, CO 80206

Phone: 720-865-3539 • Fax: 720-865-3685 • tours@botanicgardens.org

THANK YOU FOR PARTICIPATING!

For Office Use Only
Date Received: _____ Date Facility Contacted: _____
Confirmed Program Date and Time: _____