Therapeutic Horticulture Program Request Form

- Completion of this form does not guarantee a program. We will contact you to confirm your request.
- Refer to our website for price information.
- Group must be accompanied by at least one staff member that remains present at all times during the program.
- 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 work with you to re-schedule your program.

Step 1: Facility Information

Facility Name: ____

Facility Address: ____

City: ______________________________ **State:** ________ **Zip:**______________

Contact Person and Position: ______________________________________

Facility Phone:_________________________**Contact Phone (day of):** ______________

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?

☐ Sensory Garden Tour* (York Street)   ☐ Summer Sensory Program** (York Street)

*Does not include admission for the group.
**Does include admission for the group.

2. Visit day and time – Please rank your 1st and 2nd choice. We will do our best to match your request.

1. Day:________________________________Time: ____________________

2. Day:________________________________Time: ____________________

3. What activity will best serve your clients? – Rank your 1st and 2nd choice (for Summer Sensory)

_____ Flower Arranging   _____Topiary

_____ Sensory Container

4. How many people will be participating in the program?_______ *(Maximum 12 per session)*

5. 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 the Therapeutic Horticulture program?

Signature of Contact: ______________________________________ Date: ____________
(By typing your name on this line, it denotes an authorized signature.)

PLEASE RETURN this form to the Adult Program Coordinator.
Denver Botanic Gardens • 909 York St. • Denver, CO 80206
Phone: 720-865-3613 • Fax: 720-865-3685 • thprograms@botanicgardens.org

THANK YOU FOR PARTICIPATING!

For Office Use Only

Date Received:_________________________Date Facility Contacted: ____________________

Confirmed Program Date and Time: ____