



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.
- At least one staff member must remain present at all times during the program.
- Cancellations made 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.

Section 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? Yes No

Section 2: Population Information

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

1. Briefly describe the population 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?

Section 3: Program Information

1. 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: _____

2. What activity will best serve your clients?

Please rank your 1st and 2nd choice.

_____ Hardy Houseplants _____ Terrariums

_____ Seed Art

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

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

Section 4: Additional Information

1. Are photos authorized to be taken of participants 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 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 YOUR PARTICIPATION!

<p>For Office Use Only</p> <p>Date Received: _____ Date Facility Contacted: _____</p> <p>Confirmed Program Date and Time: _____</p>
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