



Therapeutic Horticulture Program Request Form

- Completion of this form does not guarantee a program. We will contact you to confirm your request.
- 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.
- Availability: Mid-May through the end of September
- Time: One-hour program, offered weekdays between 9 a.m. - 3 p.m.
- Cost: \$90 for-profits, \$75 nonprofits (includes admission to the Gardens for a group of 12 participants plus staff, program costs and all materials).
- Tour only: \$30 for a 30-minute tour for 12 participants.

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.

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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: _____