

RAY AINSWORTH



NAME: _____

ADDRESS: _____

CITY/TOWN: _____

STATE: _____ ZIP: _____

PHONE: _____

E-MAIL: _____

Please accept my deposit for the following clinic sessions:

CLINIC	FEE	#HORSES	CLASS FEES
COLT STARTING			
4 DAYS	\$650.00	_____	= \$ _____
3 DAYS	\$550.00	_____	= \$ _____
FOUNDATION HORSEMANSHIP			
4 DAYS	\$650.00	_____	= \$ _____
3 DAYS	\$550.00	_____	= \$ _____
HORSEMANSHIP 1			
4 DAYS	\$650.00	_____	= \$ _____
3 DAYS	\$550.00	_____	= \$ _____
HORSEMANSHIP 2			
4 DAYS	\$650.00	_____	= \$ _____
3 DAYS	\$550.00	_____	= \$ _____
SPECIAL PROBLEMS			
4 DAYS	\$650.00	_____	= \$ _____
3 DAYS	\$550.00	_____	= \$ _____
SPECTATOR	\$ 25.00/DAY	_____	= \$ _____
SUB TOTAL			= \$ _____
DEPOSIT			- \$ _____
TOTAL DUE			= \$ _____

Paid in full

RAY AINSWORTH



I, the undersigned hereby release Ray Ainsworth Horsemanship / Ray Ainsworth Clinics, sponsor(s), their agents, employees, contractors or assistants, from all claims, demands, action or cause of action of any kind or nature whatsoever, whether now known or ascertained, or which may hereafter develop or accrue me in favor of myself, representatives, or dependents, on account of or by animate or inanimate, belonging to me or used by me because of any matter, thing, or condition, negligence or default whatsoever, I hereby assume and accept the full risk of danger or any hurt, injury or damage which may occur through or by any reason or any matter, thing or condition, by any person whatsoever.

Horse Owner or Agent _____

Student/Spectator _____

Guardian for Minor _____

Print Name _____

Date _____