

**FIX-A-TEST
CLINIC REGISTRATION
HORSE PARK OF NEW JERSEY**

Event _____ Date _____

Name _____ Age if Minor _____

Address _____

City _____ State _____ Zip Code _____

Phone Number Home _____ Cell _____

Emergency Contact _____ Phone Number _____

Email Address _____

Horses Name _____ Age _____

Preferred Judge _____ Test To Be Ridden _____

Time Preferred 8-8:30 _____ 8:40-9:10 _____ 9:20-9:50 _____
10-10:30 _____ 10:40-11:10 _____ 11:20-11:50 _____

Clinic Fee _____

Haul in fee _____ Stall fee _____ Amount Enclosed _____

Checks Payable to: Horse Park of New Jersey

Credit Cards Accepted—VISA _____ Master Card _____ AM EX _____

Name on Credit Card _____

Card # _____ SEC. Code _____ EXP. Date _____

Mail to: Horse Park of New Jersey
PO Box 419
Cream Ridge, NJ 08514