HORSES helping HEROES

Stable Hands
HEARTS, HANDS AND HORSES - BUILDING DREAMS, CHANGING LIVES

PREMIER ACCREDITED CENTER
PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

# VOLUNTEER APPLICATION

Name_____ _____ Date_____
Last First

Address_____
Street City State Zip

Home Phone_____Cell_____Work_____Email_____

**Volunteer Jobs** My interests are:

| | | | | | |
|---|---|---|---|---|---|
| | Horse Leader | | Tack Maintenance | | Arts and Crafts |
| | Side Walker | | Photo/ Video Taping | | Summer Program |
| | Barn/Stall Duties | | Mailings | | Gala/Silent Auction |
| | Facility Set-up and Clean-up | | Office/ Phones | | Newsletter |

There are certain criteria and skills required for some of these positions, which may require further training.

Military History: (Branch of Service, when did you serve, what was your military occupational specialty)

_____

**SKILLS and INTERESTS**:

1. Previous volunteer experience:_____
2. Hobbies and interests:_____
3. Educational background:_____
4. Current occupation:_____
5. Equine background:_____Years_____
6. Experience:____Horse Care_____Sign Language_____Spanish Speaking_____Computer Skills
Other:_____
7. Do you have experience working with a particular disability?_____
8. Do you have a CPR certificate? ( ) Yes ( ) No, Are you an EMT/Paramedic? ( ) Yes ( ) No, Do you have a current First Aid card? ( ) Yes ( ) No

**Availability:** We are requesting that you consider volunteering as a minimum for a morning (typically 2 classes), afternoon (typically 2 classes), or all day (4 classes) if you are willing. * **Wednesday is for military** Veterans.

| Time | Tuesday | Wednesday* | Thursday |
|---|---|---|---|
| Mornings | | | |
| Afternoons | | | |

I can also be available to substitute as needed ( ) yes ( ) no

**Background Verification**

_____ Initials

I agree to submit to a background screening which will include a fingerprint scan.

I authorize Stable Hands to receive information from any law enforcement agency, including but not limited to, police and sheriff departments, of this state or any other state or federal government, to the extent permitted by state and federal law, pertaining to any convictions I may have had for violations of state or federal criminal laws, including but not limited to convictions for crimes committed upon children or animals.

I understand that such access is for the purpose of considering my application as a volunteer/staff, and that I expressly DO NOT authorize Stable Hands, it's directors, officers, employees, other volunteers to disseminate this information in any way to any other individual, group, agency or corporation.

I understand that the information provided above is correct to the best of my knowledge. I know of no reason why I should not participate in the Stable Hands program.

| | | | | |
|---|---|---|---|---|
| **Current Driver's License** | **Y** | **N** | **License Number**: | **State:** |
| **or Current State ID card** | **Y** | **N** | **ID number**: | **State:** |

**Photo Release**

_____ Consent

_____ Non-consent

I hereby consent to and authorize the use and reproduction by **Stable Hands** of any and all photographs and any other audio/visual material taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program (to include, but not limited to brochure, **Website**, video on our Website via hosted through YouTube, DVD or presentations).

**Confidentiality**

_____ Initials

I HAVE READ THE FOLLOWING STATEMENT OF CONFIDENTIALITY AND DISCUSSED ANY QUESTIONS I HAVE WITH THE STABLE HANDS STAFF. I UNDERSTAND AND AGREE TO ABIDE BY THE FOLLOWING STATEMENT OF CONFIDENTIALITY.

Stable Hands requires that all written, verbal and observed information concerning all clients be kept completely confidential. This includes information about clients, their disabilities, their families and interactions with others. The purpose of this policy is not only legal, but also to respect the lives of our clients and their rights to be treated with utmost courtesy, dignity and equality. As a Program Volunteer, you will most likely see and hear things which you need to agree to keep within this setting. The Therapeutic Riding Instructors and Therapists will share information with you which will help you work with particular clients ***with the understanding that this information stays within the Stable Hands Program***.

**Release, Hold Harmless and Assumption of the Risk Agreement**

_____ Initials

I would like to participate in the Stable Hands equine assisted activity and therapy program (the "Program"). In exchange for the privilege of participating in the Program, I agree that neither I nor my family, nor any legal guardian, heir or assignee, will sue or make a claim against Stable Hands or attach the property of Stable Hands for death, injury or damage resulting from any act or omission, whether the injury or the damage occurs by act of negligence or any other act by human, by physical condition of the property or by animal. I understand that I am releasing and holding Stable Hands harmless from any and all claims, demands or actions that I, my family, my heirs or any legal guardian, assignee or legal representative may have now or may have in the future for any death, injury or damage resulting from my participation in the Program or any other activities at Stable Hands. **I am fully aware that I am assuming any and all risks associated with the Program and any other activities at Stable Hands.** I am fully aware that there are many risks and dangers involved in participation in the Program and other activities at Stable Hands, and I agree to accept the consequences of such risks, including, but not limited to, the risk of injury, death, and damage to personal property. If I do not fully understand the risks, I will consult with a staff member immediately.

**Definition of Volunteering for Stable Hands**

_____ Initials

I understand that I am providing voluntary service to Stable Hands of my own accord. I understand that I am not an employee of Stable Hands, and I have no expectation of compensation, either monetary or otherwise, from the Organization. I am volunteering for the Organization because I support its work and its goals. I am not helping the Organization because I expect to get paid.

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I,_____, have read and understand the contents of this document. The information provided by me is complete, true and accurate to the best of my knowledge.

Signature_____Date_____

IF MINOR, Signature of Parent/Guardian_____

Good Faith Agreement: Consistency and commitment to our special needs riders is an important aspect of Stable Hands volunteer service. By accepting a position as a side walker and/or horse leader for a least one ten week session, I agree to honor this commitment for the entire session.

Signature_____Date_____

IF MINOR, Signature of Parent/Guardian_____

**Left Blank Intentionally**

# MEDICAL HISTORY & EMERGENCY TREATMENT RELEASE INFORMATION

**Name:** _____ _____ **Date of Birth:** _____
Last First

**Height:**_____**Weight:** _____

**MEDICAL INFORMATION**

Physician: _____

Address :_____Hospital:_____

Medical Insurance Company:_____

Address:_____

Policy Number:_____group # _____

Company or Agent Phone: _____

**Medical History**

Allergies**:**_____

_____

Current Medications:_____

_____

Please describe your current health status, particularly regarding the physical/emotional demands of working in an equine-assisted program. Address fitness, cardiac, respiratory, bone or joint function, recent hospitalizations and/or surgeries, or lifestyle changes_____

_____

_____

_____

_____

_____

_____

**IN CASE OF EMERGENCY:**

Notify:_____ Phone:_____
Address:_____ Relationship:_____
Or,
Notify:_____ Phone:_____
Address:_____ Relationship:_____
Or,
Notify:_____ Phone:_____
Address:_____ Relationship: _____

## Consent Plan

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Stable Hands to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

This authorization includes radiography, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the emergency contact person(s) above is unable to be reached.

Consent signature:_____ Date:_____
Parent/Legal Guardian:_____

## Non-Consent Plan

I DO NOT give my consent for emergency medical treatment/aid in the case of illness of injury during the process of receiving services or while being on the property of the agency.

- ***Parent/legal guardian or caregiver will remain at activity site at all times during equine assisted activities.***

In the event emergency treatment/aid is required, I wish the following procedures to take place:_____

_____

_____

Non-Consent signature:_____ Date:_____
Parent/Legal Guardian:_____