

# Volunteer Application 2017

## General Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian (if under 18): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ T-Shirt Size: XS S M L XL 2XL

Address: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Email: \_\_\_\_\_ School/Employer: \_\_\_\_\_

\*\*All volunteer correspondence is sent via email.

Would you prefer we contact you in some other way?

- Yes, contact me via \_\_\_\_\_.
- No thank you, email works fine for me!

The following information is used to complete required background checks:

Gender: \_\_\_ Male \_\_\_ Female

Ethnicity:

- |  |                     |
|--|---------------------|
| ___ American Indian/Alaska Native          | ___ Asian           |
| ___ Black/African American                 | ___ Hispanic/Latino |
| ___ Native Hawaiian/Other Pacific Islander | ___ White ___ Other |

## Experience

If you are coming to the Cheff Center to participate in a particular program, please note that here (service learning student, nursing student, OT side walker, etc.):

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Do you have previous experience with horses? Yes No

If so, please explain: \_\_\_\_\_

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Do you have previous experience with individuals with special needs? Yes No

If so, please explain: \_\_\_\_\_

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## Interests

Check any areas below that you may be interested in:

- Horse Leader
- Side-walking with a Client
- Hippotherapy (requires special training)
- Barn/Horse/Tack Care
- Grounds Maintenance
- Summer Camp (day camp in July)
- Special Events/Fundraisers
- Committee Member for Events
- Administrative Work

Do you have any special skills? \_\_\_\_\_

\_\_\_\_\_

## Availability

What days and times are you available? Please indicate in the chart below.

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Weekend
Example:	4-8 pm	None	4-8 pm	8-11 am	None	Any
Availability						

Are you interested in being on call?    Yes    No

If so, what days or times? \_\_\_\_\_

## Photo Release

I ( DO , DO NOT ) consent to and authorize the use and reproduction of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibits, social media, or for any other use for benefit of the program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Volunteer or Parent/Guardian (if under 18)

## Background Information

Have you ever been charged with or convicted of a crime? Yes No

If so, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I, \_\_\_\_\_ (volunteer), authorize the Cheff Therapeutic Riding Center to receive information from any law enforcement agency, including police departments and sheriff's 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.

I understand that such access is for the purpose of considering my application as an employee/volunteer, and that I expressly DO NOT authorize the Cheff Therapeutic Riding Center, its directors, officers, employees, or other volunteers to disseminate this information in any way to any other individual, group, agency, organization, or corporation.

Current Driver's License: Yes No License #: \_\_\_\_\_ State: \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Volunteer or Parent/Guardian (if under 18)**

## Emergency Treatment Release

Physician's Name: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_  
Physician's Address: \_\_\_\_\_ Preferred Medical Facility: \_\_\_\_\_  
Health Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

In the event of a medical emergency, please provide emergency contact information:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Any **medications** we should be aware of? \_\_\_\_\_

Any medical-related **allergies**? \_\_\_\_\_

Please choose one of the following options:

- I GIVE MY CONSENT, in the event of a medical emergency, for the Cheff Therapeutic Riding Center to provide such medical assistance as deemed to be necessary. I authorize any licensed physician and/or medical facility to provide medical surgical care and/or hospitalization for the above-named volunteer, including anesthetic, which they determine to be necessary or advisable, pending receipt of a specific consent from the undersigned.

**OR**

- I DO NOT GIVE MY CONSENT for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place: \_\_\_\_\_.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Volunteer or Parent/Guardian (if under 18)**

**Confidentiality Agreement**

As a volunteer at the Cheff Therapeutic Riding Center, I acknowledge that I will have access to and there will be made available to me certain knowledge belonging to the Cheff Center which is confidential information. Such confidential information may include, but not be limited to, student symptoms and/or diagnoses. I will hold in trust and confidence such information and will not disclose or use such information for any purpose other than to participate in my volunteering experience. I will not use the confidential information for my personal use or for the use of any other party.

The undersigned understands and agrees that the Cheff Center may apply for and have granted an injunction restraining any breach or threatened breach of any of the covenants contained herein.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Volunteer or Parent/Guardian (if under 18)**