Volunteer Application

First Name_______________________________Last Name__________________________________

Address_________________________________City, State, Zip_______________________________

H.Phone___________________C.Phone____________________W.Phone____________________

Best way to contact_________________Date of Birth________________Gender: Male or Female

Email address___________________________ Are you current volunteer or new volunteer?

Parents/Caregiver Name_________________________C.Phone__________W.Phone__________

School Group/Association Name____

Person in Charge of School Group or Association____

Number of people in charge of group?________________________

Area interest in volunteering: * Side Walking *Horse Leading *Grooming/Tacking

*Grounds Maintenance *Volunteer Coordinating *Office Work *Farm Chores

*Work with junior volunteers *Group Programs *Fundraisers *Secretary/Receptionist

*Grant Writing *Planning/Organizing *Photography *Artwork *News letter team

*Day Camp *Maintenance *Cleaning *Other______________________________________

Why do you want to volunteer?

Availability

What Days of the week are you available?

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Time In:	_______	_______	_______	_______	_______	_______	_______
Time Out:	_______	_______	_______	_______	_______	_______	_______

Explain:____

Are you comfortable around horses? Yes / No   Have you or do you own horses? Yes / No

Do you have horse experience? Yes / No explain____

____

____

Are you comfortable around farm animals? Yes / No explain ______________________________

____

____

Do you have farm experience? Yes / No explain

____

____

____

Are you comfortable around those with special needs? Yes / No / Somewhat / Not Sure

Do you have experience working with people who have special needs? Yes / No explain

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____

Explain your skills or talents you believe Horse Feather TLC would benefit from.

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EMERGENCY INFORMATION

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 Horse Feathers Therapeutic Learning Corp. Center to 1. Secure and retain medical treatment and transport if needed 2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment

Emergency Contact #1____

Relation_________________________________H.Phone_____________________

C.Phone_____________________________W.Phone_________________________

Emergency Contact#2____

Relation_________________________________H.Phone_____________________

C.Phone______________________________W.Phone________________________

Physicians Name _____________________________Phone _____-______-___________

Preferred Medical Facility ____

Health Insurance Company_________________________ Policy #_______________

Allergies to medication? ____

Current medications? ____

Consent Plan

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

Signature__________________________________Print________________________

Non Consent Plan

I DO NOT give my consent for emergency medical treatment or first aid in the event of illness or injury during the process of receiving services or while being on the property of the Horse Feathers Therapeutic Learning Center Corp.

Signature__________________________________Print________________________

PHOTO AND MEDIA RELEASE

I consent to the authorize the use and reproduction by Horse Feathers Therapeutic Learning Center Corp. of any and all photography and any other audio-visual materials taken of me for promotional material, education activities, website or for any other use for the benefit of the program.

Signature_______________________________________Print_____________________________

VOLUNTEER LIABILITY RELEASE

As a volunteer at Horse Feather Therapeutic Learning Center Corp. I acknowledge the risks and potential for risks of a horseback riding program. However, I feel that the possible benefits to myself and the clients I work with are greater than the risk assumed. I hereby, intending to be legally bound, for myself and my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Horse Feathers Therapeutic Learning Center Corp. its board of directors, instructors, therapists, volunteers, riders, and/or employees for any and all injuries and/or losses I may sustain while participating at Horse Feathers Therapeutic Learning Center Corp.

Signature_______________________________________Print______________________________

BACKGROUND CHECK

I hereby authorize Horse Feathers Therapeutic Learning Center Corp. to conduct a limited criminal history check on me through any law enforcement agency. I understand this information will be kept in strict confidence. I understand that I may request a copy of this report and that this information is strictly for the purpose of considering my application as a volunteer.

Signature______________________________________ Print _______________________________

CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT

I understand that all information (written and verbal) about participants and Horse Feathers Therapeutic Learning Corp. is confidential and WILL NOT BE SHARED WITH ANYONE without the expression written consent of the participant and their parent/guardian in the case of a minor. This includes all medical, social, referral, personal, financial, and otherwise sensitive information. I understand that individuals who breach confidentiality will be removed from the Horse Feathers Therapeutic Learning Center Corp. Program.

Signature______________________________________Print ___________________________________