



## VOLUNTEER APPLICATION

### Contact Information

Date: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Employer/School: \_\_\_\_\_  
 Work Address: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Phone: (h) \_\_\_\_\_ (c) \_\_\_\_\_  
 E-mail address: \_\_\_\_\_  
 Parent/Guardian Name, Address, and Phone: \_\_\_\_\_  
 \_\_\_\_\_

### Background Information

Please list the name, address, and telephone number of someone other than a family member who we may contact for a reference: \_\_\_\_\_  
 \_\_\_\_\_

Have you ever been convicted of a crime? If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_

### Health History

Please describe your current health status, specifically regarding the physical and emotional demands of working in a therapeutic riding program. Address fitness, cardiac, respiratory, bone or joint functions, recent hospitalizations or surgeries, and mental and emotional stability.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Allergies: \_\_\_\_\_  
 \_\_\_\_\_

Medications: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



## Liability Release

I would like to participate as a volunteer at Winslow Therapeutic Center. I acknowledge the risks of working with horses, and horseback riding. However, I feel that the possible benefits to myself are greater than the risks assumed. I hereby (for myself, my heirs and assigns, executors, or administrators) waive and release forever all claims for damages against Winslow Therapeutic Riding Unlimited, Inc., Winslow Therapeutic Center, its Board of Directors, Instructors, Therapists, Aides, Volunteers, and/or employees, for any and all injuries and losses I may sustain while participating in Winslow programs or events.

Volunteer Name (Print): \_\_\_\_\_ Date: \_\_\_\_\_

Volunteer Signature: \_\_\_\_\_

Parent/Guardian Name (if volunteer is under 18): \_\_\_\_\_

Parent/Guardian Signature (if volunteer is under 18): \_\_\_\_\_

Relationship to Volunteer: \_\_\_\_\_

## Photo Release (optional)

I hereby consent to and authorize the use and reproduction by Winslow of any and all photographs and any other audiovisual materials taken of me for promotional printed material, educational activities, exhibitions or for any other use for the benefit of the program.

Volunteer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name (if volunteer is under 18): \_\_\_\_\_

Parent/Guardian Signature (if volunteer is under 18): \_\_\_\_\_

## Confidentiality Agreement

I agree to respect and observe privacy and confidentiality of the participants of Winslow Therapeutic Riding Center and not to discuss or disclose any sensitive information about any person or their family.

Volunteer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Authorization for Emergency Medical Treatment

Volunteer Name (Print): \_\_\_\_\_

Person to Notify in Case of an Emergency (Print): \_\_\_\_\_

Relationship to Volunteer: \_\_\_\_\_

Address of Person to Notify: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_

Volunteer's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Volunteer's Health Insurance Company: \_\_\_\_\_

Phone: \_\_\_\_\_ Policy #: \_\_\_\_\_

In the event emergency medical aid/treatment is required due to illness or injury during involvement with Winslow or while on the property of the organization, I authorize Winslow Therapeutic Center to:

- a) secure and retain medical and transportation if needed
- b) release records upon request to the authorized individual or agency involved in the medical emergency treatment.

This authorization includes x-rays, surgery, hospitalization, medication and any treatment or procedure deemed "lifesaving" by the attending physicians.

Volunteer Signature: \_\_\_\_\_

(if Volunteer is a minor, parent/guardian signature required)

Relationship to Volunteer: \_\_\_\_\_ Date: \_\_\_\_\_

**STAFF ONLY**

Date Training I Completed \_\_\_\_\_

Date Training II Completed \_\_\_\_\_

Date Background Check Completed \_\_\_\_\_