

<i>Office use only</i>	Orientation Date: _____	Sidewalker Training Date: _____	Leader Training Date: _____
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Volunteer Application

General Information

Name: _____ Date: _____

Address: _____

Email: _____ Birth Date: _____

Cell Phone: _____ Other Phone: _____

If under 18, Name of Parent/Legal Guardian/Caregiver (circle one):

Name: _____ Phone: _____

Address (if different): _____

Health History

Please describe your current health status, particularly regarding the physical/emotional demands of working in an equine assisted program. Please note any hospitalizations/surgeries or lifestyle changes that may be relevant. This greatly assists us in assigning you specific tasks.

Certifications (CPR, First Aid, EMT, RN, OTR, PT, etc) Type and Expiration: _____

Previous experience working with people with special needs: _____

Previous experience working with horses: _____

Professional Expertise: _____

How did you hear about Special Equestrians? _____

Availability:

Please check the days of the week that you would be available and willing to volunteer:

	AM	PM
Sunday		
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		

Check areas of interest:

Program	Administration	Special Events
<input type="checkbox"/> Horse Handling	<input type="checkbox"/> Volunteer Recruitment	<input type="checkbox"/> Special Olympics
<input type="checkbox"/> Sidewalking	<input type="checkbox"/> Board of Directors Service	<input type="checkbox"/> Horse Show
<input type="checkbox"/> Barn Work/Horse Care	<input type="checkbox"/> Newsletter	<input type="checkbox"/> Trail Rides
<input type="checkbox"/> Stable Management	<input type="checkbox"/> Filing/Office Work	<input type="checkbox"/> Fundraisers
<input type="checkbox"/> Facility Repairs	<input type="checkbox"/> Fundraising	
	<input type="checkbox"/> Photography/Video	
	<input type="checkbox"/> Grant Writing	
	<input type="checkbox"/> Future Planning	

Volunteer Emergency Medical Treatment Authorization

Name: _____ Date: _____

Physician's Name: _____ Physician's Phone: _____

Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to medications: _____

Current medications: _____

In the event of an emergency contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Medical Consent Plan - *sign EITHER consent or non-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 SETC 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 treatment. 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.

Consent Signature: _____ Date: _____

Volunteer, Parent or Legal Guardian (circle one)

Medical Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in case of illness or injury while being on SETC property.

- If under 18, parent or legal guardian will remain on site at all times during equine assisted activities.
- In the event emergency treatment/aid is required, I wish the following procedure to take place:

Non-Consent Signature: _____ Date: _____

Volunteer, Parent or Legal Guardian (circle one)

Volunteer Background Information

Have you ever been charged with or convicted of a crime? Y N

Please explain:

I, _____, authorize SETC to obtain information from any law enforcement agency, including police 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 or animals. I understand that such access is for the purpose of considering my application as an employee/volunteer, and that all information will be kept strictly confidential.

The information provided is accurate to the best of my knowledge. I know of no reason why I should not participate in this center's program.

Signature: _____ Date: _____

Current Drivers License: Y N

License Number: _____ State: _____

Volunteer Release Agreement

Liability

The undersigned, for good and valuable consideration received from or on behalf of Special Equestrians of the Treasure Coast, Inc. the receipt and sufficiency of which is hereby acknowledged, does hereby remise, release, acquit, satisfy and forever discharge and hold harmless Special Equestrians of the Treasure Coast, Inc. its officers, directors, trustees, agents, employees, representatives, successors and assigns (collectively "SETC"), of and from any and all manner of action and actions, causes and causes of action, suits, debts, dues, sums of money, accounts, reckonings, bonds, bills, specialties, covenants, contracts, controversies, agreements, promises, variances, trespasses, damages, judgments, executions, claims, benefits, rights and demands whatsoever, in law or in equity, of whatever nature or kind, known or unknown, which the undersigned may now, or in the future, have against SETC on account of any personal injury, physical or mental condition or any other damage, known or unknown, to the undersigned and the treatment thereof, as a result of, or in any way growing out of the acts of SETC, including, but not limited to their negligence or gross negligence or as a result of any other action or activity engaged in by the undersigned in any way involving relationship with the Special Equestrians of the Treasure Coast.

Warning: Under Florida law, an equine activity sponsor or equine professional is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities.

News and Photos

The undersigned hereby grants to SETC, permission to take or have taken still and moving photographs and films, including television pictures of myself/son/daughter/spouse. I consent and authorize SETC to use and reproduce the photographs, films, pictures, and to circulate and publicize the same by all means, including without limiting media, brochures, pamphlets, instructional material, books, clinical material, newspapers, magazines, and the internet.

With respect to the foregoing matters, no inducements or promises have been made to us/me to secure my signature(s) to this release other than the intention of SETC to use or cause to be used such photographs, films and pictures for the primary purpose of promoting and aiding SETC and its work.

Confidentiality

Any information in regards to the participants at SETC must be held in strict confidentiality. Confidentiality is defined as "told in secret or private relations; trusted." Please respect the dignity and privacy of our clients and their families. I agree to keep students' names, ages, diagnoses and any other medical or personal information confidential. Your signature below confirms that you will abide by this policy.

Signature: _____ Date: _____
(Volunteer)

Signature: _____ Date: _____
(Parent/Guardian if under 18)