VOLUNTEER/STAFF INFORMATION & HEALTH FORM

VOLUNTEER/STAFF NAME______________________________________ DOB: ________________________________

GENDER: M F HOME PHONE: (___)__________WORK PHONE: (___)__________EMERGENCY (____)_______

ADDRESS: ____ CITY: _________________________ ZIP: _________

PARENTS OR GUARDIAN____

ADDRESS(if different from above): ____

Phone:___________________________________ Email:____

EMPLOYER/SCHOOL____

HAVE YOU EVER RIDDEN A HORSE: YES NO HAVE YOU EVER BEEN AROUND HORSES BEFORE: YES NO

How did you hear about the program?: ____

What is your availability?____

Describe your **HEALTH HISTORY**, particularly regarding the physical/emotional demands of working in an equine-assisted program. Address fitness, cardiac, respiratory, bone & joint function, recent hospitalizations/surgeries or lifestyle changes. Please list any major allergies or medications..

____

____

Up to date on Current Medical Vaccinations: yes or no Last Tetanus Shot: ________________

Check areas in which you are interested in:

Program	Special Events	Administration	
☐ Horse Handling	☐ Horse Show	☐ Public Relations	☐ Photography/Video
☐ Sidewalking With a Student	☐ Fundraising	☐ Grant Writing	☐ Budget & Finance
☐ Stable Management	☐ Special Olympics	☐ Newsletter	☐ Future Planning
☐ Facility Repairs	☐ Trail Rides	☐ Volunteer Recruitment	

I understand that the information provided above 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:_____________________

(volunteer/staff/caregiver; signed in presence of center staff)

Signature of Parent/Guardian (if under 18):____ Date:_____________________

(volunteer/staff/caregiver; signed in presence of center staff)

Print Name:____

Background Information

Have you ever been charged with or convicted of a crime? Yes No If yes, please explain: _________________________________

____

I, ___________________________________ (volunteer/staff), authorize Riding For Dreams 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 or animals.

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

Signature: ____ Date:___________________________

(volunteer/staff/caregiver)

Current Driver's License: YES NO License Number____________________________________ State____________________________

PLEASE CONTINUE TO PAGE 2..

Please check the box next to each of these terms if you agree.

☐

Participant Liability Release

As staff/volunteer at *Riding For Dreams Therapeutic Riding Program* 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. Thereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, released forever all claims for damages against *Riding For Dreams Therapeutic Riding Program*, its Board of Directors, instructors, volunteers and/or employees for any and all injuries and/or losses I may sustain while participating at *Riding For Dreams Therapeutic Riding Program*. *Riding For Dreams Therapeutic Riding Program* also falls under the North Dakota Statutes NDCC 53-10-01 and NDCC 53-10-02. *(The summary of the North Dakota Equine Century Codes are found under the Riding For Dreams Policies and Procedures.)*

Photo Release

I ☐ DO

☐ DO NOT

Consent to and authorize the use and reproduction by *Riding For Dreams Therapeutic Riding Program* of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program. This is valid for one year and can be revoked at my request in writing.

☐ **Policies and Procedures**

I have read the attached instructions and fully understand the policies, standards and rules put in place by *Riding For Dreams Therapeutic Riding Program* and agree to comply with them as stated. This is valid for one year and cannot be revoked.

☐ **Confidentiality**

It is the policy of *Riding For Dreams Therapeutic Riding Program* to preserve the right of confidentiality for all individuals in the program. This policy applies to all staff, volunteers, board members, and participants and their family/ guardians. This policy also restricts to photos being taken during lessons. No pictures may be taken unless otherwise authorized by the *Riding For Dreams Therapeutic Riding Program* President.

By signing this form you are agreeing to these terms set forth between you and Riding For Dreams Therapeutic Riding Program.

Signature: ____ Date:_____________________

(volunteer/staff/caregiver; signed in presence of center staff)

Signature of Parent/Guardian (if under 18):____ Date:_____________________

(volunteer/staff/caregiver; signed in presence of center staff)

Print Name:____