



# The New Mexico Center for Therapeutic Riding



## Volunteer Application 2017

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

(Last)

(First)

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

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_

My volunteer INTERESTS are:

**Check all that apply**

<input type="checkbox"/>	Horse Handler	<input type="checkbox"/>	Side Walker	<input type="checkbox"/>	Arts and Crafts
<input type="checkbox"/>	Barn Duties	<input type="checkbox"/>	Photo/Video Taping	<input type="checkbox"/>	Fundraising
<input type="checkbox"/>	Stall Cleaner	<input type="checkbox"/>	Mailings	<input type="checkbox"/>	Facility Caretaker
<input type="checkbox"/>	Horse Training Team	<input type="checkbox"/>	Administration tasks	<input type="checkbox"/>	Weekend Retreats
<input type="checkbox"/>	Volunteer Training Team	<input type="checkbox"/>	Special Events	<input type="checkbox"/>	Summer Camp

Please list any other information about yourself which you feel could be useful to the program.

### Skills and Interests:

1. Previous volunteer experience: \_\_\_\_\_

2. Hobbies and interests: \_\_\_\_\_

3. Educational background: \_\_\_\_\_

4. Equine background: \_\_\_\_\_

5. Experience:  Horse Care  Sign Language  Spanish Speaking  Computer Skills

Other: \_\_\_\_\_

6. Do you have experience working with a particular disability? \_\_\_\_\_

7. Where did you hear about NMCTR and volunteer opportunities? \_\_\_\_\_



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## BACKGROUND VERIFICATION

1. Have you ever been convicted of a criminal offense?  Yes  No

2. Have you ever been charged with neglect, abuse or assault?  Yes  No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

3. Please list 2 non-family references whom we might contact:

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

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

**LIABILITY STATEMENT:** I will not hold the New Mexico Center for Therapeutic Riding (NMCTR) liable for any accident or injury incurred while participating in the NMCTR sessions or related activities nor will NMCTR, its staff, Board of Directors, owners of the horses or owners of the premises be liable for same.

(Initial) \_\_\_\_\_

**PHOTO/VIDEO RELEASE:** I hereby grant the New Mexico Center for Therapeutic Riding permission to use any and all photographs, slides, and any other audiovisual materials in which I may appear for the express purpose of promoting the NMCTR programs and do not expect, nor shall receive any monetary reimbursement for this authorization.

\_\_\_\_\_ (CONSENT initials) \_\_\_\_\_ (NON-CONSENT initials)

**PHYSICAL REQUIREMENTS:** I realize that many of the volunteer tasks/jobs at NMCTR require me to be in good health, physically active and mentally alert and focused for the multiple hour session. I also acknowledge that I must be able to walk briskly, occasionally trot, and also be able to tolerate times when there may be severe weather and dust. (Initial) \_\_\_\_\_

I, \_\_\_\_\_, have read and understand the contents of this document. The information provided by me is complete, true, and accurate to the best of my knowledge.

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

IF MINOR, Signature of Parent/Guardian: \_\_\_\_\_



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## Authorization for Emergency Medical Treatment Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

### Medical Information:

Physician: \_\_\_\_\_

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

Medical Insurance Company: \_\_\_\_\_

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

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Company or Agent Phone: \_\_\_\_\_

### MEDICAL HISTORY

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

Allergies: (medications, insect bites, etc.) \_\_\_\_\_

#### Health History

Please describe your current health status, particularly regarding the physical/emotional demands of working in an equine assisted program. Address fitness, cardiac, respiratory, bone or joint function, recent hospitalizations/surgeries, or lifestyle changes.

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

### IN CASE OF EMERGENCY:

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

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



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## Consent Plan

In the event of an emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the NMCTR premises, I authorize NMTR 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 medical treatment.

Initials: \_\_\_\_\_

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. Emergency services from this area utilize Christus St. Vincent’s Medical Hospital.

Other preference: \_\_\_\_\_

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

SIGNATURE \_\_\_\_\_

(Signature of Parent/ Legal Guardian, or legally competent adult rider over 21)

## Non-Consent Plan

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 on the NMCTR premises.

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

SIGNATURE \_\_\_\_\_

(Signature of Parent/ Legal Guardian, or legally competent adult rider over 21)



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### Insurance Waiver and Release of Liability

VOLUNTEER'S NAME (please print): \_\_\_\_\_

In consideration of being allowed to participate in any way in The New Mexico Center for Therapeutic Riding Program, I and/or the minor participant, the Undersigned:

1. Agree that prior to participating, I will inspect, or if a parent and/or guardian, I will instruct the minor to inspect the facilities and equipment to be used, and if I believe to the best of my ability that anything is unsafe, I and/or the minor participant will immediately advise the NMCTR of such condition(s) and refuse to participate.
2. Acknowledge and fully understand that I, and/or the minor participant, will be engaging in equine-related activities both mounted and non-mounted that involve risk of serious injury, including permanent disability and death, and severe social and emotional losses which might result only from my own actions, inactions or negligence of others, the rules of play, or the conditions of the premises or any equipment used. Further, that there may be other risks not known to me or not reasonable foreseeable at this time.
3. Assume all foregoing risks and accept personal responsibility for the damages following such injury, permanent disability or death.
4. Release, waive, discharge and covenant not to sue the New Mexico Center for Therapeutic Riding, their representative administrators, directors, paid and volunteer staff, independent contractors, sponsoring agencies, sponsors, advertisers, their heirs, and if applicable, owner and leasers of premises used to conduct the New Mexico Center for Therapeutic Riding, all of which hereinafter referred to release from demands, losses or damages to property, caused or alleged to be caused in whole or part by negligence of the releases or otherwise.

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Volunteer's Name	Signature	Date
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Address	City/State, Zip
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Home Phone	Cell Phone	Work Phone	Email
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Parent/Guardian's Name	Signature	Date
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2 <sup>nd</sup> Parent/Guardian's Name	Signature	Date
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Parent/Guardian Home Phone	Cell Phone	Work Phone	Email
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# Volunteer Application 2017

## NMCTR POLICY OF CONFIDENTIALITY

### DISCLOSURE OF MEDICAL AND/OR SENSITIVE INFORMATION

**General Principles:**

NMCTR shall preserve the right of confidentiality for ALL individuals who participate in its programs.

**Procedure:** All medical, social, referral, personal, and financial information of confidentiality regarding a person and his/her family shall be kept confidential.

Anyone who works or volunteers for, or provides services to NMCTR shall be bound by this policy. This policy includes but is not limited to full and part-time staff, volunteers, independent contractors, temporary employees and board members.

Disclosure of information to outside agencies or individuals shall be done only with the specific written consent of the student. If a student is under the age of eighteen (18) and/or not competent to give consent for disclosure, then a parent or legal representative must give informed consent. Intra-agency disclosure of medical and/or sensitive information shall be on an as needed basis only. Disclosure of Specific information regarding a participant's disability is at the sole discretion of the PATH Intl. Certified Instructor and requires signed permission of the participant, parent, or guardian.

The Program Director and Director of Volunteer Services shall ensure that all staff, volunteers, and board members receive a copy of the confidentiality policy. All Staff, volunteers and board members shall sign the confidentiality statement below that pledges to protect the confidentiality of all information regarding individuals who participate in the NMCTR programs.

**Penalties:** Violations of this policy which result in a breach of confidentiality may result in reprimand, loss of certain job responsibilities or termination. The Program Director shall be responsible for reviewing any violation of this policy.

### CONFIDENTIALITY STATEMENT

I have read and understand the above policy of confidentiality for New Mexico Center for Therapeutic Riding. A copy of this policy has been made available to me. I agree to observe and follow all of the procedures contain therein.

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

IF MINOR, Signature of Parent/Guardian \_\_\_\_\_



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## Scheduling Request Form

Volunteer's Name: \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Availability: Please indicate **ALL** of the times you are available for a lesson by checking the appropriate boxes.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<b>Morning (8a-11a)</b>							
<b>Afternoon (12p-3p)</b>							
<b>Evening (4p-6P)</b>							