

**OFFICE USE ONLY:** DATE RECEIVED: \_\_\_\_\_

Type of Volunteer  CS  UNT  other

Position Assigned  SW  AD  M

## VOLUNTEER APPLICATION

Thank you for your interest in our organization that provides free therapeutic horseback riding lessons to special needs children and adults. So that we can best utilize your experience and interests, please complete this application form as fully as possible.

### I. PERSONAL INFORMATION *(Please print legibly)*

Have you ever been affiliated with SpiritHorse as a volunteer or rider?  No  Yes If yes, when? \_\_\_\_\_

Female  Male Participant's DOB (mm/dd/yy): \_\_\_\_\_

Mr.  Mrs.  Ms.  Miss.

Participant Name: \_\_\_\_\_  
*First M.I. Last*

**If under 18 years of age, print Parent/Guardian name:**

Name: \_\_\_\_\_  
*First M.I. Last*

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone#: (\_\_\_\_) \_\_\_\_\_ Cell#: (\_\_\_\_) \_\_\_\_\_ Work#: (\_\_\_\_) \_\_\_\_\_

Employer/Occupation: \_\_\_\_\_

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

*Providing my email address allows SpiritHorse to send me program news, updates, information, and etc. This email shall remain the property of SpiritHorse and will not be sold or given to any third parties.*

How did you first learn about SpiritHorse?  Radio/TV  Newspaper  Internet  School/College

Referral Please specify referring Organization/Individual/Other: \_\_\_\_\_

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### II. UNIVERSITY/COMMUNITY SERVICE INFORMATION *(Only complete if applies to you)*

If you're volunteering to complete **university curriculum service hours**, how many hours do you need to fulfill your requirement? \_\_\_\_\_ What is your major? \_\_\_\_\_

What university do you attend? \_\_\_\_\_

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**Mail this application to:** SpiritHorse Rehabilitation Center  
10363 Fort Davis Trail  
San Antonio, TX 78245

**Physical Address:**  
400 County Road 3821  
San Antonio, TX 78253

**Email this application to:** info@spirithorserehab.com

**III. INTERESTS**

Why do you want to volunteer with SpiritHorse? \_\_\_\_\_  
\_\_\_\_\_

Please list any special skills that you could offer (i.e., sign language, computer, carpentry, Spanish) \_\_\_\_\_  
\_\_\_\_\_

Please describe your general background (i.e., education, work experience) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IV. RELATED EXPERIENCE AND SKILLS**

Have you had previous experience working with youths who are at-risk or have suffered victimization or abuse?  No  Yes If Yes, please describe including specific skills/degrees: \_\_\_\_\_  
\_\_\_\_\_

Have you had previous experience working with horses?  No  Yes  
If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Are you Certified In?  First Aid  CPR Certificate expires on: \_\_\_\_\_

**V. SPECIAL OPPORTUNITIES**

Please check all volunteer areas you would be interested in.  
 Instructor  Side-walker  Grounds maintenance  Office assistance  Fundraising

**VI. TIME COMMITMENT**

What is your availability and amount of time you are interested in volunteering?  
 Weekly  Monthly  Occasionally

Our typical hours of operation are Sunday through Saturday starting around 8:00-9:00 AM to 6:00-7:00 PM. Please indicate below what time frames you are available.

Sunday \_\_\_\_\_ Wednesday \_\_\_\_\_ Saturday \_\_\_\_\_  
Monday \_\_\_\_\_ Thursday \_\_\_\_\_  
Tuesday \_\_\_\_\_ Friday \_\_\_\_\_

Describe any other issues: \_\_\_\_\_  
\_\_\_\_\_

# Volunteer Authorization for Emergency Medical Treatment Form

*Specific information is requested in the event the participant is unable to present this information on their own behalf.*

DOB (mm/dd/yy): \_\_\_\_\_

Participant's Name: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

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: (\_\_\_\_) \_\_\_\_\_

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 SpiritHorse Rehabilitation Center to:

1. Secure and retain medical treatment and transportation if needed.
2. Release volunteer records upon request to the authorized individual or agency involved in the medical emergency treatment.

## Consent Plan

I **DO** give authorization that may include x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the emergency contact person(s) above is unable to be reached.

Participant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**If under 18 years of age, parent/guardian signature required below.**

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

## 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 being on the property of the agency. In the event emergency treatment aid is required, I wish the following procedures to take place:

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

Participant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**If under 18 years of age, parent/guardian signature required below.**

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

### Volunteer Release of Liability

I, \_\_\_\_\_ (*Participant's Name*) would like to participate in the SpiritHorse Rehabilitation Center program. I acknowledge the risks and potential risks of therapeutic horseback riding. I however, feel the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs, my assigns, executors or administrators, waive and release forever all claims for damages against Jeremiah and Megan Bowen, SpiritHorse Rehabilitation Center, its Board of Directors, Guarantors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I or my son/my daughter/my ward may sustain while participating in SpiritHorse programs. **WARNING - Under Texas law (Chapter 87, Civil Practice and Remedies Code) an 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.**

Participant's Signature: \_\_\_\_\_

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

**If under 18 years of age, parent/guardian signature required below.**

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

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

### Photo and Video Consent

I, \_\_\_\_\_ **consent** \_\_\_\_\_ **or do not consent** \_\_\_\_\_ to authorize the use and reproduction by SpiritHorse Rehabilitation Center of any and all photographs, video/audio materials taken of me for the purpose of on-going studies, educational activities, exhibitions, promotional materials or for any other use for the benefit of the program.

Participant's Signature: \_\_\_\_\_

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

**If under 18 years of age, parent/guardian signature required below.**

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

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

### APPLICANT INFORMATION:

I hereby authorize SpiritHorse to request and receive any and all background information about or concerning me, including but not limited to my Criminal History, Social Security Number Trace including a consumer report under the Fair Credit Reporting Act, 15 U.S.C 1681, Driving Record, Employment History, Military Background, Civil Listings, Educational Background, Professional License, Corporation, Partnership, Law Enforcement Agency, and other entities including my Present and Past Employers.

The criminal history, as received from the reporting agencies, may include arrest and conviction data as well as plea bargains, deferred adjudications and delinquent conduct committed as a juvenile. I understand this information will be used, in part, to determine my eligibility for a volunteer position with SpiritHorse. I also understand as long as I remain a volunteer here, the criminal history check may be repeated at any time. I understand I will have an opportunity to review the criminal history as received by client/agency and a procedure is available for clarification, if I dispute the record as received.

I further release and discharge SpiritHorse and all their Subsidiaries, Affiliates, Officers, Employees, Contract Personnel, from any and all claims and liability arising out of any request for information or records pursuant to this authorization, and understand that it may contain information about my character, general reputation, personal characteristics, and mode of living, whichever are applicable.

I acknowledge I have voluntarily provided information for volunteer purposes, and I have carefully read and understand this authorization.

**Social Security Number** (required for background check): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Participant's Signature: \_\_\_\_\_

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

**If under 18 years of age, parent/guardian signature required below.**

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

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