



2017 Volunteer Information Form

General Information

Name: _____	Date of Birth: _____		
Telephone: Home: _____	Cell: _____	Work: _____	
Email Address: _____			
Best Way to Reach You: (please number in preference)	Call _____	Text _____	Email _____

Home Address: _____

City: _____ State: _____ Zip: _____

Parent/Legal Guardian- Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Address (please circle) Work or School and provide information below:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

How did you learn about the program? _____

Health History

Describe your current health status, particularly regarding the physical/emotional demands of working in a therapeutic riding program. Please address fitness, cardiac, respiratory, bone or joint function, recent hospitalizations/surgeries or lifestyle changes.

Allergies: _____

Medications: _____

Recent medical tests: Last Tetanus Shot: _____ Date: _____

Tuberculosis Test: + or - Date: _____

Photo Release

I, the volunteer ACCEPT or DECLINE consent to and authorize the use of and reproduction by Partners for Progress 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.

Signature: _____

I agree that the information provided in this form 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: _____



PARTNERS FOR PROGRESS

2017 Volunteer Information Form

- Please indicate all hours that you are available during the week.
- If you would like to be on call for a specific time, please indicate it as “on call” times.
- If there is a time that you know you cannot come in, please make a note at the bottom.
- When your schedule changes, you can fill out a new availability sheet, or modify the current one.

Mon	Mon	Tues	Tues	Wed	Thurs	Fri	Sat	Sat
10:00		10:00		10:00	9:00	10:00	9:00	9:30
11:00		11:00		11:00	10:00	11:00	10:00	10:30
	1:30	1:00	1:30	1:00	11:00	1:00	11:00	11:30
	2:30	2:00	2:30	2:00	1:00	2:00	12:00	12:30
	3:30	3:00	3:30	3:00	2:00	3:30	1:00	1:30
	4:30	4:00	4:30	4:00	3:00	4:30	2:00	2:30
	5:30	5:00		5:00	4:00	5:30		
	6:30	6:00		6:00	5:00			
					6:00			



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Background Information-----

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

I, _____ (volunteer), authorize Partners for Progress 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.

I understand that such access is for purpose of considering my application as a volunteer and that I expressly DO NOT authorize Partners for Progress, its directors, officers, employees or other volunteers to disseminate this information in any way to any other individual, group, agency, organization, or corporation.

Signature: _____ Date: _____

Current drivers license? Yes No License Number: _____ State: _____

Confidentiality Agreement

I understand that all information (written and verbal) about participants at the Partners for Progress center is confidential and will not be shared with anyone without the express written consent of the participant and their parent/guardian in the case of a minor.

Signature: _____ Date: _____

PARTNERS FOR PROGRESS, NFP RELEASE, WAIVER, HOLD HARMLESS AND INDEMNIFICATION AGREEMENT

I, as volunteer, of Partners for Progress, NFP, ("Participant" or "I"), on my own behalf, (or if as the Parent/Legal Guardian of a minor Participant, on my own behalf and on behalf of the minor Participant), understand, accept, and assume the risks of engaging in equine activities, including (i) the propensity of an equine to behave in dangerous ways that may result in injury to the participant, (ii) the inability to predict and equine's reaction to sound, movements, objects person, or animals, and (iii) the hazards of surface or subsurface conditions. I agree at all times to be responsible for my personal safety, remain financially responsible for my medical expenses, and waive my right to any claim against Partners for Progress, its sponsor(s), instructor(s), spectators, and Partners for Progress, NFP agents, affiliates, volunteers, independent contractors, employees, directors, officers, and committee or other members (collectively "Partners for Progress, NFP"), arising from my participation in, or observation of, this equine activity. I agree to release, hold harmless, and indemnify Partners for Progress, NFP for any illness, injury, death, damage, cost, or other loss incurred whether by a dangerous latent condition, negligence or otherwise.

By signing below, I certify that I have read this entire Agreement, acknowledge that the proper Warning sign has been posted, and understand, agree and intend to be bound by all of the terms and conditions contained in this Partners for Progress, NFP Release, Waiver, Hold Harmless, and Indemnification Agreement.

Signature: _____

Participant or Parent(s)/Legal Guardian(s) if Participant is under 18 years of age

WARNING

UNDER THE EQUINE ACTIVITY LIABILITY ACT, EACH PARTICIPANT WHO ENGAGES IN AN EQUINE ACTIVITY EXPRESSLY ASSUMES THE RISKS OF ENGAGING IN AND LEGAL RESPONSIBILITY FOR INJURY, LOSS, OR DAMAGE TO PERSON OR PROPERTY RESULTING FROM THE RISK OF EQUINE ACTIVITIES.



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Emergency Medical Treatment-----

In the event that 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 Partners for Progress to secure and retain medical treatment and transportation if needed.

Volunteer Name: _____

Emergency Contact: _____

Telephone: _____

Telephone: _____

Physician Name: _____

Telephone: _____

Preferred Medical Facility: _____

Health Insurance Co: _____

Policy #: _____

Please select the Consent Plan or the Non-Consent Plan in the case of an emergency

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication, and any other treatment procedure deemed "live saving" by the physician. This provision will only be invoked if we are unable to reach the emergency contacts.

Print Consent Name: _____

Consent Signature: _____

Date: _____

Volunteer, Parent or Guardian

Non-Consent Plan

I do not give my consent for emergency medical aid/treatment 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 that emergency aid/treatment is required, I wish the following procedures to take place:

Print Non-Consent Name: _____

Non-Consent Signature: _____

Date: _____

Volunteer, Parent or Guardian