Office Use Only - Date Received: _____/_____/_____

Unbridled Horse Therapy Volunteer Application

I. GENERAL INFORMATION

Volunteer Name:____ Mr. ☐ Mrs. ☐ Ms. ☐ Miss. ☐

Date of Birth: ______/_____/_____ Check: ☐ Male ☐ Female

Address:___________________________________ City:______________________ State:_______ Zip:________

Phone: (Home)_____________________ (Cell)_____________________ (Work)___________________________

E-Mail:____

Providing my email address allows Unbridled Horse Therapy to send me program news, information, etc. This email shall remain the prperty of Unbridled and will no be sold or given to any third parties.

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

Parent/Legal Guardian:____ Relation:_________________

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

☐ Referral Please specify referring Organizaion/Individual/Other:____

Check the most applicable box. "I am______" ☐ Volunteer (*includes University curriculum service hours*)

☐ Court-Ordered Community Service Worker ☐ Veteran

OFFICE USE ONLY:

BCKGRND CHECK: _______/_______/________ ENTERED INTO DATABASE: _______/_______/_______

Corespondence: ____

____

____

____

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 university do you attend? __________________

What major/clas is this required for? _____________

III. COURT-ORDERED COMMUNITY SERVICE INFORMATION *(Only complete if applies to you)*

If you're volunteering to complete your ***court mandated community service,*** how many hours do you need to fulfill your requirement? ______________ By when? __________________

What is the violation (criminal charge and level of offense)? ____

Who's the referring court? _________________________________ Judge?____________________________

Who is your probation officer? ___________________________ P.O.'s Phone # _________________________

If you are a Veteran completing court-ordered community service is it through Veteran's Court? ☐ YES ☐ NO

IV. INTERESTS

Why do you want to volunteer with Unbridled? ____

____

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)* __________________________________

____

____

V. 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 experies on:____________________

VI. SPECIAL OPPORTUNITIES

Please check all volunteer areas you would be interested in.

☐ Instructor ☐ Side-walker ☐ Grounds maintenance ☐ Office assistance ☐ Fundraising

VII. TIME COMMITMENT

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

☐ Weekly ☐ Monthly ☐ Occasionally

Our typical hours of operation vary. Please indicate below what time frames you are avaliable.

Monday __________________ Thursday __________________ Saturday __________________

Tuesday __________________ Friday ____________________ Sunday ___________________

Wednesday _______________

Describe any other issues you may have with scheduling:

____

____

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Actual signatures needed for the next three sections. No e-signatures, please!

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.

Applicant Name:____ Date of Birth: ______/_____/_______

Medical Facility:____ Phone: ____________________________

Physician's Name: ____ Phone: ____________________________

Healthy 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 Unbridled Horse Therapy 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.

***(Please sign the CONSENT PLAN or the NON-CONSENT PLAN on next page)**

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Consent Plan

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

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:

____

____

____

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 Unbridled Horse Therapy 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.

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 Unbridled Horse Therapy program. I acknowledge the risks and potential risks of horseback riding and any participation envolved with horses. 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 Robert Tavernini, Unbridled Horse Therapy, 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 Unbridled programs or on Unbridled property. **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.**

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