Heavenly Hooves

www.HeavenlyHoovesRanch.com

SpiritHorse THERAPEUTIC CENTER First Words, First Steps

OFFICE USE ONLY:
DATE RECEIVED: _____

COMMUNITY SERVICE APPLICATION

Thank you for your interest in our organization that provides free therapeutic horseback riding lessons to special needs children and adults each week. 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 Heavenly Hooves 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 Heavenly Hooves to send me program news, updates, information, and etc. This email shall remain the property of Heavenly Hooves and will not be sold or given to any third parties.

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

☐Referral Please specify referring Organization/Individual/Other:_____

II. COMMUNITY SERVICE INFORMATION

If you are volunteering to complete your ***court mandated community service,*** how many hours do you need to fulfill your requirement? _____ By when? _____

Who's the referring court? _____ Judge? _____

Mail this application to: Heavenly Hooves Therapeutic & Recreational Riding Center
18897 Johnson Ln.
Farmersville, Texas 75442

III. INTERESTS

Why do you want to volunteer with Heavenly Hooves?_____

_____

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 Monday through Saturday starting around 9:00 AM to 6:00-7:00 PM. Please indicate below what time frames you are available.

Monday _____ Wednesday _____ Friday _____

Tuesday _____ Thursday _____ Saturday _____

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 Heavenly Hooves Therapeutic & Recreational Riding 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 Heavenly Hooves Therapeutic & Recreational Riding Center program. I acknowledge the risks and potential risks of 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 Russell and/or Patricia Lynn Turner, Heavenly Hooves Therapeutic & Recreational Riding 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 Heavenly Hooves 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*** to authorize the use and reproduction by SpiritHorse Therapeutic 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 Heavenly Hooves 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 Heavenly Hooves. 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 Heavenly Hooves 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:_____