

**Volunteer Application**

*(Please Print Legibly)*

**General Information**

Name: \_\_\_\_\_  
(Last) (First)

Volunteer DOB: \_\_\_\_\_ Gender: M F

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

Address: \_\_\_\_\_  
(Street) (City, State, Zip)

Phone: \_\_\_\_\_  
(Mobile) (Home/alt.)

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

Parent/  
Legal Guardian: \_\_\_\_\_ *(If student/volunteer is under the age of 18)*

**\*If under the age of 18, must have a guardian sign consent of release.**

**\*Volunteers must be a minimum age of 13 years old to directly participate in therapy sessions as leader or sidewalker.**

Employer/School: \_\_\_\_\_

Title/Grade: \_\_\_\_\_

Parent/Guardian address (if different than above): \_\_\_\_\_

Referral Source: \_\_\_\_\_

How did you hear about the program? \_\_\_\_\_

Horse experience (please explain): \_\_\_\_\_

**Please answer/ circle all that apply for your interest in Unbridled Rehab:**

Volunteer hours for school/Other: \_\_\_\_\_

Internship/Degree type: \_\_\_\_\_

- Horse care/grooming       Side walking       Horse leading

**Internship/Volunteer Consent**

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

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I, \_\_\_\_\_, authorize URS 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 the purpose of considering my application as a volunteer, and that I expressly DO NOT authorize URS its directors, officers, employees, or other volunteers to disseminate this information in any way to any other individual, group, agency, organization or corporation.

Initial: \_\_\_\_\_

**Liability:** Riders/ interns/ volunteers and/or rider's family and guests using the facilities and equipment, do so at their own risk. URS shall not be liable for any damages arising from personal injuries or damages sustained in, on or about the premises. Rider and Responsible Party assume full responsibility for any injuries or damages, and do hereby and forever, release and discharge URS and its owners, employees and agents, from any and all claims, demands, damages, rights or causes of action, present or future, whether the same be known or unknown, anticipated or unanticipated, resulting from or arising out of the rider's, family's, or guests' use or intended use of facilities and/or equipment.

**Valuables:** Everyone is urged to avoid bringing valuables on the premises. URS, its agents or employees, shall not be liable for loss, theft or damage to personal property of riders, family members or guests.

**Absences:** URS requires a 24-hour notice of all absences either by phone or email. Unexcused absences may lead to dismissal.

**Prescription Medicine:** All non-emergency prescription medicine should be used before arrival at URS. Any persons (staff, intern/volunteer and family visitors) needing emergency medication due to a pre-existing condition should have this noted in file by a physician. In order for URS staff to administer emergency medication, release and emergency contact forms must be filled out and on file. Parents/Guardians and adult volunteers are responsible for keeping their own files current beyond URS annual update. Any emergency medication should be carried at all times and include specific directions.

**Medical Information & Approval for Volunteering:** URS reserves the right to request yearly updates of medical histories and to make the final judgment of whether the applicant/volunteer is medically able to participate in equine activities.

**Representation:** Volunteer and/or Responsible Party warrant and represent that Volunteer has no disability, impairment or ailment preventing him/her from engaging in active exercise or that will be detrimental to his/her health, safety or physical condition if he/she does so engage or participate. This representation is made by the Volunteer and Responsible Party knowing that URS will rely upon the same representation with respect to riding or other activities offered.

It is understood that photographs/videotapes are routinely made of riders, volunteers, staff members and other participants in the program. URS is hereby granted permission to make use of such photos/videos in which the rider, family or guests may appear for URS's publications, presentations for public awareness, educational/research or other purposes.

**PHOTO RELEASE**

I \_\_\_\_ **DO** / \_\_\_\_ **DO NOT** consent to and/or authorize the use and reproduction by URS of 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: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name of Parent/Guardian: \_\_\_\_\_

**Authorization for Emergency Medical Treatment**

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

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

Address: \_\_\_\_\_  
(Street) (City, State, Zip)

Primary Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Health Insurance Co: \_\_\_\_\_ Policy#: \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

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

In the event of emergency, contact:

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

Alt: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**Choose one of the following options and sign.**

**Consent Plan:** In the event of emergency medical aid or treatment is required due to illness or injury while providing assistance or while on the property of URS, I authorize URS to

- 1. Secure and retain medical treatment and transportation as needed
- 2. Release records upon request to authorized individual or agency involved in medical treatment

This authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician or emergency personnel. This provision will only be invoked if the person(s) above is unable to be reached:

Consent Signature: \_\_\_\_\_ Print: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Parent/ Legal Guardian/ if volunteer is under 18)*

**Non- Consent Plan:** I do not give my consent for emergency for medical treatment/aid in the case of illness or injury providing assistance or while on the property of URS.

- Parent/ legal guardian will remain on site at all times during committed volunteer hours.
- In the event emergency treatment/aid is required, I wish alternate procedures to take place:

\_\_\_\_\_  
Non- Consent Signature: \_\_\_\_\_ Print: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Parent/ Legal Guardian/ Caregiver)*

## **Confidentiality Policy and Agreement**

Unbridled Rehabilitation Service shall preserve the right of confidentiality for all individuals in its program. Andy and all full and part time staff, independent contractors, temporary employees, interns, volunteers and others shall keep confidential all medical, social, referral, personal, and financial information regarding a person and his/her family.

URS recognizes that a reider of his/her family members may not have legal authority to disseminate information, whether due to age or mental capacity. As a general rule, infants and children under the age of 18 years DO NOT have legal authority to consent to disclosure. Only parents, legal guardians, or others (as defined by the state statute) have this authority. Adults with developmental disabilities are presumed legally competent to give or deny disclosures unless they have been adjudicated incompetent to make this type of health care decision. If a substitute decision-maker has been appointed, URS and its representatives must obtain specific and informed written consent from that individual.

The policy extends to all situations involving URS, and its clients, whether or not any information was disseminated accidentally or on purpose.

URS shall not disseminate to its employees or others, knowledge of a person's medical or sensitive information unless there is a risk to others through casual contact and permission has been obtained.

URS shall reserve the right to use universal precautions for all situation in which staff may be exposed to the blood of a rider. URS shall act under the assumption that all riders may have a blood borne disease. Such actions do not indicate a breach of confidentiality, but rather a general policy for use in all situations in which persons are exposed to another's blood.

URS shall only disclose information to outside agencies/individuals with the specific written consent of the rider/legal representative. In cases of emergency due to illness or injury while receiving services or while on the property of URS, this policy shall recognize the required Authorization for Emergency Medical Treatment as such required written consent.

### **Confidentiality Statement**

I certify that I understand and will observe the confidentiality policy of URS.

Signature: \_\_\_\_\_ Print: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Parent/ Legal Guardian/ Caregiver)*