SpiritHorse
THERAPEUTIC CENTER
First Words, First Steps

APPLICATION

Thank you for your interest in our organization that provides free therapeutic horseback riding lessons to over 450 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 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*

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.

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

Name: _____
First *M.I.* *Last*

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

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

Check the correct box. "I am a _____" ☐ Volunteer (this includes university curriculum service hours)

☐ Court-Ordered Community Service Worker ☐ Veteran

OFFICE USE ONLY:

DATE RCVD: ___/___/___ BCKGRND CHECK: ___/___/___ ENTERED INTO DATABASE: ___/___/___

Correspondence:_____

_____

_____

_____

_____

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/class is this required for? _____

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

If you are 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 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)*_____

_____

_____

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 expires 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 available.

Monday _____ Thursday _____ Saturday _____

Tuesday _____ Friday _____ Sunday _____

Wednesday _____

Describe any other issues you may have with scheduling:

_____

_____

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.

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 Therapeutic 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 Therapeutic 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 Charles Fletcher, SpiritHorse Therapeutic 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 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:_____

Mail this application to : SpiritHorse Therapeutic Riding Center
1960 Post Oak Dr.
Corinth, TX 76210

Fax to: (940) 497-4439

Email to: Erin.SpiritHorse@gmail.com