VOLUNTEER APPLICATION
FORM & HEALTH HISTORY

First Name:_____ Last Name:_____
Address: _____
City:_____ State:_____ Zip:_____
Personal email: _____
Birthdate: _____
Cell Phone: (____)_____ Home Phone:_(_____)_____
Work Phone: (_____)_____
Preferred Phone: circle one CELL HOME WORK
Employer: _____
Title/Position:_____
Spouse Name:_____ Phone: _(_____)_____
Parent/Guardian(if under 18): _____Phone: (____)_____
How did you hear about us? _____

Areas of interest: *circle all that apply*:
Horse Handling Sidewalking Horse care Horse Conditioning Veterans Program

Days & Times available: *circle all that apply*:

Monday	morning	afternoon	Evening
Tuesday	morning	afternoon	Evening
Wednesday	morning	afternoon	Evening
Thursday	morning	afternoon	Evening
Friday	morning	afternoon	Evening

Availability Details:
Do you have any physical limitations?

Background Information:

Have you ever been convicted of a crime(s) YES NO

If Yes, please explain: _____
_____
_____
_____
_____
_____
_____

I authorize BRANDED EQUINE BASED THERAPY SERVICES 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 or animals.

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

_____

Drivers License Number:
Social Security Number: (this will be voided following background check)

Signature:
Date:

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Complete Legal Name	
Date of Birth	
Physician Name	
Medical office/Facility	
Health Insurance Company	
Allergies/Medication food/other	

Emergency Contact Information

#1 Name	
Phone	
#2 Name	
Phone	

Medical Treatment Consent

In the event that emergency medical and/treatment is required due to illness or injury during the process of receiving services, or while being on BRANDED property, I authorize BRANDED to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client/participant's records upon request to the authorized individual or agency involved in the medical emergency treatment.

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life-saving" by the physicians. This provision will only be invoked if none of the Emergency Contacts listed above can be reached.

By entering my name below I agree the medical treatment statement above:

_____

Date: _____

Orientation and Confidentiality:
I will attend an orientation at BRANDED EQUINE BASED THERAPY SERVICES and have an understanding of the information provided, will demonstrate the procedures pertaining to volunteering, and I have received and read or will read a copy of BRANDED's volunteer manual. I also have been made aware of BRANDED's confidentiality policy and understand that any information that I have become privy to about a client during my time as a volunteer shall remain confidential. The consequences of violating BRANDED's confidentiality and privacy policy may include removal from the program.

By entering my name below I agree to the Confidentiality policy statement above:

_____

Date: _____

Photo Release
_____ I consent to and authorize
_____ I do NOT consent to

The use and reproduction by BRANDED of any and all photographs and any other audio/visual materials taken of me or my family member for promotional material, educational activities, exhibitions, or for any other use for the benefit of the program or by BRANDED or PATH Int'l.

By entering my name below I agree to the photo release statement above

Signature: _____
Date: _____

Liability Release

I _____ the undersigned adult, or parent or guardian of _____, a minor, would like to participate at BRANDED EQUINE BASED THERAPY SERVICES.

I acknowledge the risks and potential for risks of equine activities. I understand that I/my son/daughter/ward, will be working with and around horses, as well as possibly, riding horses at BRANDED. However, I feel that the possible benefits to myself/son/daughter/ward are greater than the risk assumed. I, the undersigned client and/or parent or guardian, hereby, intending to be legally bound, for myself, my heirs, and assigns executors or administrator, waive and forever release, acquit, discharge and hold harmless all claims for damages against BRANDED EQUINE BASED THERAPY SERVICES, its board of directors, trustees, agents, instructors, therapists, employees, representatives, volunteers, owners of property on which BRANDED EQUINE BASED THERAPY SERVICES operates, successors or assigns on account of any personal injuries and/or personal damages known or unknown, or in any way growing out of , the acts of BRANDED EQUINE BASED THERAPY SERVICES, its board of directors, trustees, agents, instructors, therapists, employees, representatives, volunteers, owners of the property on which BRANDED EQUINE BASED THERAPY SERVICES operates, successors or assigns.

By entering my name below I understand that:

UNDER ARKANSAS LAW, AN EQUINE ACTIVITY SPONSOR IS NOT LIABLE FOR AN INJURY TO, OR THE DEATH OF, A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISK OF EQUINE ACTIVITIES.

HISTORY: Acts 1991, No. 103, § 2; Amended in 1995.

Signature _____

Date: _____