21348 County Road 1495 Ada, OK 74820
www.leapofaithtrc.org
Office-(580)272-0498 Kathy's cell-(580)453-0009

VOLUNTEER SERVICE INFORMATION

General information: Print Legibly

Name: ____

Address: ________________________________ City: ________________ Zip: ___________

Email: _____________________________________ Date of Birth: ___________ M____ F____

Phone: (Home) ___________________ (W) __________________ (Cell)____________________

Employer/School ____

Profession/Trade ____

How did you learn about the program? ____

I can begin Volunteering on ____

Check the areas in which you are interested:

Program
- ☐ Horse Handling
- ☐ Sidewalking with a Student
- ☐ Feed Team
- ☐ Facility Repairs

Special Events
- ☐ Horse Show
- ☐ Fundraising
- ☐ Special Olympics
- ☐ Annual Roundup

Administration
- ☐ Public Relations
- ☐ Grant Writing
- ☐ Budget & Finance
- ☐ Photography/Video

Relevant Education, Training, Skills and/or Experience to Volunteer Position for Sunset TRC:

____

____

____

Certifications: ____

Please list times available for each day:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

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Volunteer Health History and Confidentiality Agreement

Health History

Please describe your current health status, particularly regarding the physical/emotional demands of working in an equine-assisted program. Address fitness, cardiac, respiratory, bone or joint function, recent hospitalizations and/or surgeries, or changes in your health.

____

____

____

____

Allergies:

____

Medications:

____

____

I understand that the information provided above is accurate to the best of my knowledge. I know of no reason why I should not participate in this center's program.

Signature: ____Date ____________________

Confidentiality Agreement

I understand that all information (written and verbal) about participants at Leap O' Faith Therapeutic Riding Center, Inc. is confidential and will not be shared with anyone without the expressed written consent of the participant or their parent/guardian in the case of a minor.

Signature: ____Date ____________________

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Liability Release

_______________________________________(Participant's Name) would like to participate in program(s) offered by Leap O' Faith Therapeutic Riding Center, Inc. as a rider and/or volunteer. I acknowledge the risks and potential risks of working with horses and horseback riding. Under Oklahoma law, an equine activity sponsor or 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. However, I feel that the possible benefits to myself/my child/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs, and assigns, executors or administrators, waive and release forever all claims for damages against Leap O' Faith Therapeutic Riding Center, its Board of Directors, Instructors, Therapists, Aides, Center Property Owner, Volunteers and/or Employees for any and all injuries and/or losses I may sustain while participating in program(s) offered by Leap O' Faith Therapeutic Riding Center.

Date: __________________________ Signature:____

Participant (if over 18) or Participant's Parent or Guardian

Photo Release

☐ I DO ☐ I DO NOT consent to and authorize the use and reproduction by Leap O' Faith Therapeutic Riding Center, Inc. of any and all photographs and any other audio/visual materials taken of myself/my child/my ward for promotional material, educational activities, and exhibitions or for any other use for the benefit of the center.

Date: __________________________ Signature:____

Participant (if over 18) or Participant's Parent or Guardian

Authorization for Emergency Medical Treatment

In the event of an emergency, contact:

Name: ____ Relation: _________________________________ Phone: ______________________________

Name: ____ Relation: _________________________________ Phone: ______________________________

Consent Plan

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 Leap O' Faith Therapeutic Riding Center, Inc., I authorize **Leap O' Faith Therapeutic Riding Center, Inc.** to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client 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 physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date: ___________________________Signature::____

Participant (if over 18) or Participant's Parent or Guardian

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. Parent or legal guardian will remain on site at all times during equine assisted activities. In the event emergency treatment/aid is required, I wish the following procedure to take place:

____

Date: ___________________________Signature::____

Participant (if over 18) or Participant's Parent or Guardian

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LEAP O' FAITH CLASS SCHEDULE

Time	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
9:00		9:00 – 12:00 Therapeutic Riding	9:00 – 12:00 Therapeutic Riding	9:00 – 12:00 Therapeutic Riding	9:00 – 12:00 Therapeutic Riding	9:00 – 12:00 Therapeutic Riding	
10:00							
11:00							
12:00							
1:00		1:00 – 2:30 Therapeutic Riding	1:00 – 2:30 Therapeutic Riding	1:00 – 2:30 Therapeutic Riding	1:00 – 2:30 Therapeutic Riding	1:00 – 2:30 Therapeutic Riding	
2:00							
3:00							
4:00		4:00 – 6:00 Therapeutic Riding	4:00 – 6:00 Therapeutic Riding	4:00 – 6:00 Therapeutic Riding	4:00 – 6:00 Therapeutic Riding	4:00 – 6:00 Therapeutic Riding	
5:00							
6:00							
7:00							

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Volunteer/Staff Background ·information Form

The information obtained on this form is shared with a law enforcement agency for a background check. This form is kept separate from the remainder of this packet in a locked file cabinet in director's private office.

Name: ____

Background Information

Have you ever been charged with or convicted of a crime? Y N If yes, please explain:

____

____

I, ________________________________ (volunteer/staff), authorize Leap O' Faith Therapeutic Riding Center, Inc. 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 employee/volunteer, and that I expressly DO NOT authorize Leap O' Faith Therapeutic Riding Center, Inc., its directors, officers, employees, or other volunteers to disseminate this information in any way to any other individual, group, agency, organization, or corporation.

Signature: ____ Date ____________________

CURRENT DRIVER'S LICENSE Y N

LICENSE NUMBER _____________________________ STATE ________

Social Security Number: __________/___________/_________ Date of Birth: ______/______/______