Healing Hoof Steps Volunteer Application Packet

Please answer every item. Email completed application to susan@healinghoofsteps.org A link to complete background check will be emailed to volunteers 18 years and older once this application has been received.

Name: ____Date of Birth___/___/___Female ____Male____

Mailing Address: ____City: ___________________________
State: ____Zip Code: ___________________County: _______________________________

Telephone:

Home: (_)________________________Work: (_)________________________Cell: (_)____________________
E-Mail Address:____
Employer:____

Occupation: ____

Caregiver/Guardian Name & Phone: (If minor or dependent adult)

____

How did you hear about Healing Hoof Steps? ____

Can you walk for 30 minutes and jog for short distances in sand? Yes___No ____

Can you hold your arm above shoulder height and support a modest weight? Yes____No ___

Are you comfortable working and/or walking around horses and ponies? Yes____No____

Please identify any physical/emotional/medical or other conditions which might affect your ability to participate as a volunteer. ____

____

Have you completed any first aid/rescue breathing/CPR training? Yes____No____

Languages, including sign language: ____

What is your general availability? Circle all that apply.

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
AM	AM	AM	AM	AM	AM
MID-DAY	MID-DAY	MID-DAY	MID-DAY	MID-DAY	MID-DAY
PM	PM	PM	PM	PM	PM

Tell us in which areas you are interested in volunteering:

____Therapeutic Riding lessons
____Creative projects
____Grounds maintenance
____Farm chores
____Becoming a PATH certified riding instructor
____Becoming an Equine Specialist/Mental Health Provider in Equine Assisted Therapy

____Administration
____Events
____Field work
____Fundraising
____Deliveries
____Phone Bank
____Newsletter production
____Volunteer coordination

Please indicate the reason you are seeking a volunteer position (check all that apply): ___Personal fulfillment ___School requirement ___Community service requirement ___Skill development

VOLUNTEER HISTORY Please specify how many years and what type of experience you have had with horses:

____
____
____
____
____

Volunteers at Healing Hoof Steps acknowledge that they, or their immediate family may not enter into a clinical relationship for mental health services with any clinician at Healing Hoof Steps. Should a volunteer request mental health services for themselves or immediate family members, Healing Hoof Steps will refer the volunteer to another local therapist.

The above statements are true and complete to the best of my knowledge.

____ ___________

Applicant's Signature Date

Important to remember – Please CALL or TEXT the Volunteer Coordinator at 850-736-4110 if you cannot make your shift as many of the students depend on a horse handler and/or side-walkers so they can ride safely. We appreciate this courtesy so that we can find necessary replacements and ensure our riders are able to participate.

VOLUNTEER INFORMATION AUTHORIZATION TO RELEASE INFORMATION NOT OTHERWISE FOUND WITHIN THE BACKGROUND CHECK

Full Name: ____
Address:____Phone : _______________

I, the undersigned, authorize and consent to any person, firm, organization or corporation provide a copy (including photocopy or facsimile copy) of the Authorization for Release Information by the above stated agency to release and disclose to such agency any and all information or records requested regarding me, including, but not necessarily limited to, my employment records, volunteer experience, military records, criminal information records (if any), and background. I have authorized this information to be released to Healing Hoof Steps, either in writing or via the telephone, in connection with my application for employment or to be a volunteer at the program. Any person, firm, organization or corporation providing information or records in accordance with this authorization is released from any and all claims or liability for compliance. Such information will be held in confidence in accordance with program guidelines.

____ _______________

Signature: Date:

BACKGROUND CHECKS

Our program screens all prospective volunteers to evaluate whether an applicant poses a risk or harm to the children, youth, and adults we serve. Information obtained is not an automatic disqualification to becoming a volunteer but is considered in view of all relevant circumstances. This disclosure is required to be completed in full by all those who wish to be considered part of HEALING HOOF STEPS. Any falsification, misrepresentation, or incompleteness in this disclosure alone is grounds for disqualification or termination.

Any offense or conviction related to causing harm or death to an adult, child, or animal is an automatic disqualification.

Healing Hoof Steps requires all staff and volunteers to complete and pass a thorough background screening prior to engaging in any client-related activities on property. Healing Hoof Steps utilizes Sterling Volunteers to perform background checks for our program. Each volunteer will be sent a link from Sterling Volunteers after submitting this completed application to susan@healinghoofsteps.org . The background check fee is the responsibility of the potential volunteer. Refunds will not be accepted whether the potential volunteer does or does not pass the screening. The fee of $19 will be paid on the Sterling Volunteers website at the time of application.

CONFIDENTIALITY AND PHOTO RELEASE

I agree that as a HEALING HOOF STEPS volunteer, I will respect the privacy of participants, volunteers and all those involved and hold in confidence all information obtained during my volunteer service. I recognize that confidentiality and privacy requirements apply to everyone. I also respect and understand that all photos of participants are prohibited. As a volunteer, I hereby consent to and authorize the use and reproduction by HEALING HOOF STEPS of any photographs and any other audio-visual material taken of me for promotional material, educational activities, exhibitions, fund raising, or for any other use which may benefit the program.

____ ____________________

Signature Date

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

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 Healing Hoof Steps to secure and maintain medical treatment and transportation, if needed and incur expenses for which I will be responsible for payment.

Name: ___________________________________Phone: ___________________________

In case of emergency, contact: ___________________________Phone: ___________________________

Physician name: _______________________________________Phone: ___________________________

Preferred medical facility: ______________________________

PLEASE CHECK ONE OPTION LISTED BELOW

__***I GIVE 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. 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 below is not able to provide authorization or is unable to be reached.

__***I DO NOT GIVE 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: ____
____

____ ____________________

Signature Date

Healing Hoof Steps

LIABILITY RELEASE FORM

In consideration of the services of HEALING HOOF STEPS CORP, its managing partners, board members, employees, representatives, agents and associates (hereinafter referred to as “HHS”), I hereby agree to release, indemnify, and discharge HHS, on behalf of myself, my children, my parents, my heirs, assigns, personal representative and estate as follows:

1. I acknowledge that horseback riding, caring for horses, and all therapeutic and learning/ self-discovery and/or psychotherapeutic activities involving horses entail known and unanticipated risks which could result in physical or emotional injury, paralysis, death, or damage to me, to property or to third parties. I understand that such risks simply cannot be eliminated without jeopardizing the essential qualities of the activity.

   The risks include, among other things: loss of control, collisions; horses, irrespective of their previous behavior and characteristics, may act or react unpredictably based upon instinct, fright, or lack of proper control by rider or handler, latent or apparent defects or conditions in equipment, animals or property, acts of other students in this activity, adverse weather conditions; contact with plants, insects, or animals; my own physical conditions or my own acts or omissions; the conditions of remote roads, trails, waterways, or terrain, and accidents connected with their use; first-aid, emergency treatment or other services rendered; consumption of food and drink. Furthermore, HHS seeks safety, but they are not infallible. They might be unaware of a student’s fitness or abilities. They might misjudge weather, the elements or the terrain. They may give adequate warnings or instructions and the equipment being used might malfunction.

2. I expressly agree and promise to accept and assume all of the risks existing in this activity. My or my child participation in this activity is purely voluntary and elects to participation in spite of the risks.

3. I hereby voluntarily release, forever discharge, and agree to indemnify and hold harmless HHS from any and all claims, demands, or causes of action, which are in any way connected with my or my child’s participation in this activity or my or my child’s use of HHS equipment or facilities, including any such claims which allege negligent acts or omissions of HHS.

4. Should HHS or anyone acting on their behalf be required to incur attorney’s fees and costs to enforce this agreement, I agree to indemnify and hold them harmless for all such fees and costs.

5. I certify that I have adequate insurance to cover any injury or damage I or my child may cause or suffer while participating or else I agree to bear the costs of such injury or damage myself. I further certify that I nor my child have no medical or physical conditions, which could interfere with my safety in this activity, or else I am willing to assume-and bear the cost of-all risks that may be created, directly or indirectly, by any such condition.

6. In the event that I file a lawsuit against HHS, I agree to do so solely in the state of Florida, and I further agree that the substantive law of that state shall apply in that action without regard to the “conflict of laws” rules of that state. I agree that if any portion of this agreement is found to be void or unenforceable, the remaining portion shall remain in full force and effect.

By signing this document, I acknowledge that if anyone is hurt or property is damaged during my or my child’s participation in this activity, I may be found by a court of law to have waived my or my child’s right to maintain a lawsuit against HHS on the basis of any claim from any claim from which I have released them herein. **EQUINE WARNING: Under Florida 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. I have had sufficient opportunity to read this entire document. I have read and understood it, and I agree to be bound by its terms.**

Student/ Participant Name: ____

____   _________________________________

Teacher participant or parent/Guardian signature   Date Print Name of Guardian or Teacher

Participant Address:____

Phone:___________________________________Email:___________________________________

Emergency Contact: ____

Name/Phone