Welcome to Wings of Hope Equitherapy Volunteer Team!

You *MUST* be able to conduct most *communication via email.*

ALL volunteers are REQUIRED to read and respond to a weekly email update.

Please complete this application in its entirety.

Submit to Jennifer Shank-Volunteer Coordinator

Submit Completed Application:

emailed, faxed, or mailed:

jennifer@wingsofhopehorses.org
Phone 817-790-8810 Fax: (1-817) 783-7072
Mail: PO Box 445 Burleson,Tx 76097

I am available to start:_____

I am able to return in September____yes no____

Accepting new volunteers

ONCE YOUR APPLICATION IS PROCESSED YOU WILL RECEIVE AN EMAIL WITH A CONFIRMATION OF YOUR SCHEDULE AND YOUR START DATE.

WOH operates September- June. We are closed for lessons the months of July and August!

Wings of Hope Equitherapy Volunteer Application Form 2017-2018

To be completed by staff: Email C/C____ Name Tag___BigCont.:___PhnList____Med.Emer.____
Received____/____/____by____ Background Form:____ Completion Date_____
ER Copied ____/____/____by____
Trained____/____/____by____ Sidewalker___
Leader Training_____by____ Train as Leader___
Class Time:_____

Personal Information:
Name:_____ Birth Date:_____ ___Age:_____

Address:_____ Home Ph:_____

City:_____ Zip:_____ Cell Ph:_____

Work Ph:_____ **Contact via Facebook?☐ Yes ☐No ☐n/a**

Email:_____

Occupation:_____

Employer/School:_____

WOH uses email as the ***primary*** method of communication!

You MUST be able to read a weekly email update!

Horse Experience:
Do you currently own horses? ☐ yes ☐no
IF you ride frequently do you consider yourself **Beginner ☐ Intermediate ☐ Advanced ☐**
Discipline:_____

Do you think you qualify as a Horse Handler/Leader? ☐ yes ☐no
In order to feel qualified as a horse handler you must CURRENTLY know how to INDEPENTLY groom, tack, and lead horses and have knowledge of horse dispositions.

Describe your experience with horses:_____

Describe your comfort level/knowledge with horses:_____

_____

General Information:
Describe your experience with persons with disabilities:_____

Do you have any physical limitations? Describe:_____

How did you learn about Wings of Hope:_____

Are your volunteer hours school/civic community service or court ordered?
If yes explain:_____
# of hours needed:_____ date needed by:_____
Do you intend to continue volunteering after your obtained hours?_____

Training is 30 minutes prior to the start of your first lesson!

Wings of Hope Equitherapy
Interest Areas and Availability

Are you a veteran?

____yes no____

Are you interested in volunteering in our ***VETERENS ONLY*** Horses for Veterans program?

Interest Areas:

□ Leading a horse
□ Side Walking with a rider
□ Grooming/Tacking
□ Fund raising
□ In- House Horse Shows
□ Off-Site Horse Shows
□ Special Olympics (April-Aubrey,Tx)

Availability:

Please carefully consider what day and time slot you would be available to volunteer. It is very important to the program that we can depend on our volunteers being here for classes, weekly!

1.Place a check mark in the box for all classes for which you are available.
2. Indicate in the specified area below what day and time slot would be your first choice, then second and third.
3. Please keep in mind when choosing a time slot that volunteers are asked to arrive 30 minutes before class time each week to prepare for the lesson.

Mon		Tues		Wed		Thurs		Sat.
10:15 AM		10:00 AM				10:00 AM		Horses for Veterans
11:45 AM		11:30 AM				11:30 AM		9:30 AM
1:00 PM		1:15 PM		12:30 PM				11:00 AM
2:30PM		2:00 PM		2:00 PM		2:30 PM		12:30 PM
3:30 PM		3:30 PM		3:30 PM		3:30 PM		2:00 PM
5:00 PM		5:00 PM		5:00 PM		5:00 PM		
6:30 PM		6:30 PM		6:30 PM		6:30 PM		

Veterans only

First Choice_____

Second Choice_____

Third Choice _____

***Greatest Needs**

Are you interested in participating a weekly prayer group with other volunteers and riders?

____yes no____

*Our needs are constantly changing, the needs of the above schedule pertains to the **day** your application was sent to you. A quick response ensures accuracy of your preferences pertaining to the listed needs.*

WINGS OF HOPE EQUITHERAPY
Release and Waiver of Liability and Indemnity Agreement

Name of Volunteer Participant: _____ Age if a Minor/Ward: _____

All equine activities, including the equitherapy program of Wings of Hope Equitherapy, involve inherent risks and dangers which could result in personal injury or death to Participant. I/we acknowledge the risks and dangers of a horse-back riding program to myself or my minor child or ward ("Participant"), but believe that the possible benefits to myself, my child or my ward are greater than the risks and dangers assumed.

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 ACTIVITES RESULTING FROM THE INHERENT RISK OF EQUINE ACTIVITIES.

WAIVER AND RELEASE OF LIABILITY

I HEREBY EXPRESSLY WAIVE AND RELEASE ANY CLAIM FOR COMPENSATION OR LIABILITY ARISING OUT OF ANY PERSONAL INJURY OR DETH THAT I, MY MINOR CHILD, OR MY WARD MAY SUSTAIN IN CONNECTION WITH THE WINGS OF HOPE EQUITHERAPY ACTIVITY, REGARDLESS OF WHETHER SUCH PERSONAL INJURY OR DEATH IS CAUSED IN WHOLE OR IN PART BY THE NEGLIGENCE OR FAULT OF WINGS OF HOPE EQUITHERAPY, ITS BOARD OF DIRECTORS, GUARANTORS, INSTRUCTORS, THERAPISTS, AIDES, EMPLOYEES AND VOLUNTEERS ("RELEASEES").

INDEMNITY AGREEMENT

I HEREBY EXPRESSLY AGREE TO INDEMNIFY AND HOLD HARMLESS WINGS OF HOPE EQUITHERAPY, ITS BOARD OF DIRECTORS, GUARANTORS, INSTRUCTORS, THERAPISTS, AIDES, EMPLOYEES OR VOLUNTEERS ("INDEMNITEES") FROM ANY CLAIM FOR PERSONAL INJURY OR DEATH THAT I, MY MINOR CHILD, OR MY WARD MAY SUSTAIN IN CONNECTION WITH WINGS OF HOPE EQUINE THERAPY ACTIVITIES, REGARDLESS OF WHETHER CAUSED IN WHOLE OR IN PART BY THE NEGLIGENCE OR FAULT OF INDEMNITEES.

I understand that Wings of Hope Equitherapy, its Board of Directors, guarantors, instructors, therapists, aides, volunteers and/or employees (Indemnitees/Releasees) will not be legally liable for any personal injuries or death that I, my minor child or my ward might sustain in connection with the Equine Activities regardless of any fault or negligence on the part of Indemnitees or Releasees.

I understand that the waiver and release of liability and the indemnity agreement extend to any and all activities in connection with the Wings of Hope Equitherapy horseback riding program and related activity in which I, my child, or my ward may participate now or in the future.

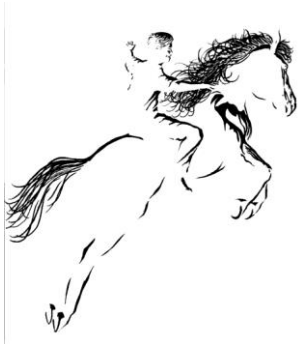
I represent to Wings of Hope that I am the parent or legal guardian of the minor child or ward listed above, and legally authorized to sign this agreement and bind myself and the minor child or ward to this agreement.

Signature: _____ Date: _____
Participant Volunteer

Signature: _____ Date: _____
Parent/Legal Guardian of Minor/Ward

Wings of Hope Equitherapy

Confidentiality and Photo/Media Release



Confidentiality Agreement:

I understand that all information (written and verbal) about participants at the Wings of Hope Equitherapy PATH International center is confidential and will not be shared with anyone without the expressed permission of the participant and their parent, guardian or caregiver in the case of a minor.

I understand that I am never to approach a Wings of Hope participant or Equine Connection Counseling client outside of the Wings of Hope facility

I also understand that all information (written and verbal) regarding mental health information of an Equine Connection Counseling client that may have been obtained by the undersigned is to be kept confidential and that I am not allowed to disclose any information obtained unless (i) authorized by the ECC client in writing, (ii) necessary to maintain someone's personal safety, or (iii) as may be required by law.

Signature: _____

Date:_____

Staff, volunteer, rider, guardian/parent

Wings of Hope Equitherapy will take all precautions to ensure the privacy of our riders, counseling clients, their families, volunteers, and staff members.

Photo/Media Release:

I DO ____ DO NOT _____ consent to and authorize the use and reproduction by Wings of Hope Equitherapy of any and all photographs, any audio-visual materials taken of me or spoken/written testimonials for promotional material, education activities, exhibitions or any other use for the benefit of Wings of Hope Equitherapy.

Signature:_____

Date:_____ Staff, Volunteer, Rider, Guardian/Parent

Please read the attached volunteer handbook before agreeing to your good faith agreement and job description!

***Good Faith Agreement*:**
Consistency and commitment to our special needs riders is an important aspect of WOH volunteer service. By accepting a permanent position as a side walker and/or horse handler for ideally one 10 month semester (We understand circumstances change). I agree to honor this commitment of 1.5 hours per week.

***Hand Book and Job Description*:** I have **read** and understand the Wings of Hope Volunteer Handbook, and will obey and abide by all rules, regulations, and job descriptions with in this handbook.

Signature _____ Date_____

Wings of Hope Equitherapy Authorization for Emergency Medical Treatment

Check One: _X__ Volunteer ___Staff ___Participant

Volunteer Name:_____ DOB:_____

Address:_____City/Zip:_____

Emergency Contact:_____ Relationship:_____

Day Phone:_____ Evening:_____ Cell:_____

Please fill out to the best of your knowledge:

Preferred Medical Facility:_____

Do you have any medical conditions or diagnosis that could effect the safety of you or the riders? ie: allergic reaction to bee stings, heat exhaustion, epilepsy, diabetes, heart conditions, etc. _____

List of allergies:_____

List medications:_____

In the event emergency medical aid/treatment is required due to illness or injury during the process of instructing, working, or while being on the property of the Agency, I authorize Wings of Hope Equitherapy to:
1.) Secure and retain medical treatment and transportation if needed
2.) Release any records upon the request to the authorized individual or agency involved in emergency treatment.

► **Consent Plan**
This authorization includes x-ray, surgery, hospitalization, medications and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the emergency contact is unable to be reached.

Consent Signature:_____Date:_____
Parent, Guardian or Adult Caregiver signature (needed if under 18 years of age)

Print Name:_____

► **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 volunteering, receiving services or while being on the property of the agency. In the event emergency treatment/aid is required I wish the following procedures take place:_____

Non-Consent Signature:_____ Date:_____
Parent, Guardian or Adult Caregiver signature (needed if under 18 years of age)Print Name:_____ *In non-consent situations; Parent, Adult Caregiver or Guardian will remain on site at all times if the person is under 18 years of age.*

Background Verification Release Form

AGENCY INFORMATION:

Date	Agency Name Wings of Hope Equitherapy
Contact Name Jennifer Shank	
Agency's Main Phone Number 817-790-8810	Agency's Fax Number 817-783-7072

APPLICANT INFORMATION:

Applicant Full Name (Last, First, MI)			Maiden or Other Name(s) Used
Current Address			
City	State	Zip Code	County
Social Security Number	Date of Birth	Driver's License Number	State Issued
Position Applied For **Volunteer**			
Gende ❑ Male ❑ Female	**Race** ❑ African American ❑ American Indian ❑ Anglo ❑ Asian ❑ Hispanic ❑ Other		

I hereby authorize VERIFYI and or its Service Provider to request and receive any and all background information about or concerning me, including but not limited to my Criminal History, Social Security Number Trace including a consumer report under the Fair Credit Reporting Act, 15 U.S.C 1681, Driving Record, Employment History from any Individual, Corporation, Partnership, Law Enforcement Agency, and other entities including my Present and Past Employers.

The criminal history, as received from the reporting agencies, may include arrest and conviction data as well as plea bargains and deferred adjudications and delinquent conduct as committed as a juvenile. I understand that this information will be used, in part, to determine my eligibility for an employment/volunteer position with this organization. I also understand that as long as I remain an employee or volunteer here, the criminal history check may be repeated at any time within 36 months from the date on this document. I understand that I will have an opportunity to review the criminal history as received by client/agency and a procedure is available for clarification, if I dispute the record as received. I also understand that the criminal history could contain information presumed to be expunged.

I further release and discharge VERIFYI and their Service Provider and all of their Subsidiaries, Affiliates, Officers, Employees, Contract Personnel, or Associates, from any and all claims and liability arising out of any request for information or records pursuant to this authorization, procurement of an investigative consumer report and understand that it may contain information about my character, general reputation, personal characteristics, and mode of living, whichever are applicable.

I understand that I have the right to make written request within a reasonable period of time to VeriFYI for additional information concerning the nature and scope of the investigation. I acknowledge that I have voluntarily provided the above information for employment/volunteer purposes, and I have carefully read and understand this authorization.

Applicant's Signature _____ Date _____

Applicant's Printed Name _____ Parent/Guardian's Signature (if under 18 years of age) _____

The cost of back ground checks on each volunteer is $9.95, would you be willing* to donate the cost for your application as a gift to Wings of Hope? Yes or No

*this is an optional gift all applications will be processed regardless of your answer