Volunteer Application

Volunteer Application Date: ____________
Name____ Date of Birth ______________________
Address ____ City _______________________
State _______ Zip __________
Home Phone ___________________ Other Phone______________________
Email_______________________________________
I prefer to be contacted by: phone ____ email ____ text____
Have you ever been convicted of a criminal offense? No____ Yes ____
If yes, when? __________ Where?__________________
Please explain:____
The above information may be verified and I give my permission for inquiry to be made as to my suitability to act as a volunteer for the OWL Center
SIGNATURE:
____
DATE: ______________
SIGNATURE OF PARENT/GUARDIAN:
____ **DATE: ______________**

Photo Release: ______ I consent to and authorize ______ I do not consent to nor do I authorize the use and reproduction by OWL Center Therapeutic Riding Program of any and all photographs and any other audiovisual materials taken of me for promotional printed material, educational activities exhibitions, or for any other use for the benefit of the program.

Acknowledgement of Confidentiality Policy: OWL Center Therapeutic Riding Program shall preserve the right of confidentiality for all individuals in its program. Anyone who works or volunteers for, or provides services to, OWL Center Therapeutic Riding Program shall keep confidential all medical, social, referral, personal and financial information regarding a person and his/her family. Any confidential information can only be used for a specific identified purpose when written authorization is given by a participant, family member or legal guardian. I understand that I will be accountable for the protection of our riders' privacy. Violation of the right to confidentiality will constitute grounds for termination of employment or involvement with OWL Center Therapeutic Riding Program. Pictures of participants may not be taken or shared without the permission of the program director.
The undersigned acknowledges that he/she has read this Volunteer application in its entirety; that he/she understands the terms of this release and has signed this release voluntarily and with full knowledge of the effects thereof.

SIGNATURE:
____
DATE: _____________
SIGNATURE OF PARENT/GUARDIAN:
____ DATE: _____________

Liability Release: I would like to participate in the OWL Center Therapeutic Riding Volunteer Program. I acknowledge the inherent risk and potential for risks of equine activities. **Warning:** Under Louisiana Law, an equine activity sponsor is not liable for an injury to, or the death of, a participant in the equine activities resulting from the inherent risks of equine activities that are obvious and necessary, Pursuant to Louisiana Revised Statutes R.S. 9:2795.1. The term "Equine Activity Sponsors" includes OWL Center Therapeutic Riding Program, Louisiana United Methodist Children and family Services, Inc, their Board of Directors, Instructors, Therapists, Aids, Volunteers, and/or all Employees.

SIGNATURE: ____ DATE: ________________
SIGNATURE OF PARENT/GUARDIAN:
____ DATE: ________________
(If volunteer is under 18)

New Volunteers

Experience with
Horses:____
____
____

Experience with persons with
disabilities:____
____

What is your main purpose in volunteering?
____
____

I am interested in volunteering with: ____Sidewalking ____Leading ____Horse Exercise Program ____Site Improvement ____Tack Cleaning ____Transporting Horses ____Fundraising Committee ____ ____Horse Show ____Special Olympics ____Newsletter ____Website ____Grant Writing ____Special Events ____Other (Please Explain)

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 **OWL Center Therapeutic Riding Program** to:

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

Name: ____ Date: ____________________

Home Phone: ____ DOB :

In case of Emergency, contact: ____

Relationship: ____________________

Primary Phone: _____________________________ Other Phone: _______________________

Physician's Name: ____ Phone : ________________

Preferred Medical Facility:

____

Health Insurance Carrier: ___________________________ Policy # :______________________

Medical conditions, medications or allergies we should know about:

____

____

Consent Plan: (To be invoked in the event that your Emergency Contact cannot be reached.)

I give consent for emergency medical treatment/aid (including x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician) in the event of illness or injury while on the property of OWL Center

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CONSENT SIGNATURE: ______________________________________DATE: ______________

CONSENT SIGNATURE OF PARENT/GUARDIAN:

____ DATE: ______________

(If volunteer is under 18)

Non-Consent Plan:

I do not give my consent for emergency medical treatment/aid in the case of illness or injury while on the property of OWL Center. In the event emergency treatment/aid is required, I wish the following procedure(s) to take place:

____

____

____

NON-CONSENT SIGNATURE: ____

DATE: ______________

NON-CONSENT SIGNATURE OF PARENT/GUARDIAN:

____ DATE: ____________