



RISING HOPE THERAPEUTIC RIDING CENTER

VOLUNTEER APPLICATION PACKET

APPLICATION INSTRUCTIONS

Thank you for considering becoming a volunteer here at Rising Hope Therapeutic Riding Center. Volunteers are extremely valued and appreciated in the Rising Hope program. Without dedicated volunteers, our program could not operate and serve the community and its individuals. Equestrian experiences are not required to be a volunteer. The minimum age to apply is 14. After acquiring your clearances and completing the application you will set up training with the volunteer coordinator.

Please complete the following:

- Completely fill out the volunteer application
- Acquire criminal history and child abuse clearances
- Turn in application to volunteer coordinator and set training date

VOLUNTEER QUESTIONNAIRE

Name: _____

1. Do you have experience working with individuals with disabilities? No Yes

If yes, explain briefly _____

2. Do you have experience working with horses or have other volunteer experience? No Yes

If yes, explain briefly _____

3. Do you have any physical restrictions? No Yes

If yes, explain briefly _____

4. Are you able to walk and run next to a horse? No Yes

Rising Hope

(814) 933-8414 | 388 Reese Rd. Bellefonte PA, 16823 | risinghope.trc@gmail.com | risinghopetrc.com

VOLUNTEER REGISTRATION

First Name: _____ Last Name: _____

Gender: Male Female DOB: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____

Work #: _____ Occupation/School: _____

Areas of Interest: *Select all that apply*

- Special Events Office Work Fundraising Working with students while riding
 Working with students in the barn Helping with barn and facility chores

PLEASE COMPLETE IF VOLUNTEER IS UNDER 18 YEARS OF AGE

Parent/Guardian: _____

Phone #: _____ Email Address: _____

Address: _____

PHOTO AND VIDEO RELEASE

- I CONSENT** (please check one)
 I DO NOT CONSENT (please check one)

to and authorize the use and reproduction by Rising Hope Therapeutic Riding Center, Inc. of any and all photographs and any other audio-visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature of Volunteer: _____ Date: _____

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VOLUNTEER CONFIDENTIALITY AGREEMENT

I understand that all information (written and verbal) regarding participants at Rising Hope Therapeutic Riding Center is confidential and will not be shared with anyone without the express consent of the participants, and, in the case of a minor, their parent/guardian.

Signature of Volunteer: _____ Date: _____

BACKGROUND INFORMATION

Have you ever been charged or convicted of a crime? No Yes

If yes, please explain

I authorize Rising Hope, Inc. to receive information from any law enforcement agency, including police department and sheriff's departments, of the Commonwealth of Pennsylvania 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.

I understand that such access is for the purpose of considering my application as a volunteer and that I expressly do not authorize Rising Hope, Inc. its directors, officers, employees, or other volunteers to disseminate this information in any way to any other individual, group, organization, or corporation.

Signature: _____ Date: _____
Consent Signature of Volunteer or Parent/Guardian

VOLUNTEER AVAILABILITY

CHECK AVAILABILITY:

Weekdays: Mon. Tues. Wed. Thurs. Fri.

Time: AM PM

Please list out preferred times

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Participant Authorization for Emergency Medical Treatment Medical Consent Plan

Participant Full Name: _____

Date of Birth: _____ Phone #: _____

Address: _____

Physicians Name: _____

Preferred Medical Facility: _____

Health Insurance Co: _____ Policy #: _____

Allergies to Medication: _____

Current Medication(s): _____

Additional Emergency Medical Information for Treating Medical Professional:

1. Emergency Contact Name: _____

Phone #: _____ Relation: _____

2. Emergency Contact Name: _____

Phone #: _____ Relation: _____

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 premises operated by Rising Hope TRC, Inc.,

I authorize Rising Hope 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 below is unable to be reached.

Signature: _____ Date: _____

Consent Signature of Volunteer or Parent/Guardian

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Participant Authorization for Emergency Medical Treatment Medical NON-Consent Plan

Participant Full Name: _____

A 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 procedures to take place:

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.

Signature: _____ Date: _____
NON-Consent Signature of Volunteer or Parent/Guardian

RISING HOPE WAIVER AND RELEASE

All Visitors, Participants, Volunteers (or Parent or guardian if under 21) **MUST SIGN THIS RELEASE WAIVING LEGAL RIGHTS AGAINST RISING HOPE THERAPEUTIC RIDING CENTER AND CYNTHIA LAMEY**. If you do not sign this release, you will not be permitted on the properties.

I, _____, a visitor to /participant of/volunteer in/the Rising Hope Therapeutic Riding Center equine assistance program (the "Program") or the parent or legal guardian of a visitor to /participant of/volunteer in/ the Program, am aware that all activities involving horses, including but not limited to riding, driving, grooming, leading, and/or any events involving horses, pose many inherent dangers, risks, and hazards. These include, but are not limited to, bodily injury and physical harm to riders, instructors, therapist, aides, groomers, leaders, handlers, side walkers, photographers, spectators and /or any other helpers. I freely and fully assume all dangers, risks, and hazards and the possibility of injury, death, property damage or other loss resulting from such dangers, risks, and hazards. I understand that I or my child or ward should not participate in the Program or visit the properties unless medically able. I agree to comply with Program rules and regulations, directions, instructions, and/or safety precautions given by Program employees, instructors, therapists, aides, and volunteers. My or my child's or ward's participation in the Program or visit to the properties is upon the express agreement and understanding that I have received, read, and understand the Waiver and Release.

In consideration of me or my child or ward's participation/volunteering in the Program or visit to the properties, I hereby, for myself and any participant for whom I am a parent or legal guardian release, discharge, hold harmless, and forever acquit Rising Hope Therapeutic Riding Center together with its officers, directors, agents, representatives, employees, instructors, therapists, aides, and volunteers, and Cynthia Lamey, in her individual capacity, and groom any and all actions, causes of action, losses, claims, or any liabilities whatsoever including but not limited to illness or injury known or unknown now existing or which may arise in the future, which may accrue to me, my heirs, my guardians, administrators, executors, or assignees, including attorney's fees and court costs, on account of or in any way related to or arising out my or my child or ward's participation in the Program or visit to the properties. Finally, assume all liability of any non-participants who accompany me.

I have had the opportunity to ask any questions that I may have and such questions have been answered to my satisfaction. I have read, understood and agree to the above. I understand and confirm that by signing this Waiver and Release that I have given up considerable future legal rights. My signature is proof of my intention to execute a complete and unconditional Waiver and Release of all liability to the full extent of the law.

Name (print): _____
Participant/Volunteer/Visitor's Signature

Signature: _____ Date: _____
Participant/Volunteer/Visitor's Signature

AGREEMENT AND CONSENT OF PARENT OR GUARDIAN OF MINOR

I, as the parent of guardian of the above visitor or participant, give my permission for my child or ward to participate in the Program or visit the properties. And further, in consideration of allowing my child or ward to participate in the Program or visit the property, I agree individually and on behalf of my child or ward to the terms of the above Waiver and Release.

Name (print): _____
Participant/Volunteer/Visitor's Signature

Signature: _____ Date: _____
Participant/Volunteer/Visitor's Signature

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