EQUINEABILITY THERAPEUTIC RIDING CENTRE

VOLUNTEER APPLICATION FORM

PERSONAL INFORMATION

DATE: _____
(YYYY, MM, DD)

NAME: _____
(LAST NAME) (FIRST NAME) (INITIAL)

AGE: Are you over the age of 18? YES ❑ NO ❑ If no, are you at least 14 years of Age? YES ❑ NO ❑

HOME ADDRESS: _____

CITY/PROVINCE: _____ POSTAL CODE: _____

PHONE (HOME): _____ CELL: _____ EMAIL: _____

TEMPORARY ADDRESS (IF A STUDENT AND APPLICABLE):

HOME ADDRESS: _____

CITY/PROVINCE: _____ POSTAL CODE: _____

PARENT(S) OR GUARDIAN(S) – (IF UNDER 18 YEARS OLD): _____

ADDRESS: _____

NAME OF SCHOOL: _____

FIELD OF EMPLOYMENT: _____

WORK TELEPHONE: _____

MAY WE CALL YOU AT THIS NUMBER? YES ❑ NO ❑ IF YES, WHAT ARE YOUR HOURS OF WORK? _____ TO _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE NUMBER: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE NUMBER: _____

BACKGROUND INFORMATION

DESCRIBE YOUR PREVIOUS VOLUNTEER EXPERIENCE: _____

_____

DESCRIBE YOUR EXPERIENCE WORKING WITH PEOPLE WITH DISABILITIES: _____

_____

BRIEFLY DESCRIBE YOUR EXPERIENCE WITH HORSES: _____

_____

DO YOU HAVE ANY PONY CLUB EXPERIENCE? YES ❑ NO ❑ IF YES, HIGHEST LEVEL ATTAINED:_____

DO YOU HAVE ANY COACHING EXPERIENCE? YES ❑ NO ❑ IF YES, PLEASE DESCRIBE: _____

_____

DO YOU HAVE AN EQUINE CANADA COACHING LEVEL? YES ❑ NO ❑ IF YES, HIGHEST LEVEL ATTAINED:_____

CERTIFICATES HELD (E.G. UNIVERSITY DEGREE, COLLEGE DIPLOMA, LIFEGUARD, FIRST AID/CPR, SIGN LANGUAGE ETC.)

_____

WHAT DO YOU HOPE TO GAIN FROM YOUR EXPERIENCE AT EQUINEABILITY THERAPEUTIC RIDING CENTRE?

_____

_____

WHAT QUALITIES DO YOU BRING TO THIS VOLUNTEER POSITION?

_____

_____

HOW DO YOU WISH TO VOLUNTEER YOUR TIME? (PLEASE CHECK ALL THAT APPLY)

THERAPEUTIC RIDING		
❑ Weekly Lessons	❑ Weekend Barn Chores	❑ Cleaning Tack

PUBLIC RELATIONS/FUNDRAISING		
❑ Golf Tournament	❑ Mall Displays	❑ Special Events

HOUSE AND HOME	
❑ Baking	❑ Food Preparation

TECHNICAL			
❑ Computers	❑ Photography	❑ Video Filming	❑ Office Support

PROPERTY MAINTENANCE			
❑ Painting	❑ Carpentry	❑ Yard Work	❑ Gardening

AVAILABILITY:

❑ MORNING ❑ AFTERNOON ❑ EVENING ❑ ALL ❑ SPECIFIC DAYS:_____

HOW DID YOU HEAR ABOUT EQUINEABILITY?

❑ Local Newspaper	❑ Leisure Guide	❑ Website	❑ Poster Ad
❑ Cable TV	❑ Radio	❑ Word of Mouth	❑
❑ Other			

REFERENCES:

Please give the name and daytime telephone number of two people who will be prepared to act as references for you. They should not be members of your family or close friends, but preferably someone you have worked for or who is a teacher/professor or other professional person.

Name:_____ Telephone: ( )_____ Relationship:_____

Name: _____ Telephone: ( )_____ Relationship: _____

I give the EquineAbility Therapeutic Riding Centre authorization to contact my references. If my application is accepted, I agree to abide by the policies and procedures in the Volunteer Training Manual and any other requirements that may be added.

_____ _____

Signature Date

If you have any questions or feel that you need more training in a particular area, please speak with the Volunteer Coordinator.

THANK YOU FOR APPLYING TO BECOME A VOLUNTEER WITH OUR PROGRAM

THIS SECTION FOR OFFICE USE ONLY

VOLUNTEER INTAKE CHECKLIST

❑ ORIENTATION	DATE COMPLETED
❑ RECEIVED VOLUNTEER MANUAL	DATE COMPLETED
❑ TRAINING CLINIC	DATE COMPLETED
❑ REFERENCE CHECK	DATE COMPLETED
❑ POLICE RECORD CHECK	DATE COMPLETED
NOTES:	

EQUINEABILITY THERAPEUTIC RIDING CENTRE

VOLUNTEER APPLICATION FORM

LIABILITY RELEASE

I,_____ would like to volunteer with the _____
(Volunteer's name) (Program's Name)
program. I acknowledge the risks, and potential for risk, of horseback riding and working around horses. However, I feel that the possible benefits to myself/my son/my daughter/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 _____, its
(Program's name)
Board of Directors, Instructors, Therapists, Aides, Volunteers and /or Employees for any and all injuries and /or losses I/my son/my daughter/my ward may sustain while participating as a volunteer in _____.
(Program's name)

Date: _____ Signature: _____
(Volunteer, parent or guardian)

Witness Signature: _____

PHOTO RELEASE

I hereby consent to and authorize the use and reproduction by _____
(Program's name)
of any and all photographs and/or any other audiovisual materials taken of me/my son/my daughter/my ward, for promotional printed material, educational activities, exhibitions, or for any other use for the benefit of the program.

Date: _____ Signature: _____
(Client, parent or guardian)