



# Maryland Therapeutic Riding, Inc. Volunteer Application

Date Entered \_\_\_\_\_  
Training Date \_\_\_\_\_

## Volunteer Information

Name: \_\_\_\_\_  
(Last Name) (First Name) (Middle Initial)

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Age:  14-17,  18-21,  22-29,  30-39,  40-49,  50-59,  60 and above

Date of Birth: \_\_\_\_\_

## Underage Volunteer

(Complete this section if the volunteer is 17 years old or younger.)

Parent/Guardian Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Employer/School: \_\_\_\_\_ Occupation: \_\_\_\_\_

Driver's License Number: \_\_\_\_\_ State: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

How did you hear about MTR? \_\_\_\_\_

Why do you wish to volunteer? \_\_\_\_\_

Do you have experience with horses?

No  Yes If yes, please describe: \_\_\_\_\_

Have you had any training or experience working with people with disabilities?

No  Yes If yes, please describe: \_\_\_\_\_

Do you have any physical limitations that should be considered when you volunteer?

No  Yes If yes, please describe: \_\_\_\_\_

Can you walk for 45 minutes and jog short distances?

No  Yes

Can you hold your arm above shoulder height and support a modest amount of weight?

No  Yes



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## *Volunteer Interests*

- Horse Leader       Side Walker       Stable Assistant  
 Committee Member (interests) \_\_\_\_\_  
 Administrative Support (interests) \_\_\_\_\_

List any special talents/skills/interest you would like to contribute to our program: \_\_\_\_\_

## *Volunteer Questionnaire*

Are you currently using any drugs?

- No     Yes If yes, please explain:

\_\_\_\_\_

Have you ever been convicted of a criminal offense?

- No     Yes If yes, please explain:

\_\_\_\_\_

Have you ever been charged with neglect, abuse or assault?

- No     Yes If yes, please explain:

\_\_\_\_\_

Has your driver's license ever been suspended or revoked in any state?

- No     Yes If yes, please explain:

\_\_\_\_\_

Have you ever had a background check/investigation?

- No     Yes If yes, by whom: \_\_\_\_\_ and what date: \_\_\_\_\_

## *Health Information*

Please describe any medical conditions you may have regarding the physical and/or emotional demands of working with equine assisted activities where volunteer responsibilities may include walking for extended periods of time, jogging short distances, working in hot/humid/cold conditions throughout the year, working with clients who may have mild to severe mental and/or physical issues, working with large animals.

\_\_\_\_\_

\_\_\_\_\_

Please list any allergies: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_



# Maryland Therapeutic Riding, Inc. Volunteer Application

## *Photo Release*

I consent to and authorize the use and reproduction by Maryland Therapeutic Riding, Inc. of any and all photographs and other audiovisual material taken of me for promotional printed materials, educational activities, exhibitions, or for any other use of the program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Volunteer or Parent/Guardian if the volunteer is 17 years old or younger.)

## OR *Non-Consent Photo Release*

I do not consent to and do not authorize the use and reproduction by Maryland Therapeutic Riding, Inc. of any and all photographs and other audiovisual material taken of me for promotional printed materials, educational activities, exhibitions, or for any other use of the program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Volunteer or Parent/Guardian if the volunteer is 17 years old or younger.)

## *Affirmation*

I understand that:

- 1) In the course of volunteering for MTR, I may be dealing with confidential information about MTR rider's medical information and I agree to keep said information in the strictest confidence.
- 2) The relationship between MTR and volunteers is an "at will" arrangement and it may be terminated at any time without cause by either the volunteer or MTR.
- 3) I grant MTR permission to use my likeness, voice and words in television, radio, film or in any form to promote activities of MTR.
- 4) I am responsible for informing MTR of ALL changes regarding information contained in this application and for updating all paperwork annually.
- 5) In case of medical emergency, the undersigned authorizes MTR to provide such medical assistance as they determine necessary.

I affirm that I have read and understand this application and that the information given is true and complete. I also understand that in the event false information is provided, I may be terminated from my volunteer position.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Volunteer or Parent/Guardian if the volunteer is 17 years old or younger.)



# Maryland Therapeutic Riding, Inc. Volunteer Application

## *Liability Information*

Name: \_\_\_\_\_  
(Last Name) (First Name) (Middle Initial)

**Maryland Therapeutic Riding, Inc. (MTR), its Officers, employees and agents will not be responsible for any damages to person, animal or property at the MTR riding center or its grounds. Nor will they be responsible for any property that is lost or destroyed. The undersigned volunteer/rider/parent/guardian hereby releases MTR, its officers, employees from damages, injuries, claims and damages whatsoever (including costs, expenses and attorney fees) that might result from damages, injuries or losses to person or property during, or in connection with, or arising out of any show, clinic, event or function whether or not such damages, injuries or losses result in direct or indirectly the negligent act or omission of such released parties.**

**WARNING: UNDER MARYLAND LAW, AN EQUINE PROFESSIONAL IS NOT LIABLE FOR ANY INJURY TO OR DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM INHERENT RISKS OF EQUINE ACTIVITIES.**

In exchange for the use of property leased by MTR and other valuable consideration, I agree that my use of the premises and any animals, facilities or equipment owned or leased by MTR is at my own risk. I further agree to indemnify and hold harmless MTR their respective officers, employees and agents from any and all suits, actions or claims of any type arising from my use of premises or participation in the equine activity of such use by my guest, whether or not such claims result directly or indirectly from the negligent act or omissions of the indemnified parties or otherwise.

I acknowledge that riding and involvement with horses is a high risk activity. I have read this agreement and fully understand its consent.

SIGNATURE: \_\_\_\_\_  
(Volunteer or Parent/Guardian if the volunteer is 17 years old or younger)

DATE: \_\_\_\_\_



**Maryland Therapeutic Riding, Inc.**  
P. O. Box 6477, Annapolis, MD 21401  
410-923-1187 (phone) 410-923-1432 (fax)  
[www.horsethatheal.org](http://www.horsethatheal.org)





# Maryland Therapeutic Riding, Inc. Volunteer Application

## Authorization for Emergency Medical Treatment Form

Participant    Staff    Volunteer

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Preferred Medical Facility: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

I am allergic to the following: \_\_\_\_\_

I am taking the current medications: \_\_\_\_\_

I have the following ongoing medical condition(s): \_\_\_\_\_

In the event of an emergency, contact:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

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 the staff of Maryland Therapeutic Riding, 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.

### **Consent Plan**

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(s) above is unable to be reached.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Volunteer or Parent/Guardian if the volunteer is 17 years old or younger)

### **OR 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 receiving services or while being on the property of the agency.

- 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 procedure to take place:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Volunteer or Parent/Guardian if the volunteer is 17 years old or younger)