



Maryland Therapeutic Riding, Inc.
Volunteer Application
Update

Volunteer Information

Name: _____
(Last Name) (First Name) (Middle Initial)

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

Age: 13 and below, 14-17, 18-21, 22-29, 30-39, 40-49, 50-59, 60 and above

Emergency Information

Volunteer's Name: _____ Date of Birth: _____

Home Address: _____

Phone Number: _____ Alternate Number: _____

Physician's Name: _____ Physician's Phone: _____

Preferred _____ Medical _____ Facility: _____

Insurance Company: _____ Policy Number: _____

Describe any medical condition requiring special precautions or treatment and any medications and dosages: _____

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.)

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.)

