CHASTAIN HORSE PARK

Healing through Horses

CHP VOLUNTEER FORMS

Name: _____ Date of Birth: _____Gender: _____Height: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Contact Phone Number(s) in order of preference: (please designate m=mobile, h=home, w=work)

Phone 1: ( )_____ Phone 2: ( )_____ Phone 3: ( )_____

Email: _____ How many years have you been a volunteer for CHP? _____

What is the best way for us to get in touch with you? _____

Parent/Guardian Name (if under 18 years of age): _____

Best Contact Method for Parent/Guardian: _____

How did you learn about CHP?
□ Board Member □ CHP Volunteer □ Client □ Staff □Friend □Relative
□ Media, if so which: _____ □ National Charity League □ Jr. League Atlanta
□ Web search, which one: _____ □ Other: _____

Reason for volunteering:
□Personal Fulfillment □School/Org. Requirement □Court required community service □Other:_____

Have you been trained as a Side Walker or Horse Leader in the past by CHP or another PATH Intl. Premiere Accredited Center?
If so, which center and which role?_____

POTENTIAL AVAILABILITY: _____
(Example: Tuesday and Thursdays from 8AM-3PM)
May we add you to our volunteer substitute list? No Yes for ☐weekday mornings ☐ w/d afternoons ☐ w/d evenings ☐ weekend mornings ☐ w/e afternoon

Mark your interests as a volunteer:
□ Administration (assist with filing, mailings, publications, and office work)
□ Facility Maintenance (tidy barn, carpentry work, and help with outdoor jobs)
□ Lesson Horse-leader (horse handling)
□ Lesson Side-Walker (assist the rider during the lesson)
□ Special Events (help with horseshows, fundraisers, or other events)
□ Other: _____

Are you certified in CPR? Yes No Are you certified in First Aid? Yes No

Race or Ethnicity *(not mandatory question; use info for grant writing)*: ☐Asian ☐American Indian ☐Black/African American ☐Caucasian ☐Latino/Hispanic ☐Pacific Islander ☐Other:_____ ☐ Choose not to answer

Most recent employment or school? _____
OR
Occupation: _____
My employer gives time off for volunteering ☐ My employer matches has a matching gift program ☐

Do you possess any special skills that would benefit CHP? Ex. Farrier, photographer, fundraiser, computer expert, social media, languages, grant writing?

_____

_____

Please tell us about your experience with horses: _____

_____

_____

Please tell us about your experience with disabilities: _____

_____

_____

Are there any physical or medical issues that may impede your ability to perform the essential functions of a volunteer, with or without a reasonable accommodation? Examples may include allergies, a knee replacement that restricts your ability to run along with a trotting horse, or a sore shoulder that inhibits your range of motion. By sharing this information, you allow the Volunteer Coordinator to place you in a class that suits your needs and the safety needs of the rider.

_____

_____

Volunteer Confidentiality Statement

Volunteers are a valuable part of Chastain Horse Park (CHP). This document confirms that I am recognized as a volunteer of CHP, which exists to provide quality recreation and therapy services, in a safe environment. This document is in compliance with the provisions of the volunteer immunity law.

As a volunteer of CHP, I have completed available and appropriate training. I understand and agree that in the performance of my duties as a volunteer, I must hold personal and medical information regarding riders/families confidential. Clients' issues may be discussed with the CHP Volunteer Coordinator, Director, Staff, Instructors, and/or the Physical or Occupational Therapist directly associated with the CHP volunteer support meetings.

I understand that all information (written and/or verbal) about participants at this center is confidential and will not be shared with anyone outside the center. I will endeavor to keep my standards of conduct high in order to uphold the quality of the CHP program.

Signature: _____ Date: _____

(If under 18yrs old, parent or legal guardian must sign)

Volunteer Liability Release

As a volunteer for CHP, I acknowledge the risks and potential for risks of at an Equine Assisted Activities & Therapies Program. However, I believe that possible benefits to the clients I work with and myself are greater than the risks 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 CHP, its Board of Directors, Executive Director, Instructors, Therapists, Volunteers and/or Employee for any and all injuries and/or losses I may sustain while participating with CHP.

WARNING: Under Georgia law, an equine activity sponsor or equine professional is not liable for an injury or the death of a participant in equine activities resulting from the inherent risks of equine activities, pursuant to Chapter 12 of Title 4 of the Official Code of Georgia Annotated.

Signature: _____ Date: _____

(If under 18yrs old, parent or legal guardian must sign)

CHP & PATH Intl. Photograph, Film, Media, & Publicity Release

□ I DO Consent to and authorize the use and reproduction by CHP of any and all photographs and any other audio/visual materials taken of me for promotional material, Facebook, educational activities, exhibitions, or for any other use for the benefit of the program.

Signature: _____ Date: _____

(If under 18yrs old, parent or legal guardian must sign)

PHOTO IDENTIFICATION
Please submit a copy of your **driver's license or other photo ID**
If not submitted please indicate the reason: _____

Background Information
Have you ever been convicted of a criminal offense or have a conviction pending, including any misdemeanors? (Do not include convictions that are sealed, eradicated or expunged, or convictions that resulted in referral to a diversion program).
NOTE: Convictions may not necessarily disqualify a prospective candidate. Yes No
If Yes, please explain: _____
_____
Are there any criminal charges currently pending against you? If Yes, please explain: _____
_____

I, _____ (name), authorize CHP to receive information from any law enforcement agency, including police departments and sheriff's departments, of this state 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 or animals. I understand that such access is for the purpose of considering my application as a volunteer, and I expressly DO NOT authorize the PATH center, its directors, officers, employees, or other volunteers to disseminate this information in any way to any other individual, group, agency, organization, or corporation.
Signature: _____ Date: _____
(If under 18yrs old, parent or legal guardian must sign)

Volunteer Code of Conduct
By signing this agreement, I, _____*(Please print volunteer's name)* agree to the following:

- I understand that the goal of volunteering is to engage and educate the public, and my attitudes and actions should always further that goal.
- I agree to work my entire volunteer shift as scheduled, to conduct myself in an appropriate manner, to dress in attire that follows the volunteer dress code, to follow safety procedures, and to be prepared for my shift.
- I understand that if I cannot make a volunteer shift (or any part of a shift), it is important to notify the Volunteer Coordinator ahead of time by emailing volunteer@chastainhorsepark.org AND calling the supervising instructor of that session directly.
- During my scheduled volunteer shift, I agree to follow directions given by staff, and understand that while I am at the riding center my focus should be on the client/horse/duties assigned to me.
- I understand that I am responsible for reviewing all materials given to me at orientation and trainings.
- I know that I represent CHP, and I promise not to engage in any activity that may cause harm to the organization, others or me.
- I understand that failing to observe the above pledges will result in further action and can result in my dismissal from the volunteer program.

Signature: _____ Date: _____
(If under 18yrs old, parent or legal guardian must sign)

Authorization for Emergency Medical Treatment

I, _____("volunteer" if over 18 years of age and fully competent to sign this Emergency Medical Treatment Form, which I have read and understand. If under age, "Volunteer" has obtained the signature of his/her parent/guardian, who, by such signature, represents he/she has read and understands this form.)

PLEASE CHOOSE ONE—do or do not

□ I **DO** give my consent and authorization in the event emergency medical aid/treatment (including x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician) is required due to illness or injury while being on the property of the agency. In case of medical emergency or necessity, CHP is authorized to seek or provide for "Volunteer" such medical assistance as may be necessary, "Volunteer" further authorizes CHP to secure and retain medical treatment and transportation if needed, to seek the assistance of any physician or medical facility to provide any medical/surgical care, including, but not limited to, hospitalization, with such treatment to include anesthesia as necessary or advisable, that the physician or medical facility deems or determines to be necessary or advisable, pending receipt by the physician or medical facility of any other consent to treatment from or on behalf of "Volunteer". The undersigned hereby agrees to pay all fees and expenses of doctors, hospitals, ambulances and other medical expenses reasonably and necessarily incurred.

□ I **DO NOT** give my consent for emergency medical treatment/aid in the case of illness or injury while being on the property of CHP. In the event emergency treatment/aid is required, I wish the following procedure to take place:

_____

_____

"Volunteer" understands that NO LIABILITY can be accepted by any of the organizations concerned, including CHP, in the event such accident may occur. In the event any provision of this form is determined to be unenforceable, all other provisions should remain in full force and effect.

IN THE EVENT OF AN EMERGENCY, please contact:

1. Name: _____ Relation: _____ Phone: _____
2. .Name: _____ Relation: _____ Phone: _____

Please indicate any allergies: _____
Current medications: _____
Preferred medical facility: _____ Preferred Provider: _____
Health Insurance Carrier: _____ Policy Number: _____

Signature: _____ Date: _____
(If under 18yrs old, parent or legal guardian must sign)
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