



'Harnessing the magic of horses
to change lives'

Volunteer Application

First Name: _____ Last Name: _____ Date: _____

Pronouns: _____

Address: _____

Email: _____ Phone: _____ DOB: _____

Occupation: _____

Best way to contact (circle one please): Phone Text Email

IF UNDER 18 YEARS OLD:

Name of parents/guardian emergency contact: _____

Relationship: _____ Contact Number _____

Questionnaire:

1. Height (circle one. This is needed to help match volunteers with horses and participants):

under 5'4"

5'4" to 5'7"

5'7" or above

2. How much time are you wanting to volunteer? (circle one)

2-4 hours a week

6-8 hours a week

other (specify) _____

3. Days you are available (circle all that apply)

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday



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4. Shifts you're interested in (circle all that apply)

Mornings

Mid-day

Evenings

5. What type of volunteering are you interested in? (circle all that apply)

SIDEWALKER
(Working with riders)

HORSE/BARN CARE
(Feeding/Stall Cleaning)

Special Projects
(Events,Fundraising)

Greeter

Board Committees

Other (specify)

***No prior experience is necessary, but please fill in the sections that apply to you: ***

Your experience with horses:

Your experience with people with special needs:

Are you First Aid/CPR Certified? (circle one) Yes No

Are you willing to have a criminal background check performed? (circle one) Yes No

Why do you want to volunteer?:



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How did you hear about us? (Circle all that applies)

Facebook Group
(Please specify below)

Instagram

Word of mouth
(Please specify below)

Poster/Flyer
(Where?)

Outreach Events

Others (please specify)

Specifications: _____

Print name and Signatures:

Participant Name: _____

Parent/guardian name, if under 18: _____

Participant/guardian Signature: _____ Date: _____



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Emergency Medical & Treatment Authorization

In the event that emergency medical and/or treatment is required, the undersigned authorizes Horses Adaptive Riding and Therapy to secure and retain medical treatment and transportation:

Name: _____ Phone: _____

Address: _____

Physicians Name: _____

Physicians Phone and City: _____

Health History:

Allergies (please list): _____

Medications (please list): _____

Consent Plan:

The authorization includes medication, x-rays, surgery, hospitalization, and any treatment procedure considered "life threatening" by the attending physician. This provision will only be invoked if the person listed below is unable to be reached.

Emergency Contact: _____

Relationship: _____ Cell phone: _____

Home phone: _____ Work phone: _____

Participant Name: _____

Parent/guardian name, if under 18: _____

Participant/guardian Signature: _____ Date: _____

Non-Consent Plan:

I do not give my consent for emergency medical treatment in the case of an injury or illness. In the event that emergency treatment is required, I wish the following procedures to take place:

Participant Name: _____

Parent/guardian name, if under 18: _____

Participant/guardian Signature: _____ Date: _____



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Assumption of Risk and Release of Liability

On behalf of myself, _____, and/or a minor child, I recognize that horseback riding is an inherently dangerous activity that can result in injury or death.

I hereby assume all risk in connection with being on or around the horses at Horses Adaptive Riding and Therapy's (HART's) activity sites, and agree to release, defend, hold harmless and indemnify HART, its officers, directors, employees, staff and agents, licensees and invitees from all claims, damages, liabilities of judgment (including costs and expenses incurred in connection therewith) arising from injury, death, or damages to any person or property whatsoever arising out of or in connection with me or my minor child's use and occupancy of the premises and its facilities, whether or not the death, injury or damage is caused in whole or in part, by the act, neglect, fault of, or omission of any duty by me or my minor child.

Under Oregon Law, ORS 30.687 to 30.397, an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities.

Participant Name: _____

Parent/guardian name, if under 18: _____

Participant/guardian Signature: _____ Date: _____



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Photo Release

- ☐ I DO
- ☐ I DON'T give my permission for Horses Adaptive Riding and Therapy (HART) to use my/my child's name and share details of my/his/her sessions and experiences as a client in communications produced by or on behalf of HART, and consent to take and make use of my/my child's audio/video/photographic images in publications produced by or on behalf of HART. This permission extends both to electronic versions on the HART websites and other internet/electronic applications as well as printed, filmed and taped versions.

Initial: _____

I am not required to sign this authorization. HART does not condition treatment, payment, benefit eligibility, or enrollment activities on the signing of this form.

Initial: _____

I can request a copy of this authorization be mailed to me. I understand that I will not be entitled to any payment or other form of remuneration as a result of any use of any information and audio/video/photographic material. If I decide to sign this form, I have the right to request that audio/video recording/photographing cease at any time.

Initial: _____

Participant Name: _____

Parent/guardian name, if under 18: _____

Participant/guardian Signature: _____ Date: _____