Dear Prospective Volunteer,

Thank you so much for your interest in our Rein-Bow Riding Academy Program. We could not offer this program without our dedicated volunteers! Every individual who rides relies on three volunteers to assist him/her.

Horse experience is not necessary to volunteer for this program. You will be provided with training about how to safely and effectively help our riders and staff. Volunteers must be at least 14 years old to provide hands on support to our riders.

The first step is becoming a volunteer is to complete and return the volunteer application packet. Please see the instructions on the last page of the application that will explain exactly what information must be submitted. Once your application has been received and processed, we will contact you to schedule orientation and training.

Please contact Therapy and Learning Center below if you have questions.

Thanks again for your interest and we look forward to seeing you at the Barn!!

Mailing Address:
Therapy & Learning Center
34 Garland Dr.
Jackson, TN 38305
Phone: (731) 668-3322
Fax: (731) 664-2941

Barn Address:
James K. Taylor Memorial Arena
(Stanfills' Barn)
150 Frays Lane
Huron, TN 38345

VOLUNTEER APPLICATION

Name: ____ Age: ____________________

Date of Birth: ______________________________ Social Security: ___________________________________

Address: ____ City: ________________ State: _____ Zip_________

Phone: ____ Cell: _______________________________________

Work: _______________________________________ Email Address: __________________________________

How can we reach you? ___Home phone ___Cell phone ___Text ___Email ___Work phone

Employer/School: ____

Within the past seven years, have you either (1) been convicted by any court, including court of military justice, of a felony or (2) been released from prison following conviction of a felony? (For purposes of this application, consider felonies to include any crime which is punishable by imprisonment or execution.)

☐ No ☐ Yes If "yes," state date, place, and nature of each conviction: _________________________________

____

Personal References (other than relatives):

Name Address Phone

1.____

2.____

3.____

Additional Information:

Have you volunteered for Rein-Bow Riding Academy in the past? ☐ No ☐ Yes (when? ______________________)

Can you walk for 60 minutes and jog short distances? ☐ Yes ☐ No

Do you have any physical limitations that we should be aware of? If so, please explain: ________________________

____

Please tell us why you are interested in becoming a volunteer: ____

Adult Volunteers (Ages 18+):

I hereby certify that all answers given by me on this application are true to the best of my knowledge. I authorize West Tennessee Healthcare, Inc, to contact references whom I have listed on the application for the purpose of obtaining information about me. I also authorize West Tennessee Healthcare, Inc. to check my criminal record for the purpose of investigating any past convictions that could prohibit certain areas of volunteer assignment. I release West Tennessee Healthcare, Inc. from any liability based upon such.

Printed Name____

Signature____ Date__________________

Junior Volunteers (Ages 14-17) - Parent/Guardian's Consent (MANDATORY):

Permission to Participate in Volunteer Program

☐ My son/daughter **may** participate in the Rein-Bow Riding Academy volunteer program.
☐ My son/daughter **may not** participate in the Rein-Bow Riding Academy volunteer program.

Confidentiality of Patients

My son/daughter understands that clients served by the Therapy & Learning Center are entitled to privacy. My son/daughter understands that he/she may recognize some clients but the fact that they are participating in services should not be discussed with anyone. We, myself as well as my son/daughter, understand that we may be held personally liable and can be fined if a client's confidentiality is violated.

Waiver and Release

I recognize that my son's/daughter's participation in the Rein-Bow Riding Academy volunteer program may expose my son/daughter to risks associated with physical activity and other matters, which risks include, but are not limited to, serious personal injury. I and my son/daughter hereby voluntarily assume all risks of loss, damage, or personal injury that may be sustained by my son/daughter during his/her participation in the program. I (for myself, my heirs, executors, and personal representatives) agree to release, discharge, and hold harmless and indemnify the Rein-Bow Riding Academy, Therapy & Learning Center, and Jackson-Madison County General Hospital and its employees and agents from and against any and all liability, claims or demands arising out of or related to any loss, damage, or injury that my son/daughter may sustain that occurs as a result of or that relates to his/her participation in the program.

Photo Release

I understand that participating in this program may result in a possibility that my child will be photographed during their time as a volunteer. I grant permission to photograph my son/daughter.

I/we authorize my child, a minor, to participate in such volunteer activities at the Therapy & Learning Center's Rein-Bow Riding Academy program as may be prescribed. I/we understand the child's services are donated to the agency without contemplation of compensation or future employment. I/we acknowledge the child's date of birth is accurate.

Volunteer's Printed Name____

Volunteer's Signature____ Date____________________

Parent Signature____ Date____________________

EQUINE WARNING

Attention: Volunteers and Staff

The staff of the Therapy & Learning Center each strives to provide a safe environment for clients to receive the highest quality therapy and therapeutic riding. Unfortunately, there is always some risk when working with horses as their behavior is not completely predictable. Horses selected for use in the Rein-Bow Riding Academy Program are chosen for their gentle demeanor. Each horse is monitored closely during sessions by staff and the horse leader, either of whom should be able to control the horse and minimize incidents in the event of an emergency.

The utmost safety precautions will be taken during each riding session to protect volunteers, clients, and staff. However, the following warning must be presented to all those involved with the program.

WARNING

Under Tennessee law, and equine professional is not liable for an injury or death of a participant in equine activities resulting from the inherent risks of equine activities, pursuant to Tennessee Code Annotate, Title 44, Chapter 20, Section 1.

I have read the aforementioned *Warning*. I understand that I will participate in the Rein-Bow Riding Academy program at my own risk.

Printed name____

Signature____ **Date**____________________

Parent Signature____ **Date**____________________

(Required if Volunteer is under 18 years of age)

CONSENT TO PHOTOGRAPH

I, ____, hereby grant and assign to Jackson-Madison County General Hospital District and/or West Tennessee Healthcare a non-exclusive, royalty-free license to use any and all photographs, videotapes, digital images, and audio recordings taken of me and/or my child by or for representatives of the system. I understand and agree that this material may be used in one or all of the following:

Radio / Television Broadcasts

Newspaper / Magazine Articles

Print Materials / Advertisements

Website / Internet

Reinbow Riding Academy Facebook Page

This consent will not expire until such time as the District and/or WTH no longer desires to use or disclose the information described above for the general purposes for which this consent was obtained. You may revoke this consent, and if you wish to do so, you may send a letter to the Privacy Coordinator, West Tennessee Healthcare, 620 Skyline Drive, Jackson, TN 38301.

Signature: ____ Date: ___________________________

Address: ____

Phone Number: ____

Witness: ____

AUTHORIZATION FOR MEDICAL TREATMENT

Name: ____ DOB: _____________ Phone: _________________

Address: ____

Physician's Name: __________________________________ Preferred Medical Facility: _____________________

Health Insurance Company: __________________________ Policy #:___________________________________

Allergies to medications: ____

Current medications: ____

In the event of emergency contact:

Name: ___________________________________ Relation: ___________________ Phone: __________________

Name: ___________________________________ Relation: ___________________ Phone: __________________

Name: ___________________________________ Relation: ___________________ Phone: __________________

Consent Plan
In the event that 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 Rein-Bow Riding Academy to:

1. Administer emergency treatment.
2. Secure and retain medical treatment and transportation, if needed.
3. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

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.

Date:_____________ Consent Signature:____
Client, Parent or Legal Guardian

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 will the following to take place:

____

____

____

Date:_____________ Non-Consent Signature:____
Client, Parent or Legal Guardian

BACKGROUND CHECK AUTHORIZATION (REQUIRED FOR VOLUNTEERS AGE 18 & OLDER ONLY)

I, the undersigned consumer, do hereby authorize West Tennessee Healthcare, by and through its independent contractor, **Verified Credentials**, to procure a consumer report and/or investigative consumer report on me.

These above-mentioned reports may include, but are not limited to, employment and education verification; personal references; personal interviews; my personal credit history based on reports from any credit bureau; my driving history, including any traffic citations; a social security number verification; present and former addresses; criminal and civil history/records; any other public record.

I understand that I am entitled to a complete and accurate disclosure of the nature and scope of the investigative consumer report prepared on me upon my written request to **Verified Credentials** that is made within a reasonable time after the date hereof. I also understand that I may receive a written summary of my rights under 15 U.S.C. 1681 et.seq.

I further authorize any person, business entity or governmental agency who may have information relevant to the above to disclose the same to West Tennessee Healthcare through **Verified Credentials**, including, but not limited to, any courthouse, any public agency, any and all law enforcement agencies and any and all credit bureaus, regardless of whether such person, business entity or governmental agency compiled the information itself or received it from other sources.

I hereby release West Tennessee Healthcare, **Verified Credentials** and any and all persons, business entities and governmental agencies, whether public or private, from any and all liability, claims and/or demands, of whatever kind, to me, my heirs, or others making such claim or demand on my behalf, for procuring, selling, providing, brokering and/or assisting with the compilation or preparation of the consumer report and/or investigative consumer report hereby authorized.

Signature: ____

Printed Name: ____ Date: ________________
First Middle Last

Other Names You Have Used: ____

7 years of residence

Current Address:

____
Street/PO Box City State Zip Code County How Long

Former Address:

____
Street/PO Box City State Zip Code County How Long

Former Address:

____
Street/PO Box City State Zip Code County How Long

Social Security Number: ______________________ **Daytime Phone Number**: ________________

Driver's License Number: ____________________ **State of Issuance**: _________

Date of Birth*: ____________________ Gender*: __ Male __ Female

***Without this information, we will be unable to properly identify you in the event we find adverse information during the course of our background search.**

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (MARKETING/PUBLIC RELATIONS)

NAME: **ADDRESS:** **TELEPHONE:**	**Date of Birth:**	**SS No. (optional)**
	RELEASE PROTECTED HEALTH INFORMATION TO: **JACKSON-MADISON COUNTY GENERAL HOSPITAL DISTRICT; THERAPY & LEARNING CENTER**	

INFORMATION BEING RELEASED BY: N/A

Purpose of Disclosure: ☐ At the Request of the Individual Identified Above
☒ Media, Public Relations, Marketing, Advertising, Posting, or Radio or Television Broadcasting
☒ Other, Please Explain: Reinbow Riding Academy Facebook page

Description of Information to be Used or Disclosed: __xx___ Photographs/Video of me and/or my child
____Other (specify):

I understand that:

1. I may revoke this authorization in writing at any time, but if I do so, it will not have any effect on any actions taken by the facility releasing the information (hereafter referred to as "the facility") prior to the facility's receiving the revocation. Further details regarding the manner in which this authorization may be revoked may be found in the facility's Notice of Privacy Practices.
2. This authorization allows the facility to release the above requested documents. The released information may no longer be protected by federal privacy regulations and may be redisclosed.
3. The facility is hereby released from any liability and the undersigned will hold the facility harmless for complying with this authorization.
4. The facility will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization, except for research related purposes and as otherwise permitted under applicable law.
5. The authorization will expire in five (5) years unless I provide an alternate expiration date or event.
6. If the facility will use or disclose my protected health information for marketing purposes, the facility will not receive remuneration or compensation for such use or disclosure for marketing purposes unless the WTH Privacy Coordinator completes and signs the following statement:

I, __________________________________ (signature of WTH Privacy Coordinator) hereby certify that the facility will receive remuneration or compensation for the use or disclosure of this patient's protected health information from _______________________________ (fill in source of remuneration or compensation).

I have read and understood this authorization. I hereby authorize the use and disclosure of the above-requested protected health information.

_______________________________ **Signature**

_______________________________ **Signature of Authorized Representative**

_______________ **Date**

_______________________________ **Description of Representative's Authority to Act for Individual**

1. **Volunteer Training Acknowledgement**

I acknowledge that I have attended on-site volunteer training at the riding arena.

2. **Code of Conduct Acknowledgement**

West Tennessee Healthcare has always been committed to conducting activities with integrity and in accordance with state and federal laws, rules, and regulations. The Code of Conduct serves as a guide for carrying out our daily activities within appropriate ethical and legal standards.

- I have received a copy of the Code of Conduct Policy.
- I have either read or had the Code of Conduct Policy explained to me.
- I understand and agree to comply with the policy.

3. **Confidentiality Acknowledgement**

West Tennessee Healthcare is dedicated to protecting the confidentiality of its patients and maintaining a high level of security to all who have access to WTH Information Systems. It is your responsibility as an employee, student, volunteer, or other position with West Tennessee Healthcare to continue this standard. By signing this form, you acknowledge the following:

- I have received a copy of Policy No. 7577 – Patient and System Confidentiality.
- I have read or had the Patient and System Confidentiality policy explained to me.
- I understand and agree to comply with the policy.
- I understand if I fail to adhere to these policies, I may be subject to disciplinary action up to and including termination depending upon the nature of the offense, as determined by management.

4. **Volunteer Handbook Acknowledgement**

The Rein-Bow Riding Academy Volunteer Handbook serves as a guide for carrying out volunteer tasks.

- I have received a copy of the Volunteer Handbook.
- I have either read or had the Handbook explained to me.
- I understand and agree to comply with the information contained therein.

Printed Name: ____ Date: _______________________

Signature: ____

The program is held at the James K. Taylor Memorial Arena located at 150 Frays Lane, Huron, TN.

Directions to the Arena

From the west:
Take I-40 East to Exit 93 (Law Rd).
Turn right at the exit ramp onto Law Rd.
Turn left onto US-412 East toward Lexington.
After approximately 5.5 miles, turn right onto Crucifer Rd. (toward Westover Elementary School)
Travel approximately 1.7 miles; you will pass a retirement home on your right just before Frays Lane.
Turn right onto Frays Lane. The Arena is immediately to your right.

From the east:
Take US-412 West toward Jackson.
Turn left onto Crucifer Rd. (toward Westover Elementary School)
Travel approximately 1.7 miles; you will pass a retirement home on your right just before Frays Lane.
Turn right onto Frays Lane. The Arena is immediately to your right.

Parking:
Riders - Park in the area just outside the barn. Follow the gravel road to the barn entrance.
Volunteers - Park in the gravel lot at the bottom of the hill (by fenced area) or along Frays Lane

** If you get lost, call Therapy and Learning Center for assistance 731-343-8944**