



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

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

