Volunteer Application *Capital Area Therapeutic Riding Association, Inc.*

PO Box 339, Grantville, PA 17028 717-469-7517, fax 717-469-0095 www.catra.net

Name _____ Date of Birth _____ Date _____

Address _____

City _____ County _____ Zip _____

Phone1 _____ Phone2 _____ Phone3 _____

Email (PRINT)_____ ❑ Please include me on the CATRA email list

❑ Employer or ❑ School District _____

Address _____

Does your employer match funds or support volunteerism in any way? _____

How did you hear about CATRA? _____

❑ Additional family member(s) in my home will also be volunteering at CATRA **[List names & ages ABOVE]**

❑ I will be volunteering with a group, which is _____

❑ A case-manager or aid will be accompanying me/us. Name _____

Organization _____ Phone _____

❑ I am volunteering at CATRA to fulfill a community service requirement for

❑ School ❑ Church ❑ Court ❑ Other _____

Hours required _____ Due date _____ Reason _____

CATRA staff is 100 % volunteer.. Our volunteers assist wherever there is work to be done. We would like to know the tasks which you would like to do and for which you are qualified.

❑ Horse Leading	❑ Small Animal Feed, Water, Brush	❑ Photography/Video Taping
❑ Side Walking	❑ Small Animal Enclosure Cleaning	❑ Fund Raising
❑ Tacking up and Simple Grooming	❑ Gardening	❑ Special Events Organization
❑ Barn and Stall Cleaning	❑ Telephone Contacting	❑ Volunteer Coordination
❑ Horse Feeding and Watering	❑ Art Work	❑ Volunteer Recruitment

Please list any medical considerations that might limit your volunteer activities _____

_____

Have you ever owned a horse? (if yes, please include when, how long, type of riding, breed, etc)

_____

My horse skills are ❑ None ❑ Walk ❑ Trot ❑ Canter/Lope ❑ Jump

I have been involved in ❑ Huntseat ❑ Jumping ❑ Dressage ❑ Western Pleasure ❑ Driving ❑ Trail Riding

❑ other _____

My previous experience with a therapeutic riding program _____

Prior experience working with people with disabilities _____

Are you currently certified in ☐ First Aid ☐ CPR

Interests/Hobbies _____

I ☐ **can** ☐ **cannot** walk and jog (mostly walk)next to a horse for up to ½ hour at a time. I understand that no liability can be accepted by any organizations or individuals concerned with this instruction, including the New Day Equestrian Center, in the event of any accident occurring.

Volunteer Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Parent Name (please PRINT) _____

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Liability Release

_____ would like to participate in the Capital Area Therapeutic Riding Association as a volunteer. I acknowledge the risks and potential of risks of such a program. However, I feel that the possible benefits to myself/my son/my daughter/ my ward are greater than the risk assumed. I hereby intend to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Capital Area Therapeutic Riding Association, its Board of Directors, Instructors, Therapists, Aides, Volunteers, and/or employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating as a volunteer in the Capital Area Therapeutic Riding Association.

Signature _____ Date _____
(volunteer, parent or guardian)

Photo release (optional)

I hereby consent to and authorize the use and reproduction by Capital Area Therapeutic Riding Association of any and all photographs and any other audio/visual materials taken of me/my son/my daughter/ my ward for promotional material including printed materials, websites, social media sites, educational activities, exhibitions or for any use for the benefit of the program.

Signature _____ Date _____
(volunteer, parent or guardian)

Authorization for Emergency Medical Treatment

Volunteer Name: _____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, volunteering or while being on the property of **Capital Area Therapeutic Riding Association**, I, the signature volunteer, or guardian of said volunteer, authorize the Capital Area Therapeutic Riding Association to:

1. Secure and retain medical transportation and medical/dental treatment if needed. This authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedure deemed life "life-saving" by the physician. This provision will only be invoked if the contact below is unable to be reached
2. Release client record upon request to the authorized individual or agency involved in the medical emergency treatment.

Every effort will be made to notify significant other/parents/guardians immediately in case of emergency.

EMERGENCY CONTACT
Name_____ Relationship _____
Home Ph._____ Work Ph._____ Cell Ph._____

ANY KNOWN ALLERGIES OR MEDICAL CONDITIONS:

_____

MEDICAL INSURANCE INFORMATION

Name of Company_____ Phone_____
Name of Member_____
Policy #_____Group Number_____

I agree to be responsible for the cost of such emergency medical care.

Signature of adult volunteer: _____ Date: _____

Signature of Parent/Guardian:_____ Date: _____