



Medicine Horse Program

...dedicated to improving the quality of life
for adolescents, families, and adults.

8778 Arapahoe Road
Boulder, CO 80303
720•406•7630

volunteercoordinator@medicinehorse.org

VOLUNTEER APPLICATION

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Email _____ Cell Phone _____

Birthdate (month/day) _____

Occupation _____ Employer _____

School/College Name _____ Year in School _____

How did you hear about Medicine Horse Program?

Why do you want to volunteer with Medicine Horse Program?

HORSE EXPERIENCE – not necessary for all activities:

- Little or None (Level 1: Comfortable around horses)
- Some (Level 2: Able to go into pasture alone to catch, halter, lead horse, open and close gates properly, and tie horse up with quick release knot)
- Considerable (Level 3: Very knowledgeable about horse behavior and safety issues, able to predict how a horse will react to environment, able to keep boundaries, etc.)

Please briefly describe your experience:

TRAINING, and/or experience in the treatment of people with emotional, behavioral, social, mental, physical, and/or spiritual needs (also not necessary for all activities):

Little or None Some Considerable

Please briefly describe:

VOLUNTEER ACTIVITIES - please check all areas of interest:

✓	Activity
<input type="checkbox"/>	Classes: horse safety
<input type="checkbox"/>	Community outreach
<input type="checkbox"/>	Corporate sponsorship
<input type="checkbox"/>	Facilities / Construction
<input type="checkbox"/>	Fundraising
<input type="checkbox"/>	Gardening/groundskeeping

✓	Activity
<input type="checkbox"/>	Grooming
<input type="checkbox"/>	Grant writing
<input type="checkbox"/>	Mucking
<input type="checkbox"/>	Marketing
<input type="checkbox"/>	Feeding
<input type="checkbox"/>	Accounting/bookkeeping

✓	Activity
<input type="checkbox"/>	Office work
<input type="checkbox"/>	Public relations
<input type="checkbox"/>	Tack cleaning
<input type="checkbox"/>	Volunteer committee
<input type="checkbox"/>	Web site
<input type="checkbox"/>	Database development

Other areas of expertise you could share, or areas of interest:

Please indicate days and times you are available:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

Do you have any health issues or physical limitations of which we should be aware? Yes No

If yes, please briefly describe, such as allergies (including insect bites or bee stings), asthma, medical issues, etc.

Have you had a tetanus shot in the last 10 years? Yes No

REFERENCES:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Have you ever been convicted of a felony? Yes No

If yes, please briefly describe:

PHOTO RELEASE (optional)

I hereby consent to and authorize the use and reproduction by the Medicine Horse Program of any and all photographs and other audiovisual material taken of me for promotional printed materials, educational activities, exhibitions, or for any other use for the benefit of the program.

Volunteer's signature: _____ Date _____

Signature of parent/guardian if volunteer is under 18: _____

LIABILITY RELEASE

Under Colorado Law, 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, pursuant to section 13-21-119, Colorado Revised Statutes. Medicine Horse Program (MHP) seeks and strives for safety at all times. However, I understand that there are certain risks inherent in equine related activities. I acknowledge that all activities involving horses (including but not limited to: horseback riding, handling, leading, groundwork and other contact) involve this degree of risk.

I, (print name) _____ would like to volunteer at the Medicine Horse Program. I acknowledge the risks in working with and around horses. However, I feel that the benefits of the program to all associated with it are greater than the risks assumed. I hereby, intending to be legally bound, for myself, my heirs, assigns, executors and/or administrators, waive and release forever all claims for damages against the Medicine Horse Program, its Board of Directors, Instructors, Therapists, Aides, other volunteers, and/or employees for any and all injuries and/or losses I may sustain while participating in the program. I further acknowledge that I am not covered under Medicine Horse Program's insurance policy. I have read and understand this Release.

Volunteer's signature: _____ Date _____

Signature of parent/guardian if volunteer is under 18: _____

AUTHORIZATION FOR
EMERGENCY MEDICAL TREATMENT

Volunteer's name _____ Date _____

In case of emergency, contact:

1) Name _____ Relationship _____

Phone (home) _____ (work) _____ (cell) _____

2) Name _____ Relationship _____

Phone (home) _____ (work) _____ (cell) _____

Please sign one of the following two options:

1) Consent Option

In the event emergency medical aid/treatment is required due to illness or injury while serving as a volunteer or while on the property of Medicine Horse Program, I authorize Medicine Horse Program to secure and retain medical treatment and transportation if needed. This authorization includes but is not

limited to x-ray, surgery, hospitalization, medication and any treatment deemed "life-saving" by the physician. This provision will be invoked only if the emergency contact person(s) listed above is/are unable to be reached. The financial charges will be paid by the ill/injured person.

Physician's name _____ Phone number _____

Preferred medical facility _____

Health insurance company _____ Policy # _____

Volunteer's signature

(or signature of parent/guardian if volunteer is under age 18)

2) Non-Consent Option

I do not give my consent for emergency medical treatment in the case of illness or injury while serving as a volunteer or while on the property of Medicine Horse Program. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Volunteer's signature

(or signature of parent/guardian if volunteer is under age 18)

CONFIDENTIALITY POLICY

The Medicine Horse Program respects the privacy of clients, their families, and all who come into contact with our program. We recognize other's right to have control over any information about them that might be personal or sensitive. Confidentiality and trust are critical components for our Program, and are essential for achieving human growth and potential.

Therefore, all those connected in any way with Medicine Horse Program are required to be bound by our Confidentiality Policy, including but not limited to: volunteers, board members, full/part-time staff, temporary employees, contractors, instructors, and aides.

Please be considerate of clients and staff while on Medicine Horse Program property, and do not interrupt or otherwise interfere with sessions.

Information considered to be confidential includes all medical, familial, social, behavioral, referral, personal, legal, and financial concerns regarding clients and their families. Such information is considered confidential regardless of how it is obtained, whether directly from the client or family, staff, volunteers or others associated with Medicine Horse Program, or inadvertently from other sources such as but not limited to a form, computer screen or overheard conversation.

Any person violating these policies will be subject to penalties ranging from reprimand to alteration of job responsibilities to termination to legal action.

I have read and understand the Confidentiality Policy and agree to observe its principles.

Signature: _____ Date _____

Signature of parent/guardian if under 18: _____

THANK YOU FOR YOUR INTEREST IN Medicine Horse Program!