Green Hill Therapy Volunteer Application and Liability Release

Personal Information:

Name: ____________________

Home Address: ____________________

City: ____________ State: ____________ Zip: ________

Home Phone: ____________________ Cell Phone: ________

E-mail Address: ____________________

Date of Birth: ____________

Circle Primary Contact: Home Phone, Cell Phone (Text/Call), or Email

As a volunteer at Green Hill Therapy, I acknowledge the risks and potential for risks of a horseback riding program. However, I feel the possible benefits to myself and the clients I work with are greater than the risks assumed. I hereby, intending to be legally bound for myself, my heirs and assigns, executors or administrators, waive and release all claims for damages against Green Hill Therapy, its board of directors, instructors, therapists, volunteers and/or employees for any and all injuries and/or losses I may sustain while participating in Green Hill Therapy's program.

Green Hill Therapy reserves the right to decline volunteer applications. Volunteers must be a minimum 16 years of age unless in an approved project or group activity.

WARNING

Under Kentucky law, a farm animal activity sponsor, farm animal professional, or other person does not have the duty to eliminate all risks of injury of participation in farm animal activities. There are inherent risks of injury that you voluntarily accept if you participate in farm animal activities." KRS 247.401 – 247.4029

Signature: ____________________ Date: ____________

If under 18, Name of Parent/Guardian:

Address, if different from above: ____________________

City: ____________ State: ____________ Zip: ____________

Home Phone: ____________________ Cell Phone: ____________

E-mail Address:

Circle Primary Contact: Home Phone, Cell Phone (Text/Call), or Email

Parent/Guardian Signature: ____________________ Date: ____________

Employment/School Information:

Employer: ____________________

Occupation: ____________________

School: ____________ Major: ____________ Class of: ________

Availability and Interests:

Green Hill Therapy schedules volunteers for weekly sessions.
We ask that volunteers show up at the same day and time each week for a minimum of two hours.

Please check all times during the week that you are available to volunteer:

	Monday	Tuesday	Wednesday	Thursday
8:00am-12:00pm				
1:00pm-3:00pm				
3:00pm-6:30pm				

How many hours/days a week would you like to volunteer?

____

Interests/Previous Experience:

Please circle areas that interest you or you have experience in:

Hippotherapy
Leading Horses
Sidewalking with patients
Horse Grooming/Care
Barn Chores

Fundraising
Administration
Facility Maintenance
Work Days
Shadowing OT/PT

How did you hear about Green Hill Therapy?

____

Do you have previous experience with horses?

____

____

Do you have previous experience working with persons with developmental disabilities?

____

____

Authorization for Emergency Medical Treatment:

Green Hill Therapy asks for medical information to ensure the safety of all of our volunteers.

In the even 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 Green Hill Therapy to:

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

Consent Plan:

The authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "lifesaving" by the physician. This provision will only be evoked if the person(s) below cannot be reached.

Medical Information:

Hospital Preference:____

Physician's Name: ______________________Physician's Phone Number: ________________________

Health Insurance Company:______________Policy #: ____

Emergency Information:

Emergency Contact 1: __________________________ Phone Number:_____________________________

Emergency Contact 2: __________________________ Phone Number:_____________________________

Able to walk for 30 minutes at a time? Circle **Yes** or **No**

List any Health Issues, Previous Injuries, or Physical Limitations:

____

____

Current Medications:

____

____

Information for emergency responders/Allergies:

____

Consent Signature:_____________________________________ Date:_________________________

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. In the event emergency treatment/aid is required, I wish the following procedures to take place:

____

____

____

____

Non-Consent Signature:______________________________ Date:________________________

Background Check:

If over 18 years of age, both a confidential Background Check and Sex Offender Registry Check are required. Green Hill Therapy runs a background check with the state of Kentucky on all prospective employees and volunteers over age 18. Frankfort will email you a copy of any record they send to us, so check that you have given us your email address on this form.

Green Hill requires a $25 processing fee.

Driver's License #: ____________________________State of Issue:_________________________

Social Security Number (if no driver's license): ____

Have you lived in other states? If so, please list: ____

How long have you resided in Kentucky?__________

If less than 5 years, please provide previous address:

Address:____ Apt #: __________________________

City, State and Zip: ____

How long at this address:____

If currently employed, please provide the following:

Employer:____ Job Title: ________________________

Address:____ Suite #: _________________________

City, State and Zip: __________________________________ Phone Number:___________________

Photo Release:

I consent to and authorize the use and reproduction by Green Hill Therapy, of any and all photographs and any other audio-visual materials taken of me for promotional material, educational activities, exhibitions, or for any other use for the benefit of the program.

Signature:____ Date:_________________________

Volunteer Confidentiality Release

Volunteers are a valuable part of Green Hill Therapy. This document confirms that I am recognized as a volunteer of Green Hill Therapy, which exists to provide quality therapy, in a safe environment. This document is in compliance with provisions RSA 508.17, the volunteer immunity law.

I understand and agree that in the performance of my duties as a volunteer, I must hold personal and medical information regarding clients/families confidential.

I will endeavor to keep my standards of conduct high in order to uphold the quality of the Green Hill Therapy program.

Volunteer Signature:________________________________ Date:____________________________

Witness Signature: _________________________________ Date:____________________________