Spirit Therapies
Therapy on Horseback

WHAT IS SPIRIT THERAPIES?

Spirit Therapies is a place where riders with Down's Syndrome, Angelman's Syndrome, MS, Autism, Muscular Dystrophy, spinal cord injuries, emotional distress, and other disabilities experience the expansion of their worlds through the magic of connecting with horses.

Our horses are really four legged therapists, who help out our riders improve their lives through physical contact, exercise, and interaction with others which increases communication and social skills.

As our rider's skills increase, so does their self-esteem and general well being. Research has proven that exercise and interpersonal interaction produces profound benefits for disabled individuals working to reach their full physical, mental, and social potential.

Spirit Therapies is dedicated to helping our riders discover their dreams and goals – to help them expand their physical and mental horizons, so they can free their true Spirit and be the best that they can be!

Spirit Therapies is a 501 (c) 3 non-profit organization. Someday through support of our friends, riders, volunteers, sponsors and the public we will be able to offer our services free of charge through our Pegasus program.

For more information please visit our website at www.SpiritTherapies.org
or feel free to call
Laurie Willmott (702) 219-1728
for more information on making a donation or volunteering.

9140 La Madre Way, Las Vegas, Nevada 89149
(702) 562-9434 or (702) 219-1728 www.SpiritTherapies.org

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VOLUNTEERING; WHAT CAN I DO?

We are excited to have you join our team!
Please help us find you the perfect position!

What can I do? Just like you would want a paid position to "fit", we want you to feel comfortable in your volunteer position. Spirit Therapies has volunteer opportunities for many different kinds of skills.

Horse Leader: Leads horse during mounted lessons. You must be comfortable with horses and reading horse body language.

Side Walker: Walks with mounted students. Assist with lessons at the instructor's direction.

Please note for the safety of riders and volunteers: to work directly with the horse and rider, a volunteer must be able to see and hear and understand instructions well and be able to stand and walk for ½ hour to 2 hours at a time sometimes in hot and cold weather.

Barn Volunteer: Works around horses, cleans stalls and barn, feeds and grooms horses.

Office Volunteer: Works in office, filing, typing, works on mail outs, and data entry.

Lesson Volunteer: Assists rider at arrival, helmet fitting, and visiting until lesson begins.

Signature: _____ Date: _____

Printed name: _____

Spirit Therapies reserves the right to dismiss a volunteer of their duties. In this regard, any person who violates the center rules, the center's confidentiality policy, or any unnamed incident that negatively or reflects on the center may be asked to leave.

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VOLUNTEER INFORMATION SHEET

Volunteer's Name: _____

Preferred Phone: _____ 2nd Phone: _____

Spirit Team Preference: ☐ Barn ☐ Equine ☐ Lesson ☐Clerical ☐ Other

If you selected "Other" describe what you would like to do:

_____

_____

Time and days you are able to volunteer:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

- ☐ Mornings
- ☐ Afternoons
- ☐ Nights

Remarks:

_____

_____

_____

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VOLUNTEER/STAFF INFORMATION FORM AND HEALTH HISTORY

General information

Name: _____ Date: _____

Address: _____

Date of Birth: _____ Primary phone: _____ 2nd phone: _____

Employer/School: _____

Address: _____

Parent/Legal Guardian/Caregiver Name: _____

Address: _____ _____

Primary Phone: _____ 2nd phone: _____

How did you learn about the program?

_____

Recent medical tests: Last Tetanus Shot Date: _____

Tuberculosis Test Date: _____ ☐ POSITIVE ☐ NEGATIVE

(Consult your physician or local health department if you are not up to date with these shots/tests)

Health History

Please describe your current health status, particularly regarding the physical/emotional demands of working in an equine assisted program. Address fitness, cardiac, respiratory, bone or joint function, recent hospitalizations/surgeries, or lifestyle changes.

_____

_____

_____

_____

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Allergies: _____

_____

Medications: _____

_____

Check which areas you are interested in:

Program	**Special Events**	**Administration**	
☐ Horse Handling	☐ Volunteer Day	☐ Public Relations	☐ Photography/Video
☐ Sidewalking with a Student	☐ Fundraising	☐ Grant Writing	☐ Budget & Finance
☐ Stable Management	☐ Wine & Beer Tasting	☐ Newsletter	☐ Future Planning
☐ Facility Repairs	☐ Trail Ride	☐ Volunteer Recruitment	

I understand that the information provided above is accurate to the best of my knowledge. I know of no reason why I should not participate in this center's program.

Signature: _____ Date: _____
(volunteer/staff/caregiver; signed in presence of center staff)

Name: _____

Address: _____

Primary phone: _____ Date of Birth: _____

Photo Release: ☐ I DO ☐ DO NOT consent to and authorize the use and reproduction by Spirit Therapies 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 center.

Signature: _____ Date: _____

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Background Information

Have you ever been charged with or convicted of a crime? □ Y □ N

If yes please explain

_____

_____

I, _____ (volunteer/staff), authorize Spirit Therapies to receive information from any law enforcement agency, including police departments and sheriff's departments, of this state or any other state or federal government, to the extent permitted by state and federal law, pertaining to any convictions I may have had for violations of state or federal criminal laws, including but not limited to convictions for crimes committed upon children or animals.
I understand that such access is for the purpose of considering my application as an employee/volunteer, and that I expressly DO NOT authorize the NARHA center, its directors, officers, employees, or other volunteers to disseminate this information in any way to any other individual, group, agency, organization, or corporation.

Signature: _____ Date: _____
(volunteer/staff)

Current Driver's License Number: _____ State: _____

Confidentiality Agreement

I understand that all information (written and verbal) about participants at this NARHA center is confidential and will not be shared with anyone without the expressed written consent of the participant and their parent/guardian in the case of a minor.

Signature: _____ Date: _____

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

☐ Participant ☐ Staff ☐ Volunteer

Name: _____ DOB: _____ Phone: _____

E-Mail Address: _____

Address: _____

Physician's Name: _____Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to Medications: _____

Current Medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

In the event emergency medical aid/treatment is required due to illness of injury during the process of receiving services, or while being on the property of the agency,

I authorize Spirit Therapies 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.

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Consent Plan

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.

Consent Signature: _____ Date: _____

Client, Parent or Legal Guardian

Signed in presence of center staff

Printed Name: _____

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 wish the following procedure to take place:

_____

_____

_____

Consent Signature: _____ Date: _____

Client, Parent or Legal Guardian

Signed in presence of center staff

Printed Name: _____

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VOLUNTEER JOB DESCRIPTION WORKSHEET

Job Title: _____

Supervised by: _____

General Description of Duties (indicate major functions): _____

_____

_____

Specific Job Responsibilities (list major tasks and standards of performance): _____

_____

_____

Conditions of Assignment (location, time required, degree of supervision and support, ect.):

_____

_____

_____

Qualifications, Training and Preparation for Assignment (list knowledge, skill and attitudes needed for job): _____

_____

_____

Medications (include prescription, over-the-counter; name, dose and frequency): _____

_____

_____

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Describe your abilities/difficulties in the following areas:
(*include assistance required or equipment needed*)

Physical Function (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

_____

_____

_____

Psycho/Social Function (i.e. Work/School including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, ect.)

_____

_____

_____

Goals (i.e. Why are you applying for participation? What would you like to accomplish?)

_____

_____

_____

Signature: _____ Date: _____

Photo Release

I ☐ DO

I ☐ DO NOT

consent to and authorize the use and reproduction by Spirit Therapies of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions of for any other use for the benefit of the program.

Signature: _____ Date: _____
Client, Parent or Legal Guardian
Signed in the presence of center staff

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VOLUNTEER TIME SHEETS

Name: _____

Date	Number of Hours

Therapist Signature: _____

This may be a tax deduction, please check with your accountant

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RELEASE OF LIABILITY

The undersigned is a business guest and/or patron and/pr visitor, or is the owner of a horse(s) kept upon the premises at 9140 La Madre Way, Las Vegas, Nevada, 89149 and fully understands that there is a certain amount of inherent danger in the keeping, handling, owing, riding, and being in the presence of horses, and in consideration of the owner/renters/guests, Jeff and Laura Willmott, permitting the undersigned to keep, board, ride, or train a horse(s) on said premises, or in consideration of permission granted to the undersigned and guests to visit upon said premises, or to receive any and all types of equestrian instruction upon said premises, the undersigned and guests, do hereby agree to assume all risk to loss, injury, or illness to all horses belonging to the undersigned, and to assume all loss, damage, or injury to any equipment or personal property to the undersigned.

Furthermore, the undersigned does hereby agree to assume all risk of personal injury to the undersigned, or guests of the undersigned, at any time while at the location of 9140 La Madre way, and does hereby release owners/renters/guests/Jeff and Laura Willmott, agents, employees, and staff, from any and all liability occurring from damage to or loss of property or equipment, or injury to or illness of any horse(s) or animals of the undersigned while at/on said property, facility and premises. The undersigned does hereby waive any and all claims of any and every kind of nature growing out of or based upon the operation of the aforementioned property, owners/renters/guests, and Jeff and Laura Willmott, agents, employees, and staff.

THE UNDERSIGNED HAS READ AND FULLY UNDERSTANDS THE CONTENTS OF THIS RELEASE OF LIABILITY AND BY SIGNING BELOW AGREES TO COMPLY AND BE BOUND BY THE CONTENTS STATED WITHIN.

Dated this _____ Day of _____ 20____.

Signature: _____

Printed Name: _____

Address: _____

_____

Primary phone: _____ 2nd Phone: _____

Witness Printed Name: _____

Witness Signature: _____