Riley Equine Center, Inc.

Therapeutic Horseback Riding for the Handicap

Dear Prospective Volunteer,

Thank you for your inquiry about the volunteer opportunities at Riley Equine Center. We are a not-for-profit organization that uses horses to encourage physical and mental development in people with disabilities.

Next to our horses, our volunteers are the most critical element in the success of this program. We rely on volunteers in every aspect and could not exist without their support, dedication, and abilities.

Enclosed are the necessary forms each volunteer must fill out and return before entering the volunteer training session at Riley Equine Center. Please notice the Child Abuse and Neglect Check Form.

We cannot accept any applicant with a history of abusing or neglecting a child.

Meanwhile, the volunteer application/information, emergency medical treatment and release needs to be sent to our mailing address.

Bonnie Riley
Owner/Director

Mailing Address
Riley Equine Center
17244 Doyle Road
Boonville, MO 65233
660-882-2377

Please feel free to contact us if you have any questions. We look forward to working with you in this challenging yet rewarding program.

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Volunteer Application

Last Name: _____ First name: _____

Mr. _____ Mrs. _____ Ms. _____ Other: _____

Preferred nickname: _____

Birthdate: _____

Address

Street: _____

City: _____

State: _____ Zip code: _____

Contact Information

Phone - Home: _____

Work: _____

Cell: _____

E-mail: _____

Is anyone at this a volunteer at Riley Equine Center? Yes or No

If yes, what is his/her name? _____

What is his/her relationship to you? _____

Employment

Employed: Fulltime _____ Part-time _____

Retired: _____ Other: _____

Employer: _____

Occupation:

_____

Address:

_____

City: _____ State: _____ Zip:

_____

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About you

What are your skills and/or talents?

_____

_____

_____

_____

_____

What are your hobbies and/or interests?

_____

_____

_____

_____

Do you have any previous volunteer experience? Yes No

If yes, where?

_____

For how long? _____

Do you have any experiences with horses? Yes No

If yes, please explain:

_____

_____

_____

_____

_____

Do you have experience with people with disabilities? Yes No

If yes, please explain:

_____

_____

_____

_____

_____

_____

Do you have experience working with the victims of abuse? Yes No

If yes, please explain:

_____

_____

_____

_____

_____

_____

Have you ever been convicted of a crime? Yes No

(Conviction will not necessarily disqualify applicant from volunteering)

If yes, please explain:

_____

_____

_____

_____

_____

_____

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About Us

How did you find Riley Equine Center?

_____

_____

_____

_____

What are the reasons you would like to volunteer with Riley Equine Center?

_____

_____

_____

_____

_____

For which areas of the program would you like to volunteer?

_____ Administrative/Office
_____ Fund Raising
_____ Public Relations
_____ Groundskeeper
_____ Lesson Organizer
_____ Horse Handler
_____ Side Walker
_____ Leader
_____ Barn Buddy Horse Care
_____ Other/Wherever I'm needed

If volunteer is under 18 years of age:

Parent's name:

_____

Parent's Number: Home - _____

Work - _____

Cell - _____

Parent's E-mail:

_____

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Availability

Riley Equine Center is open Monday – Saturday and will be making class times according to the clients needs. Please consider your schedule and check a time that you could be regularly available.

Monday: AM_____ PM_____
Tuesday: AM_____ PM_____
Wednesday: AM_____ PM_____
Thursday: AM_____ PM_____
Friday: AM_____ PM_____
Saturday: AM_____ PM_____

Daytime special events:

_____

I certify that the statements made in this volunteer application are true and correct and have been given voluntarily. I understand that this information may be disclosed to any party with legal and proper interest and I release Riley Equine Center, Inc. from any liability whatsoever for supplying such information.

I understand that I will not be paid for my services as a volunteer.

Applicants Signature: _____ Date: _____

Legal Guardians Signature: _____ Date: _____

(If applicant is less than 18 years of age)

WARNING: Under Missouri 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 the Revised Statutes of Missouri.

Riley Equine Center, Inc.

Authorization for Emergency Medical Treatment Form

In the event emergency medical aid/treatment is required due to illness of injury during the process of receiving services, or while on the property of the agency, I authorize Riley Equine Center, Inc. to:

1. Secure and retain medical treatment and transportation if needed
2. Release client records upon request to authorized medical personnel

Participants name: _____ Phone: _____
Address: _____
In the event I cannot be reached contact: _____ Phone: _____
Or: _____ Phone: _____
Physicians name: _____ Phone: _____
Preferred Medical Facility: _____
Health Insurance Co.: _____ Policy #: _____

Consent Plan

This authorization includes x-rays, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician. The provision will only be invoked if the person below is unable to be reached.

Date: _____ Consent Signature: _____
(Volunteer if 18 or older, Parent or Guardian)
Print Name: _____ Phone: _____
Address: _____

Non-Consent Plan

I do not give my consent for emergency medical aid/treatment in the case of illness or injury during the process of receiving services or while on the property of the agency. In the event emergency aid/treatment is required, I wish the following procedures to take place:

_____
_____
_____
_____

Date: _____ Non-Consent Signature: _____
(Volunteer if 18 or older, Parent or Guardian)
Print Name: _____ Phone: _____
Address: _____

This form is valid for a period of one (1) year from date signed.
A copy of the completed medical history should be attached to this form.

Volunteer Release and Indemnification Agreement

I acknowledge and understand the inherent risks of equine activities and that horsemanship experiences can result in injury and even death. In consideration for being accepted into the Riley Equine Center Therapy Program and for the benefits I receive from participating in the program, I, _____, (Volunteer if 21 or older, parent or guardian) hereby consent to assume the risks of _____ (Volunteer's) participation in the horsemanship program sponsored by Riley Equine Center, Inc.

Accordingly, I hereby, intending to be legally bound, for myself, my heirs and assigns, executors, or administrators, waive and forever release, acquit, discharge and hold harmless, Riley Equine Center, Inc., the owners of the facilities and properties on which Riley Equine Center, Inc. conducts its therapeutic horseback riding program, including, but not limited to Riley Paint Horses, Bonnie and Jerry Riley, the officers, directors, agents, employees, representatives, therapists, instructors, and volunteers, of Riley Equine Center, Inc. and any other person associated with Riley Equine Center, Inc. therapeutic horseback riding program, and the successors and assigns of each of them, from all manner of claims, demands and damages of every kind and nature whatsoever I may now or in the future have against these parties on account of any losses or personal injuries, physical or mental condition, known or unknown to myself and the treatment thereof, as a result of, or in any way connected with Riley Equine Center, Inc. therapeutic horseback riding program, or growing out of acts of omission or caused by negligence or in any way incidental to the Riley Equine Center, Inc. therapeutic horseback riding program.

Date: _____ Signed: _____
(Volunteer is 21 or older, parent or guardian)

Witnesses: _____

_____

WARNING: Under Missouri law, an equine professional is not liable for any injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities pursuant to the Revised Statutes of Missouri.

Confidentiality Statement

Volunteers, riders, and their facilities have a right to privacy that gives them control over the dissemination of their medical and/or other sensitive information. Riley Equine Center, Inc. shall preserve that right of confidentiality for all individuals in its program. I, _____, by signing below, acknowledge this policy and will abide by it.

Signature of Volunteer: _____
(Volunteer is 21 or older, parent or guardian)

Date: _____

Witnesses: _____ (Riley Equine Center Staff)

_____ (Riley Equine Center Staff)

WARNING: Under Missouri law, an equine professional is not liable for any injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities pursuant to the Revised Statutes of Missouri.

Photo Release

In consideration for being accepted into the Riley Equine Center, Inc. therapeutic horseback riding program and for the valuable benefits I receive from participating in the program and promoting the program I, _____, hereby authorize Riley Equine Center, Inc., its advertising agencies or the news media to have photographs, films or other audio-visual materials taken of the participant for promotional material, educational activities, exhibitions or for any other use for the benefits of the Riley Equine Center, Inc. therapeutic horseback riding program. I hereby indemnify and hold Riley Equine Center, Inc. harmless against any and all claims of damages arising out of the use of any such photographs or films of me or audio-visual materials containing the participants' image.

Signature of Volunteer: _____

(Volunteer is 21 or older, parent or guardian)

Date: _____

Witnesses: _____

_____

WARNING: Under Missouri law, an equine professional is not liable for any injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities pursuant to the Revised Statutes of Missouri.

Therapeutic Horseback Riding for the Handicap

SHP-159H 02/10

Missouri State Highway Patrol / Missouri Department of Social Services

REQUEST FOR CHILD ABUSE OR NEGLECT / CRIMINAL RECORD

TYPE OF SERVICE (Check **ALL** that apply) See reverse side for further instructions.	TYPE OF DAYCARE PROVIDER
☐ (1) CD Central Registry Child Abuse Search Only - No Charge ☐ (2) Name Search - $10.00 (Criminal record, child abuse, or neglect, central registry search) ☐ (3) Fingerprint Search ☐ $14.00 (Authorized Statute 210.487) ☐ $20.00 (All other request)	☐ (1) License ☐ (2) License Exempt ☐ (3) Registered

IDENTIFYING DATA (Please type or print information legibly in ink.) The subject of the request must complete the next section and sign.

APPLICANT'S NAME (Last, First, MI, Jr., Sr., III)				
MAIDEN NAME	DATE OF BIRTH (MM/DD/YY)	STATE OF BIRTH	SEX	RACE
ALIAS NAME(S)	SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER / STATE /		

ADDRESSES FOR PAST 5 YEARS

STREET	CITY	STATE	STREET	CITY	STATE

Have you ever been found guilty to or been convicted of any criminal act in this state or any state?

☐ YES (Complete section below) ☐ NO, I have not been found guilty to or been convicted of any criminal offense in this state or any state.

DATE	CITY	STATE	COUNTY	CIRCUMSTANCES (Identify charges, attach separate page, if necessary.)

Have you ever been substantiated as a perpetrator in any child abuse or neglect report made to the Children's Division in this state or any state?

☐ YES (Complete section below) ☐ NO, I have not been substantiated as a perpetrator in any child abuse or neglect report.

DATE	CITY	STATE	COUNTY	CIRCUMSTANCES (Attach separate page, if necessary.)

The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant permission to the Department of Social Services to obtain any and all information needed to process my request and to use the information as permitted by law.

SIGNATURE OF APPLICANT **(REQUIRED IN INK)**	DATE
SIGNATURE OF REQUESTOR (Required in ink)	DATE
TITLE OF CHILD CARE PROVIDER	TELEPHONE
STATE AGENCY	STATE VENDOR OR CONTACT NO. (If applicable)

CHECK APPROPRIATE BOX

☐ CHILD CARE RELATED EMPLOYMENT ☐ DOH / CCB CHILD CARE BUREAU ☐ SCHOOLS / PUBLIC AND PRIVATE

☐ CHILD CARE RELATED VOLUNTEER ☐ DMH / DMH VENDOR ☐ CD CONTRACT PROVIDER

☐ CD LICENSURE ☐ HEALTH CARE ☐ OTHER _____

COMPLETE RETURN ADDRESS (REQUIRED ON EACH APPLICATION)
Complete your mailing label below
Confidential Mail

AGENCY NAME
ATTENTION
ADDRESS
CITY, STATE, ZIP CODE

SEND FEE & FORM TO:

Missouri State Highway Patrol
Criminal Justice Information Services Division
P.O. Box 9500
Jefferson City, MO 65102

MO 821-0353 (2-10)