Centenary University
400 Jefferson Street
Hackettstown, NJ 07840
908-852-1400 x 2174 Fax: 908-813-1984

Thank you for your interest in volunteering for Therapeutic Riding At Centenary!

We have enclosed the registration paperwork required of all volunteers. Please complete all forms as indicated.

The Volunteer Registration should be completed, signed and dated. If you are under the age of 18, a parent or guardian must also sign the form.

Please note that this form includes the following releases:

- The liability release *must* be signed and dated.
- TRAC educational photo release **must** be signed and dated. This covers only photographs/videos used for the purpose of educating trainee instructors. This material will not be used for any other purpose.
- The commercial photograph/video release is optional.

Physical fitness

It is important for you to understand that leading a horse or acting as a sidewalker is strenuous and can include significant time jogging in variable arena footing. If you have any doubts about your ability to perform these duties for up to an hour at a time, there are several other extremely useful volunteer jobs available to you that would be less physical.

Commitment to your assigned lesson time

Our clients depend on volunteers to be there every week for their lesson/therapy session. If your schedule does not permit you to make this commitment, we are very happy to place your name on our "Substitute List," so that you could fill in for an absent volunteer.

Please return your completed paperwork to our office if possible before your orientation and training session. The orientation takes about an hour, the training about an hour and a half. Your volunteering schedule will be worked out at that time.

Once again, welcome to TRAC! We look forward to meeting in person in the near future.

Sincerely,

Octavia J. Brown
TRAC Director

VOLUNTEER INFORMATION

Name _____ Date _____

Phone (h) _____ cell _____(w)_____

Address _____
Street Town State & zip

e-mail _____Date of birth _____

(if under 18) Parent/legal guardian name _____

Address (if different)_____

Phone (h) _____ cell_____ (w)_____
(if different)

HEALTH HISTORY

Please describe your current health status. Take into account the physical demands of working in a therapeutic riding program, requiring up to 45 minutes of walking and jogging with a rider. Address fitness, cardiac condition, bone or joint function, any recent surgeries or health problems. NOTE: If unable to jog, you can still work in lessons – we just need to know!

Allergies:_____

Other: _____

_____

_____

Date last Tetanus shot _____ NOTE: important to be current, within last 8 to 10 years

STATEMENT of UNDERSTANDING

The information provided is accurate to the best of my knowledge. I know of no reason why I should not participate in TRAC's lesson program.

Signature: _____ Date _____
Volunteer

LIABILITY RELEASE

I hereby certify that, being aware of the risks and exposures to personal injury involved through equestrian activities, I hereby release Therapeutic Riding At Centenary and Centenary University and its employees assisting in any official capacity on their behalf, from all and every claim for damages which may occur to me or my property in any connection with any lesson, clinic, practice, schooling or any work with horses on the University grounds or away from the grounds of the Centenary University Equestrian Center, Long Valley, New Jersey.

Signature _____ Date_____
Volunteer, **or if under 18**, Parent/Legal Guardian

VOLUNTEER INFORMATION

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EDUCATIONAL PHOTOGRAPHY RELEASE (Mandatory)

I hereby consent to allow Therapeutic Riding At Centenary/Centenary University to use photographs and/or videos of me *exclusively* for the purpose of educating Centenary University student instructors. I understand that these will not be used for any promotional purpose without my written permission.

Signature_____ Date _____
Volunteer

PROMOTIONAL PHOTOGRAPHY RELEASE (Optional)

I hereby irrevocably consent _____ do not consent _____to allow Therapeutic Riding At Centenary/Centenary University to use photographs and/or videos of me for any purpose, and in any manner without limitation, including for print media, television, exhibition, publication and any trade or advertising purpose, providing such uses are not made so as to constitute a direct endorsement by me of any product or service.

Signature _____ Date _____
Volunteer

BACKGROUND INFORMATION

I,_____ (volunteer name) authorize Therapeutic Riding At Centenary/Centenary University to receive information from any law enforcement agency, including police departments and sheriff's departments, of this state or any other state or the federal government, to the extent permitted by state and federal law, pertaining to a criminal background status check, e.g. violations of state or federal criminal laws.
I understand that such access is for the purpose of considering my application as a volunteer, and will be kept confidential, and that I expressly DO NOT authorize Therapeutic Riding At Centenary/Centenary University, 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, **or if under 18**, Parent/Legal Guardian

Current driver's License # (if applicable) _____ State _____

CONFIDENTIALITY AGREEMENT

I understand that all information (written and verbal) about participants at Therapeutic Riding At Centenary is confidential and will not be shared with anyone without the express written consent of the participant or his/her parent/legal guardian.

Signature _____ Date_____
Volunteer

Authorization for Emergency Medical Treatment Form

❑ Participant ❑ Staff ❑ Volunteer

Name:_____ DOB:_____

Phone: (h) _____ (c) _____(w)_____

Address:_____

Street Town State and Zip

Caregiver information: Name_____

(Please fill in below if different from above information)

Phone: (h) _____ (c)_____(w)_____

Address: _____

Street Town State and Zip

Physician's Name, town, Phone: _____

Health Insurance Company:_____

Policy #: _____Group # _____

Allergies to medications or other:_____

Current medications and dosage: _____

In the event of an emergency, contact:

Name: _____Relation: _____ Phone: _____

Name:_____ Relation: _____ Phone: _____

CONSENT PLAN

In the event 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 TRAC personnel 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.

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 none of the person(s) above can be reached.

Date:_____Consent Signature:_____

Client/Volunteer/Staff, Parent (if under 18) or Legal Guardian

To my knowledge, the information I have given on this form is complete and accurate.

Date: _____ Consent Signature: _____

Client/Volunteer/Staff, Parent (if under 18) or Legal Guardian