



Proven, playful intervention.

VOLUNTEER LIABILITY RELEASE:

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 risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever 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.

Signature: _____ Date: _____

and, If required,
Parent/Guardian's Signature: _____ Date: _____

Check which areas you are interested in:

Program Volunteer

- Leading horses
- Sidewalking with Patient
- Stable Management
- Horse Grooming
- Special Olympics Horse Shows

Administration

- Clerical
- Fundraising
- Newsletter
- Photography
- Future Planning
- General labor
- Special Skills (please list, e.g. Painting, Carpentry, etc.)

IF A STUDENT:

Circle current Grade Level – High School (9 10 11 12) or College (Fres. Soph. Jr. Sr. Post-grad)

Name of School: _____

AGE: _____ & DATE OF BIRTH: ___/___/___

If under 18 years old, Name of Parent/Guardian: _____

Their address, if different from above: _____

Their Phone numbers Home _____ - _____ - _____ Work _____ - _____ - _____

IF OVER 18 years of age - Confidential Background Check and Sex Offender Registry Check information is required. Green Hill runs a background check **with the state of Kentucky** on all prospective employees and volunteers over age 18. **Frankfort** will e-mail you a copy of any record they send to us, so check that you have given us your e-mail address on the Volunteer Information Form. Please provide Drivers License and SSN# (below), and Date of Birth (above):

Drivers License: _____ State of Issue: _____

SSN: _____

Have you Lived in any other States? If so, please list: _____

FOR OFFICE USE: DATE SENT: _____ DATE RECEIVED: _____

STATUS: _____



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Volunteer Information Form

Name: _____

E-mail: _____

Address: _____

Home Phone: _____

City: _____

State: _____ ZIP: _____

Employer: _____

Work Address: _____

Work Phone: _____

City: _____

State: _____ ZIP: _____

How long have you resided in Kentucky? _____

If less than 5 years in KY please give previous address with state and Zip code and how long resided there:

How Long at this Address: _____

Address: _____

City: _____

State: _____ ZIP: _____

How did you hear about Green Hill Therapy?

Please briefly describe your experience with horses, if any:

Please briefly describe your experience working with persons with developmental disabilities, if any:

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: _____

FOR OFFICE USE: _____

Added to Newsletter: _____



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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.

Signature: _____

Date: _____

Witness: _____

Date: _____



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Volunteer's Authorization For Emergency Medical Treatment Form

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 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.

Volunteer Name: _____

Address: _____ Phone: _____

In the event, I _____ cannot be reached,

Contact: _____ Phone: _____

Contact: _____ Phone: _____

Physician's name: _____

Preferred Medical Facility: _____

Health Insurance Company: _____

Consent Plan

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

Consent Signature (Volunteer, Parent, Guardian): _____ Date: _____

Print Name: _____ Phone: _____

Address: _____

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:



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Non-Consent Signature (Volunteer, Parent, Guardian): _____ Date: _____

Print Name: _____ Phone: _____

Address: _____