



Northern Virginia Therapeutic Riding Program, Inc.  
6429 Clifton Rd. • Clifton, VA 20124 • 703.764.0269  
www.NVTRP.org

## **2018 New Volunteer Paperwork**

Welcome new volunteer!

Thank you for your interest in volunteering. Your gift of time is essential to the success of the program.

### **Background Check Policy**

All volunteers 18 years of age and older must complete a background check through NVTRP prior to volunteering. Link to background check will be provided at the Intro Training.

### **Start Up Fee**

A small, one-time fee of \$25.00 is due at or before your Intro Training. This helps to cover our administrative costs, training, background checks, and name tag. Please contact Shelby Morrison with questions – smorrison@nvtrp.org.

**Name:** \_\_\_\_\_

Volunteers help in a variety of ways from the care of our horses to working with our riders and helping in the office. Please circle any area you are interested in:

Horse Leading	Annual Horse Show	Public Relations
Sidewalking with a rider	Polo Classic	Photography
Horse Care	Community Outreach	Fundraising
Facility Maintenance	Volunteer Recruitment	Date Entry

**As a volunteer (please initial):**

**I have read and understand the policies and procedures outlined in the Volunteer Training Manual \_\_\_\_\_**

**I am physically able to lift 20lbs and be on my feet for up to 2 hours \_\_\_\_\_**

**I will conduct myself in a professional manner with fellow volunteers, riders and staff \_\_\_\_\_**



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## Volunteer Information Form

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  
 DOB \_\_\_\_\_ Parent or Guardian (if under 18) \_\_\_\_\_  
 Height: \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_  
 (Cell) \_\_\_\_\_ Okay to text: Y N  
 E-Mail \_\_\_\_\_ Do you check E-Mail Regularly? Y N

Employer/School: \_\_\_\_\_ Job Title/Year: \_\_\_\_\_  
 How did you hear about NVTRP: \_\_\_\_\_  
 Have you ever been charged with or convicted of a crime? Y or N (circle one)  
 Please explain: \_\_\_\_\_

## Confidentiality Agreement

This confidentiality Agreement is made between the Northern Virginia Therapeutic Riding Program (referred to as "The Program") and \_\_\_\_\_ (referred to as "The Volunteer").

*Please print name here*

The Program is engaged in therapeutic horseback riding for individuals with physical and cognitive limitations. The Volunteer is engaged in assisting the Program's instructors by leading horses, side walking, and preparing facilities. Information about the Program's student riders may be disclosed to the Volunteers from time to time to permit them to properly employ safety measures during riding sessions. The Volunteer agrees to protect the confidential material and information which may be disclosed between the Program and Volunteer. Therefore, the parties agree as follows;

- I. Confidential Information: the term "Confidential Information" means any medical information or material which is private to the Program's student riders and their parents.
- II. Protection of Confidential Information: The Volunteer understands and acknowledges that the Confidential Information is to be considered privileged information. Therefore, the Volunteer agrees to hold in confidence and to not disclose the Confidential Information to any person or entity.
- III. Volunteer understands and will hold confidential all personal information learned of riders, staff and other volunteers.

By: \_\_\_\_\_

Volunteer Signature	Print Name	Date
_____	_____	_____
Signature of Parent/Guardian if under 18	Print Name	Date



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## Emergency Treatment Release Form

Name \_\_\_\_\_  
Caretaker Name (if applicable) \_\_\_\_\_ Phone \_\_\_\_\_

.....  
**Emergency Contact:**

1. Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_  
2. Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

.....  
**Primary Physician:**

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Health Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_  
Name of Insured \_\_\_\_\_ Policy Number \_\_\_\_\_

**++Please describe your current health status, disability (if applicable), particularly regarding the physical/emotional demands of working in a therapeutic riding program and any special precautions we need to know.** \_\_\_\_\_  
\_\_\_\_\_

**++Please list any allergies and current medications:**

A) None \_\_\_\_\_ B) Please list \_\_\_\_\_

### Consent Plan

In case of medical emergency, due to illness or injury during the process of receiving services, or while being on the property of the agency, the undersigned authorizes NVTRP 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, anesthetic, 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 (Signature of parent or guardian if under 18)**

\_\_\_\_\_  
**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.

- 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:

Date: \_\_\_\_\_ Non-Consent Signature: \_\_\_\_\_



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**Release and Hold Harmless Agreement**

In consideration of receiving permission from the Northern Virginia Therapeutic Riding Program, Inc. (referred to as “the Program”) to participate in or observe horseback riding lessons and in further consideration of receiving permission to enter upon the premises of the Program property or other premises upon which the Program’s riding lessons may be conducted, the undersigned and his/her family and hereby forever release, acquit, discharge and holds harmless the Program, as well as its officers, governors, staff, agents instructors, volunteers, contributors and any property or horse owners affiliated with the Program of and from any and all liabilities, claims, any loss, damage, illness, injury, or death that may be sustained by any or each of the undersigned while in on or upon the premises while participating in or observing the riding lessons or while en route to or from these premises.

The undersigned acknowledges that there are certain risks inherent in participation in equine activities including (i) the propensity of an equine to behave in dangerous ways that may result in injury to the participant; (ii) the inability to predict an equine’s reaction to sound, movements, objects, persons, or animals; (iii) the possibility of equipment failure; and (iv) hazards of surface or subsurface conditions. While the Program makes every effort to minimize these risks, the undersigned is duly aware of these risks and hazards inherent upon participation in or observing equine activities and/or upon entering upon said premises. The undersigned also agrees to represent the potential for these hazards to others that may accompany or substitute for him/her at activities sponsored by the Program. These persons also, by their voluntary presence, assume the same risks and agree by their presence to the same release of liability described herein.

The undersigned and all others that may accompany, represent, and/or substitute for those persons agrees to indemnify and will hold harmless the Program, its officers, trustees, agents, instructors, volunteers, contributors, and other property and horse owners from any and all costs, charges, claims, demands, and liabilities of any kind arising either from the improper or negligent use by those listed and all that may accompany, represent, and/or substitute for those listed below of any equine, bridle, saddle, grooming tool, and/or other animal or tool or from the willful or negligent acts of said persons.

**++By:** \_\_\_\_\_

<b>Participant Signature</b>	<b>Print Name</b>	<b>Date</b>
_____	_____	_____
<b>Signature of Parent/Guardian if under 18</b>	<b>Print Name</b>	<b>Date</b>

**News and Photo Release**

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grants permission to the Northern Virginia Therapeutic Riding Program, Inc to take or have taken, still and moving photographs and films including television pictures of my daughter/son/ward/self and consents and authorizes the Northern Virginia Therapeutic Riding Program, news media, and any other persons interested in the subject of riding for individuals with disabilities and its work, to use and reproduce the photographs, films and pictures and to circulate and publicize the same by all means including and without limiting the generality of the foregoing newspapers, television media, brochures, pamphlets, books, social media including Facebook, instructional material and clinical material.       

With respect to the foregoing matters, no inducements or promises have been made to me to secure my signature to this release other than the intention of the Northern Virginia Therapeutic Riding Program to use or cause to be used such photographs, films, or pictures for the primary purpose of promoting and aiding the field of riding for individuals with disabilities and its work.

**By:** \_\_\_\_\_

<b>Participant Signature</b>	<b>Print Name</b>	<b>Date</b>
_____	_____	_____
<b>Signature of Parent/Guardian if under 18</b>	<b>Print Name</b>	<b>Date</b>

*If you DO NOT grant permission, please check the box, sign here, print name and date*

\_\_\_\_\_



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**Please complete if you are 18 years of age or older:  
Background Check Authorization**

**Print Name:** \_\_\_\_\_

I have applied for employment/volunteer service or I am currently an employee/volunteer with the Program. I understand that in connection with my application for employment/volunteer service, or for continued employment/volunteer service, Verified Volunteers, their agents, assigns or any other authorized third parties (collectively, the “investigators”) may be performing, requesting, obtaining or conducting a background check on me. This background check may include an inquiry into my employment history, education, general character or reputation, work experience, volunteer experience, driving and/or criminal history (collectively the “information”). However, unless my position involves handling money or having access to monies and/or other transferable monetary instruments, my credit history will not be checked.

I understand that the Program may rely on any part or all of the information in determining whether to extend an offer of employment/volunteer service to me, or in determining my eligibility for continued employment/volunteer service. I further understand that if any adverse action is taken by the Program, or if the Program chooses not to extend an offer of employment/volunteer service to me based upon the information, that I will be provided a copy of such information along with a summary of my rights under the Fair Credit Reporting Act.

I understand that the background check is being performed by investigators as part of the process to evaluate me for fitness for employment/volunteer service or for continued employment/volunteer service, and is not conducted for any purpose other than in connection with my application for employment/volunteer service or determining my eligibility for continued employment/volunteer service.

I have read this pre-employment and continued employment/volunteer service disclosure and by signing below, hereby authorize investigators to conduct a background check as described herein in conjunction with my application for employment/volunteer service or for continued employment/volunteer service. I hereby release any and all investigators and the Program from any and all liability related to the procurement or disclosure of any information provided by me or obtained about me in connection with my application with the Program. I further direct and authorize investigators to conduct the background check and further authorize any third parties who may be the custodians of or in possession of the requested information, to disclose such information to investigators in connection with the background check.

I understand that the Program and its designated agents and representatives shall maintain all information received from this authorization in a confidential manner in order to protect the applicants personal information, including but not limited to, addresses, social security numbers and dates of birth.



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+By:

Participant Signature

Print Name

Date