

Today's Date: _____
Database Entry Date: _____

Training Date	_____
Shadow Date	_____
Raiser's Edge	_____
Volunteer Database	_____
Emergency Proc.	_____
Leading & Longing	_____

Giant Steps Volunteer Application

Name: _____ Date of Birth: ____/____/____ Age: _____ Height ____' ____"
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Business Phone: _____
Mobile Phone: _____ Email Address: _____
School or Place of Employment: _____ School/Work Address: _____
Spouse/Partner: _____ Spouse/Partner's School or Place of Employment: _____
Are you: First Aid Certified? ____ Date: _____ CPR Certified? ____ Date: _____
Driver's License #: _____ State: _____ Expiration Date: _____
Has your driver's license ever been suspended or revoked? ____ Yes ____ No If yes, When? _____
Where? _____ Why? _____
Have you ever been convicted of a criminal offense? ____ Yes ____ No If yes, When? _____
Where? _____ Please Explain: _____

The above information may be verified, and I give permission for inquiry to be made as to my suitability to act as a volunteer at Giant Steps.

SIGNATURE: _____ DATE _____
SIGNATURE OF PARENT/GUARDIAN: _____ DATE _____

LIABILITY RELEASE: I acknowledge the risks and potential for risks of horseback riding and activities in and around a facility where horses are kept and farm machinery operated. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. Intending legally to bind myself, my heirs and assigns, executors or administrators, I hereby waive and release forever all claims for damages against Giant Steps Therapeutic Equestrian Center, Inc., its Board of Directors, Instructors, Therapists, Aides, Volunteers, Employees for any and all injuries and losses I/my son/my daughter/my ward may sustain while participating in Giant Steps' therapeutic riding program. This release includes without limitation the risk of negligent instruction and supervision. I engage in activities at Giant Steps Therapeutic Equestrian Center, Inc. voluntarily with knowledge of the risks and I assume all risks of injury, death, and property damage that may result. I agree to bear any loss myself. I acknowledge that Giant Steps Therapeutic Equestrian Center, Inc. and the property owners are materially relying on this waiver and assumption of risk in allowing me or my son/my daughter/my ward to participate in activities at Giant Steps Therapeutic Equestrian Center, Inc.

PHOTO RELEASE: ____ I consent to and authorize
____ I do not consent to nor do I authorize
the use and reproduction by Giant Steps Therapeutic Equestrian Center, Inc. of any and all photographs and any other audiovisual materials taken of me for promotional printed material, educational activities, exhibitions, or for any other use for the benefit of the program.

POLICY OF CONFIDENTIALITY: Confidentiality is defined as "told in secret or private relations; trusted." Any information in regards to the participants (clients) at Giant Steps must be held in strict confidentiality. It is critical that we respect each individual. Confidentiality is considered one of the most basic responsibilities of our facility. In failure to abide by this policy, the quality of the services we provide may diminish and result in legal ramifications. I have read and understand Giant Steps' Policy of Confidentiality and agree to abide by same.

The undersigned acknowledges that he/she has read this Volunteer Application in its entirety; that he/she understands the terms of this release and has signed this release voluntarily and with full knowledge of the effects thereof.

SIGNATURE: _____ DATE _____
SIGNATURE OF PARENT/GUARDIAN: _____ DATE _____

Name: _____

GENERAL INFORMATION

Please tell us of your experience with:

- A. Horses: _____
- B. Leading Horses and/or Sidewalking: _____
- C. People With Disabilities: _____

I am interested in being involved in the following way(s):

A. Riding Program

____ Horse Leading ____ Sidewalking ____ Interning** ____ Horse Care

** Requires a dedication of 14 plus hours per week

B. Barn and General Maintenance Program

____ Field and Barn Maintenance ____ Carpentry ____ Equipment Repair

C. Office Program

____ Special Events (Steppin' Out, Silent Auction Items, Open Houses, Fundraisers) ____ Public Outreach & Volunteer Recruitment

____ Office Back-Up (Database Entry, Phone Reception, Word Processing, Mailings) ____ Computer Technical Support

D. Special Skills

____ Photography ____ Sign Language ____ Maintenance ____ Mane & Tail Braiding ____ Baking

____ Grant Writing ____ Word Processing ____ Gardening ____ Graphic Design ____ Long Lining

____ Other (Describe) _____

Your Potential Volunteer Schedule. This will serve as a guideline **only**. Please put an X in the days and times when you are able to volunteer.

Date & Time	9-10 am	10-11 am	11-noon	12-1 pm	1-2 pm	2-3 pm	3-4 pm	4-5 pm
Monday								
Tuesday								
Wednesday								
Thursday								
Friday								
Saturday								

I would like to commit to a regular day/time: ____YES ____NO

I cannot commit to a regular day/time right now, but would like to serve as a substitute: ____YES ____NO

In addition to my regular hours (if applicable), I would like to act as a substitute on the following day(s)/time(s): _____

How did you learn about Giant Steps? _____

Does your employer give time off to volunteer? _____

Does your employer have a donation-matching program? _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury while being on the property of the agency, I authorize Giant Steps to:

1. Secure and retain medical treatment and transportation, if needed.
2. Release records upon request to the authorized individual or agency involved in the medical emergency treatment.

Volunteer's Name: _____ Today's Date: _____

In case of Emergency, contact*: _____ Relationship: _____ Phone: _____

Physician's Name: _____ Phone: _____

Preferred Medical Facility: _____ Health Insurance Carrier: _____ Policy #: _____

Medical conditions, medications or allergies we should know about: _____

Date of last Tetanus shot: _____ We recommend Tetanus shots every ten years.

*Emergency contact person needs to be a local resident

CONSENT PLAN: (to be invoked in the event that your emergency contact cannot be reached.) I give consent for emergency medical treatment/aid (including x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician) in the event of illness or injury while on the property of the agency.

Date: _____ Consent Signature: _____

(Parent or Guardian if volunteer is under 16 years of age)

NON-CONSENT PLAN: I do not give consent for emergency medical treatment/aid in the event of illness or injury while on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedure(s) to take place:

Date: _____ Non-Consent Signature: _____

(Parent or Guardian if volunteer is under 16 years of age)

Thank you for taking the time to answer this questionnaire. Your responses provide useful information to help us better assess our volunteer corps, as well as make the best assignment for you. If, at any time, you would like to change your time, day, or job assignment, please don't hesitate to let us know.

WELCOME!

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Phone: 707-769-8900 Fax: 707-769-4770**