



Equestrian Center

14674 S. HWY 169 Oologah, Ok 74053

(918) 371-1750

FAX: (918) 371-1930

## Volunteer Form

### Health History and General information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer/School: \_\_\_\_\_

Parent/Legal Guardian/Caregiver Name /Address/Phone number:

\_\_\_\_\_

For grant and recording purposes:

Please share your race: (Caucasian, Latino, Asian, Other) \_\_\_\_\_

Are you a registered member of an American Indian or Alaskan Native tribe or nation?

Y/N and Which Tribe \_\_\_\_\_

How did you learn about the program?

\_\_\_\_\_

In what way would you most like to help Bit by Bit? Rate with a 1 as your favorite and least with a 3:

\_\_\_\_\_ Classes and helping students with goals: specific students' weekly classes

\_\_\_\_\_ Horses and Facility Maintenance: seasonal/weekend work (special training given by staff)

\_\_\_\_\_ Special events: for volunteers who have busy schedules but still want to help

In the event of an emergency, contact:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Phone: \_\_\_\_\_

Have you ever been charged with or convicted of a crime? Y N; please explain

I, \_\_\_\_\_ (volunteer), authorize \_\_\_\_\_ Bit By Bit \_\_\_\_\_ to receive information from any law enforcement agency, including police departments and sheriff's departments, of this state or any other state or federal government, to the extent permitted by state and federal law, pertaining to any convictions I may have had for violations of state or federal criminal laws, including but not limited to convictions for crimes committed upon children or animals. I understand that such access is for the purpose of considering my application as an employee/volunteer, and that I expressly DO NOT authorize the PATH Int'l center, 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)

Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_

Maiden \_\_\_\_\_ Social Security Number \_\_\_\_\_ DOB \_\_\_\_\_

CURRENT DRIVER'S LICENSE NUMBER \_\_\_\_\_ STATE \_\_\_\_\_

Previous Address:  
\_\_\_\_\_  
\_\_\_\_\_

## Photo Release

Circle one:      I DO      I DO NOT

consent to and authorize the use and reproduction by \_\_\_\_\_ Bit By Bit \_\_\_\_\_ 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 center.

Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

## **Confidentiality Agreement:**

I understand that the information provided above is accurate to the best of my knowledge. I know of no reason why I should not participate in this center's program. I understand that all information (written and verbal) about participants at this PATH Int'l center is confidential and will not be shared with anyone without the expressed written consent of the participant and their parent/guardian in the case of a minor.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **Consent Plan:**

### **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 Bit by Bit Therapeutic Riding Center 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 the person(s) above is unable to be reached.

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_  
*Client, Parent or Legal Guardian*

### **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 being on the property of the agency.

Parent or legal guardian must remain on site at all times during equine assisted activities

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

## **Volunteer Service Agreement and Release**

I understand and agree that my volunteer service is in no way an offer of employment by Bit by Bit Therapeutic Riding Center, Inc. and that I shall not receive nor be entitled to receive any compensation, reimbursement or remuneration for my participation in my volunteer service. I further agree to release Bit by Bit Therapeutic Riding Center, Inc. from any and all claims to compensation, reimbursement or remuneration related to my volunteer service. I also understand and agree that at no time will I be considered or deemed to be an agent, servant or employee of the therapeutic center. I understand that I will be volunteering at a therapeutic center for those with special needs and I therefore agree to act appropriately and in a professional, courteous manner during my volunteer service. I understand that Bit by Bit may terminate my volunteer service at any time, with or without cause. I understand that during my volunteer service, I may have access to, or may observe, certain information that is proprietary to Bit by Bit and its clients and I agree not to disclose, discuss or reveal any such information to parties outside Bit by Bit and to keep any Bit by Bit records or files, confidential. In consideration of my being allowed to participate in volunteer service, I agree to release, indemnify and hold harmless the Board of Directors of Bit by Bit Therapeutic Riding Center, Inc. or Rogers State University Foundation, including its present and former Board, Bit by Bit's officers, directors, employees and agents and Participants from and against any and all losses, expenses, claims, actions, liabilities and judgments (including attorney fees through the appellate levels), which I, my dependents, assigns, personal representatives, heirs or next of kin may sustain or suffer as a result of or arising out of my participation in the volunteer service, whether caused by negligence, action or inaction of Bit by Bit persons acting on its behalf or otherwise. I also agree that I shall be fully responsible for any and all loss or damage that I inflict upon any person or upon Bit by Bit facilities during my participation in the volunteer service. I understand that as a Bit by Bit volunteer, Bit by Bit does not provide me with accident or medical insurance, and is therefore not responsible for any accident or medical expenses incurred by me. Further, I understand that I am not entitled to employee benefits as a result of my Bit by Bit affiliation. I understand that this release is intended to be as broad and inclusive as is permitted by the laws of the State of Oklahoma. I have read and understood this Volunteer Service agreement and Release and do voluntarily sign said document of my own accord and as a condition of being allowed to participate with my volunteer service. Further, by signing this agreement I attest to the fact that I am eighteen years of age or older. If not, my guardian or parent's signature is required to allow me to be a volunteer participant at Bit by Bit therapeutic Riding Center, Inc. Print

Name: \_\_\_\_\_ Participant Signature: \_\_\_\_\_

Parent/Guardian Signature (if minor): \_\_\_\_\_ Date: \_\_\_\_\_