Opening Doors to the Future
for Breast Cancer Survivors
in the Rogue Valley

Volunteer Application

I would like to volunteer with Riding Beyond.

Name. . . . .

Address. . . . .

Phone(s) . . . .

Email (required to be checked at least twice a week.) . . . .

Here are some of the Riding Beyond Jobs. Please check the ones you are interested in, and note your relevant experience. 1-2 hours/week is anticipated for each, except side walking and horse leading.

❍ **Side Walker**

❍ **Horse Leader**

❍ **Client Finder**
Contact likely sources of clients - support groups, doctors, clinics, etc. and identify/invite clients

❍ **Grant Finder/ Grant Writer**
Internet research, library research

Research and write grants to targeted sources

❍ **Volunteer Coordinator**
Advertise and assist at volunteer trainings
Ensure enough volunteers show up at sessions

❍ **Horse Caretaker and Trainer**

❍ **Research Person**
Document results for grants and possible research projects (SOU student?)

❍ **Public Awareness**
Schedule presentations
Schedule radio/newspaper/tv coverage
Distribute posters
Manage Facebook page
Manage blog
Manage Website

❍ **Crowd Funding Campaign managers**

❍ **Something Else (Describe what you'd like to offer.)**

Photo Release

I ❍ DO ❍ DO NOT

consent to and authorize the use and reproduction by GREEN HORSE 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: _ ____________________________

Background Information

Have you ever been charged with or convicted of a crime? Y N If yes, please explain__________________

____

____

I, ______________________________________*(volunteer/staff)*, authorize Green Horse 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 I expressly DO

NOT authorize Green Horse, 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/staff)

CURRENT DRIVER'S LICENSE Y N LICENSE NUMBER_______________________________ STATE ___________

Confidentiality Agreement

I understand that all information (written and verbal) about participants at Green Horse is confidential and will not be shared with anyone without the expressed written consent of the participant and his/her parent/guardian in the case of a minor.

Signature: ____ Date: ___________________________

(volunteer/staff)

Liability Release and Emergency Medical Treatment Authorization

Participant's name: ____________________________ would like to volunteer with Riding Beyond. I acknowledge the risks of work around horses and riding horses. I recognize that horses/equines by their nature are easily startled and when frightened may risk human life and limb. However, I believe the possible benefits to myself are greater than the risk assumed. I hereby, intending to be legally bound, for myself and my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Green Horse, Patricia Broersma, Pat Super, Kathy Farmer, volunteers, employees, staff, and facilities for any and all injuries and/or losses I may sustain while participating in this intensive.

Signature: ____ Date: ___________________

In the event emergency medical treatment is required due to illness or injury during the intensive or while being on the property of the facility, I authorize Trish Broersma and Green Horse personnel to:

1. Secure and retain medical treatment and transportation if needed.
2. Release participant records upon request to the authorized individual or agency involved in the medical emergency treatment.
3. In the event I cannot make my wishes knows, contact:

Name of relative – designee: ____

Phone: _________________________ Work: ________________________ Cell: __________________________

Address: ____City: ________________________________

State/Prov:_________ Zip: ________________

Personal Physician's Name: ____

Phone: _______________________________Preferred Medical Facility: _______________________________________

Health Insurance Company: ____

Group Name/Number: ______________________ Location of card: ________________

Please note any allergies: _______________________________________

Consent Plan: 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 listed below is unable to speak/ communicate for self.

Your printed name: ____

Your consent Signature: ____

Today's Date: _________

RIDING BEYOND IS A COMMUNITY SERVICE PROGRAM SPONSORED BY GREEN HORSE