



5325 Harrison Road
Fredericksburg, VA 22407
hazelwildtrpriding@gmail.com

HAZELWILD FARM THERAPEUTIC RIDING PROGRAM **VOLUNTEER APPLICATION**

Thank you for your interest in volunteering with Hazelwild Farm's Therapeutic Riding Program. Whatever your reason for volunteering, the relationships you form with our riders, horses, fellow volunteers and staff is sure to leave a lasting impression. No matter what your horse experience, your willingness to give of yourself and your time is much appreciated.

Hazelwild Farm's Therapeutic Riding Program meets on Tuesday evenings from 4:30-8:30. The riding ring is outside so we are weather dependent – that means we may cancel a week here or there due to thunderstorms and we take a short break in the hottest part of Summer and the coldest part of Winter. Please contact **hazelwildtrpriding@gmail.com** for additional information.

NAME _____ DATE OF BIRTH _____ / _____ / _____ AGE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

Home Phone () _____ Work Phone () _____ Cell Phone () _____

E-Mail Address _____

PLACE OF EMPLOYMENT OR SCHOOL _____

PARENT/GUARDIAN NAME _____ PHONE _____
(If volunteer is under 16 years of age)

REFERENCE NAME _____ PHONE _____

Relationship _____

Driver's License # _____ State _____

Has your driver's license ever been suspended or revoked in any state? _____ No _____ Yes If yes, when? _____

Where? _____ Why? _____

Have you ever been convicted of a criminal offense? _____ No _____ Yes If Yes, When? _____

Where? _____ Please explain _____

(Upon request, you can be asked to submit an application for a criminal background check.)

The information that I have provided may be verified, and I give permission to Hazelwild Farm Educational Foundation to make inquiry of others concerning my suitability to act as a volunteer at Hazelwild.



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Date _____

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

GENERAL INFORMATION

Please tell us of your experience with the following:

Horses:

Leading horses and/or sidewalking:

People with disabilities:

PHOTO RELEASE: _____ I consent to and authorize

_____ I do not consent to nor do I authorize

The use and reproduction by the Hazelwild Farm Therapeutic Riding, 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.

DATE _____

SIGNATURE _____

SIGNATURE OF PARENT OR GUARDIAN _____

(If volunteer is under 16 years of age, **both** signatures are needed)

POLICY OF CONFIDENTIALITY: Confidentiality is defined as “told in secret or private relations; trusted.” Any information in regards to the participants (clients) at Hazelwild 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



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abide by this policy, the quality of the services we provide may diminish and result in legal ramifications. I have read and understand Hazelwild's Policy of Confidentiality and agree to abide by the same.

DATE _____ SIGNATURE _____

SIGNATURE OF PARENT OR GUARDIAN _____

(If volunteer is under 16 years of age, **both** signatures are needed)

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FOR VOLUNTEERS

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

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

In case of Emergency, contact _____ Phone _____

Or _____ Phone _____

Physician's Name _____ Town _____ Phone _____

Preferred Medical Facility _____

Health Insurance Carrier _____ Policy # _____

Medical conditions and/or medications we should know about: _____

Allergies _____ Other _____

Date of last Tetanus shot _____

CONSENT PLAN (To be invoked in the event that you 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 Hazelwild Farm.

Date _____ Consent Signature _____

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

NON-CONSENT PLAN – I do not give consent for emergency treatment/aid in the event of illness or injury while on the property of Hazelwild Farm. In the event emergency treatment/aid is required, I wish the following procedures to take place: _____

Date _____ Non-consent Signature _____

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