Volunteer Application

Equine-Assisted Therapy, Inc.

Therapeutic Horseback Riding
3369 Hwy 109 Wildwood MO 63038
Come ride with us at www.eatherapy.org

A note from our Executive Director…

Equine-Assisted Therapy is a not-for-profit organization that strives to improve the quality of life and health for people living with mental, physical, social, and cognitive challenges through therapeutic activities with the horse. We rely on volunteers in every aspect and could not exist without their support, dedication, and abilities.

If you love animals and people, you will find yourself at home at EAT. No experience necessary! Our volunteers are so very vital to our participants and our organization. ***We hope you will have fun but take this responsibility seriously. Without you, our riders cannot ride!***

Enclosed are the necessary forms each volunteer must fill out and return before volunteering with us. Please do not overlook the Request for Child Abuse and Neglect/Criminal Record Form. We cannot accept any applicant with a history of abusing or neglecting a child.

Welcome to our EAT family and I look forward to meeting you in person!

Lulu Bogolin
Executive Director

Here's how to volunteer

1. **Fill out application completely.** Please type or write legibly. Make sure you sign all the signature lines. ***NOTE:*** *You must be at least 14yrs old to volunteer with EATherapy*

2. **Return the competed application to our Wildwood facility** (3369 Hwy 109 - 63038).
Email or fax the completed application to info@eatherapy.org or fax 1-636-587-6100.

3. **We will contact you by email** as soon as your application has been processed. We will discuss what volunteer role you would like, what times work best for you, and then get you going just as soon as we can.

Our participants and horses thrive on consistency so we require a *minimum* commitment of ***1 hour a week for a 6-week session***. Our Wildwood location operates year-round with classes Mon-Fri 10am-7pm and Sat 9am-2pm. Our Town and Country location operates May through October. If you need service hours, we are not able to guarantee any number of hours.

Volunteer Application

Equine-Assisted Therapy, Inc.

Date: _____

Contact and Personal Information

Last Name: _____ **First Name:** _____ **I prefer to be called:** _____

Date of Birth: _____ **Email:** _____

Home Phone: _____ **Cell Phone:** _____

Street: _____

City: _____ **State:** _____ **Zip:** _____

Would you like to receive our newsletter? Yes – No

Availability

Which location would you prefer? Wildwood – Town & Country – Either

I am regularly	**Mon:** ☐ AM ☐ PM	**Tue**: ☐ AM ☐ PM	**Wed:** ☐ AM ☐ PM
available:	**Thur:** ☐ AM ☐ PM	**Fri:** ☐ AM ☐ PM	**Sat:** ☐ AM ☐ PM

I'd like to help with:

☐ Side-walking in classes
☐ Horse leading in classes
☐ Assist with groups
☐ Groundskeeping
☐ Fundraising / Grant Writing
☐ Wherever I'm Needed

How did you hear about us? _____

Volunteer Agreement

I certify that the information provided in this volunteer application is true and correct and has been given voluntarily.
I understand that this information may be disclosed to any party with legal and proper interest and I release Equine-Assisted Therapy, Inc. from any liability whatsoever for supplying such information.
I understand that I will not be paid for my services as a volunteer.

Volunteer Applicant's Name (please print): _____

Signature: _____ **Date:** _____

Complete if Volunteer is less than 18 years of age:

Name:_____**Signature**:_____**Date**:_____
(First parent/legal guardian)

Name:_____**Signature**:_____**Date**:_____
(Second parent/legal guardian)

***WARNING: UNDER MISSOURI LAW, AN EQUINE PROFESSIONAL OR ANY EMPLOYEE THEREOF, IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES PURSUANT TO THE REVISED STATUTES OF MISSOURI* R.S.Mo.§537.325**

For office use only:	☐ Signatures	☐ Outreach	☐ Scheduled
	☐ Background Check	☐ In Contacts	☐ Start Date:

Equine-Assisted Therapy, Inc.

More About You

Why would you like to volunteer with us? _____

What do you consider your strengths? _____

Do you have experience with people with disabilities? Yes - No

If yes, please explain: _____

Do you have experience with horses? Yes - No

If yes, please explain: _____

List previous volunteer locations and roles: _____

Volunteer Authorization for Emergency Medical Treatment

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services/volunteering, or while on the property of the agency, I authorize Equine-Assisted Therapy, Inc. to:

1. Secure and retain medical treatment and transportation if needed; and
2. Release volunteer records upon request to authorized medical personnel.

Volunteer's Name: _____

Emergency contact name: _____ **Phone:** _____

2nd Emergency contact name: _____ **Phone:** _____

Physician's Name: _____ **Phone:** _____

Preferred Medical Facility: _____

Health Insurance Company: _____ **Policy #:** _____

Consent

Consent is given for emergency medical aid/treatment in the case of illness or injury during the process of receiving services/volunteering or while on the property of Equine-Assisted Therapy, Inc. This authorization includes x-rays, surgery, hospitalization, medication, and any treatment procedure deemed "lifesaving" by the physician. The provision will only be invoked if the volunteer is not responsive and the emergency contact is unable to be reached.

Consent Signature:_____ **Date**:_____

(First parent/legal guardian OR Participant if 18 or older)

Consent Signature:_____ **Date**:_____

(Second parent/legal guardian)

Non-Consent

Consent is NOT given for emergency medical aid/treatment in the case of illness or injury during the process of receiving services/volunteering or while on the property of Equine-Assisted Therapy, Inc. In the event emergency aid/treatment is required, I wish the following procedures to take place: _____

_____

Non-Consent Signature:_____ **Date**:_____

(First parent/legal guardian OR Participant if 18 or older)

Non-Consent Signature:_____ **Date**:_____

(Second parent/legal guardian)

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Equine-Assisted Therapy, Inc.

Volunteer Release and Indemnification Agreement

I acknowledge and understand the inherent risks of equine activities and that horsemanship experiences can result in injury and even death. In consideration for being accepted into the Equine-Assisted Therapy Program and for the benefits I receive from participating/volunteering in the program, I, _____, *(volunteer if 18 or older, parent or guardian)* hereby consent to assume the risks of _____, *(volunteer's)* participation in the horsemanship program sponsored by Equine-Assisted Therapy, Inc. (hereinafter "EAT, Inc.").

Accordingly I hereby, intending to be legally bound, for myself, my heirs, assigns, executors, and/or administrators, waive and forever release, acquit, discharge and hold harmless, EAT, Inc.; the owners of the facilities and properties on which EAT, Inc. conducts its therapeutic and equine-related programs and activities, including but not limited to, the City of Town & Country and the City of Wildwood; the officers, directors, agents, employees, representatives, therapists, instructors, and volunteers of EAT, Inc.; and any other person associated with EAT, Inc. therapeutic and equine-related programs and activities, and the successors and assigns of each and all of the above-mentioned parties, from all manner of claims, demands, and damages of every kind and nature whatsoever I may now or in the future have against these parties due to any loss or personal injury, physical or mental condition, whether known or unknown to myself, and the treatment thereof, as a result of, or in any way connected with EAT, Inc. therapeutic and equine-related programs and activities, ***or growing out of acts or omissions or caused by negligence or in any way incidental to EAT, Inc therapeutic and equine-related programs and activities.*** I have asked, or have had the opportunity to ask, any and all questions that I may have relating to the risks involved in therapeutic and equine-related programs and activities. I fully understand and accept these risks.

Name: _____ **Signature:** _____ **Date:** _____
(First parent/legal guardian OR Participant if 18 or older)

Name: _____ **Signature:** _____**Date:** _____
(Second parent/legal guardian)

Photo Release

In consideration for being accepted as a volunteer into the Equine-Assisted Therapy, Inc. therapeutic horseback riding program and for the valuable benefits I receive from participating in the program and promoting the program I hereby authorize Equine-Assisted Therapy, Inc., its advertising agencies and/or the news media to have photographs, films or other audio-visual materials taken of myself for promotional material, educational activities, exhibitions or for any other use for the benefit of the Equine-Assisted Therapy, Inc. therapeutic horseback riding program. ***I hereby indemnify and hold Equine-Assisted Therapy, Inc. harmless against any and all claims of damage arising out of the use of any such photographs or films of me or audio-visual materials containing my image.***

Name: _____ **Signature:** _____ **Date:** _____
(First parent/legal guardian OR Participant if 18 or older)

Name: _____ **Signature:** _____**Date:** _____
(Second parent/legal guardian)

***WARNING: UNDER MISSOURI LAW, AN EQUINE PROFESSIONAL OR ANY EMPLOYEE THEREOF, IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES PURSUANT TO THE REVISED STATUTES OF MISSOURI* R.S.Mo.§537.325**

Equine-Assisted Therapy, Inc.

Missouri State Highway Patrol/Missouri Department of Social Services

REQUEST FOR CHILD ABUSE OR NEGLECT/CRIMINAL RECORD

TYPE OF SERVICE (Check only one) See reverse side for further instructions

- ☐ (1) Name Search - $5.00 (Criminal Record and Child Abuse Search)
- ☒ (2) Fingerprint Search - $14.00 (Criminal Record and Child Abuse Search)
- ☐ (3) DFS Central Registry Child Abuse Search Only – No Charge

IDENTIFYING DATA (Please type or print information legibly in ink.) The subject of the request must complete the next section and sign.

APPLICANT'S NAME (Last, First, MI, Jr., Sr., III)				
MAIDEN NAME	DATE OF BIRTH (MM/DD/YY)	STATE OF BIRTH	SEX	RACE
ALIAS NAME(S)	[redacted]			

ADDRESES FOR PAST 5 YEARS STREET	CITY	STATE	STREET	CITY	STATE

Have you ever been charged / pled guilty to or been convicted or any criminal act in this state or any state?

☐ YES (Complete section below) ☐ NO, I have not been charged / pled guilty to or been convicted or any criminal offense in this state or any state.

DATE	CITY	STATE	COUNTY	CIRCUMSTANCES (Identify charges, attach separate page, if necessary.)

Have you ever been substantiated as a perpetrator in any child abuse or neglect report made to the Division of Family Services in this state or any state?

☐ YES (Complete section below) ☐ NO, I have not been substantiated as a perpetrator in any child abuse or neglect report..

DATE	CITY	STATE	COUNTY	CIRCUMSTANCES (Attach separate page, if necessary.)

The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant permission to the Department of Social Services to obtain any and all information needed to process my request and to use the information as permitted by law.

SIGNATURE OF APPLICANT (REQUIRED IN INK)	DATE
SIGNATURE OF CHILD CARE PROVIDER (Required in ink)	DATE
TITLE OF CHILD CARE PROVIDER	TELEPHONE
STATE AGENCY	STATE VENDOR OR CONTRACT NO. (If applicable)

CHECK APPROPRIATE BOX

☒ CHILD CARE RELATED EMPLOYMENT	☐ DOH / CCB CHILD CARE BUREAU	☐ SCHOOLS / PUBLIC AND PRIVATE
☐ CHILD CARE RELATED VOLUNTEER	☐ DMH / DMH VENDOR	☐ DYS
☐ DFS LICENSURE	☐ HEALTH CARE	☐ OTHER _____

RETURN ADDRESS (REQUIRED ON EACH APPLICATION)
Complete your mailing label below
Confidential Mail

AGENCY NAME	Equine-Assisted Therapy, Inc.
ATTENTION	Lulu Bogolin
ADDRESS	3369 Hwy 109
CITY, STATE, ZIP CODE	Wildwood, MO 63038

Equine-Assisted Therapy, Inc.

HIPPA VOLUNTEER CONFIDENTIALITY AGREEMENT

THIS AGREEMENT entered into this ____ day of_____, 20_____, by and between EQUINE-ASSISTED THERAPY, INC. known as the "Therapeutic Facility", and _____ known as the "Volunteer", and known collectively as the "Parties", set forth the terms and conditions under which information created or received by or on behalf of this Therapeutic Facility (known collectively referred to as protected health information, or "PHI") may be used or disclosed under State law and the Health Insurance Portability and Accountability Act of 1996 and updated through HIPAA Omnibus Rule of 2013 and will also uphold regulations enacted there under (hereafter "HIPAA").

THEREFORE, in consideration of the premises and the covenants and agreements contained herein, the Parties hereto, intending to be legally bound hereby, covenant and agree as follows:

1. **Confidential Information.** The Parties acknowledge that safety while volunteering may or will necessitate disclosure of Confidential Information by this Therapeutic Facility to the Volunteer and use of Confidential Information by the Volunteer. The term "Confidential Information" includes, but is not limited to, PHI, any information about participants or other volunteers, participant records or billing information, any participant lists, any financial information about this Therapeutic Facility or its participants that is not public, any intellectual property rights of Practice, any proprietary information of Practice and any information that concerns this Therapeutic Facility's contractual relationships, relates to this Therapeutic Facility's competitive advantages, or is otherwise designated as confidential by this Therapeutic Facility.

2. **Disclosure.** Disclosure and use of Confidential Information includes oral communications as well as display or distribution of tangible physical documentation, in whole or in part, from any source or in any format (e.g., paper, digital, electronic, internet, social networks, magnetic or optical media, film, etc.). The Parties have entered into this Agreement to induce use and disclosure of Confidential Information and are relying on the covenants contained herein in making any such use or disclosure. This Therapeutic Facility, not the Volunteer, is the records owner under state law and the Volunteer has no right or ownership interest in any Confidential Information.

3. **Applicable Law.** Confidential Information will not be used or disclosed by the Volunteer in violation of applicable law, including but not limited to HIPAA Federal and State records owner statute; this Agreement; the Practice's Notice of Privacy Practices, as amended; or other limitations as put in place by Practice from time to time. The intent of this Agreement is to ensure that the Volunteer will use and access only the minimum amount of Confidential Information necessary to perform the Volunteer's duties and will not disclose Confidential Information outside this Therapeutic Facility unless expressly authorized in writing to do so by this Therapeutic Facility. All Confidential Information received (or which may be received in the future) by Volunteer will be held and treated by him or her as confidential and will not be disclosed in any manner whatsoever, in whole or in part, except as authorized by this Therapeutic Facility and will not be used other than in connection with the employment relationship.

4. **Gate and Door Codes and Password.** The Volunteer understands that he or she may be given a gate and or door code or password by Practice, which may be changed as this Therapeutic Facility, in its sole discretion, sees fit. The Volunteer will not change the gate and or door code or password without this Therapeutic Facility's permission. Nor will the Volunteer leave this Confidential Information unattended.

5. **Returning Confidential Information.** Immediately upon request by this Therapeutic Facility, the Volunteer will return all Confidential Information to this Therapeutic Facility and will not retain any copies of any Confidential Information, except as otherwise expressly permitted in writing signed by this Therapeutic Facility. All Confidential Information, including copies thereof, will remain and be the exclusive property of this Therapeutic Facility, unless otherwise required by applicable law. The Volunteer specifically agrees that he or she will not, and will not allow anyone working on their behalf or affiliated with the Volunteer in any way, use any or all of the Confidential Information for any purpose other than as expressly allowed by this Agreement. The Volunteer understands that violating the terms of this Agreement may, in this Therapeutic Facility's sole discretion, result in disciplinary action including termination of employment and/or legal action to prevent or recover damages for breach. Breach reporting is imperative.

6. **Breach.** The Parties agree that any breach of any of the covenants or agreements set forth herein by the Volunteer will result in irreparable injury to this Therapeutic Facility for which money damages are inadequate; therefore, in the event of a breach or an anticipatory breach, Practice will be entitled (in addition to any other rights and remedies which it may have at law or in equity, including monetary damages) to have an injunction without bond issued enjoining and restraining the Volunteer and/or any other person involved from breaching this Agreement.

7. **Binding Arrangement.** This Agreement shall be binding upon and endure to the benefit of all Parties hereto and to each of their successors, assigns, officers, agents, volunteers, shareholders, and directors. This Agreement commences on the date set forth above and the terms of this Agreement shall survive any termination, cancellation, expiration, or other conclusion of this Agreement unless the Parties otherwise expressly agree in writing.

8. **Governing Law.** The Parties agree that the interpretation, legal effect, and enforcement of this Agreement shall be governed by the laws in the State of Missouri and by execution hereof, each party agrees to the jurisdiction of the courts of the State. The Parties agree that any suit arising out of or in relation to this Agreement shall be brought in the county where this Therapeutic Facility's principal place of business is located.

9. **Severability.** If any provision under this Agreement shall be held invalid or unenforceable for any reason, the remaining provisions and statements shall continue to be valid and enforceable.

IN WITNESS WHEREOF, and intending to be legally bound, the Parties hereto have executed this Agreement on the date first above written, when signing below and after training on HIPAA Law with full understanding this agreement shall stand.

The Health Insurance Portability Act of 1996 (HIPAA) requires our privacy officer to train volunteers on our health information privacy policies and procedures to the HIPAA Omnibus Standards of 2013 which also includes HI-TECH and Protected Health Information (PHI), Electronic Protected Health Information (ePHI), and Electronic Health Records (EHR). All volunteers with treatment, payment, or Therapeutic operations responsibilities, which allow access to protected health information, are trained with updates periodically as State and Federal mandates require. HIPAA also requires that we keep this documentation (that the training was completed) for six years after the training.

I, the undersigned, do hereby certify that I have received, read, understood, and agree to abide by this

Therapeutic Facilities HIPAA Policies and Operating Procedures.

Name: _____ **Signature:** _____ **Date:** _____

(First parent/legal guardian OR Participant if 18 or older)

Name: _____ **Signature:** _____**Date:** _____

(Second parent/legal guardian)

Equine-Assisted Therapy, Inc.

Drug and Alcohol Policy

Equine-Assisted Therapy. Inc. (EAT) is an alcohol and drug-free workplace. EAT prohibits the possession, sale, consumption, or being under the influence of alcoholic beverages, marijuana, or any illegal drugs by employees, contract workers, or volunteers while on the premises of EAT in Wildwood or any satellite location, during working hours, outside the office, while on agency business, or in an agency vehicle. Any employee, contract worker, or volunteer found possessing, selling, consuming, or being under the influence of alcoholic beverages or marijuana while on duty will be subject to discipline, up to and including termination or be precluded from being a volunteer. Prescription drugs or over-the-counter medications, taken as prescribed, are an exception to this policy.

Occasional exceptions to this policy against the consumption of alcoholic beverages may be made at the Executive Director's or vote by the Board of Directors' discretion for small quantities of such beverages reasonable under the circumstances, usually wine or beer, which may be available at office parties or EAT sponsored events on property. At such parties and events, all personnel are expected to exercise good judgment and moderation. In no event may any underage individual consume alcohol at any EAT sponsored event, and all personnel are expected to comply fully with all laws (including laws prohibiting the operation of motor vehicles while under the influence of alcohol), and to take safety precautions including arranging for a designated sober driver.

Code of Conduct

Equine-Assisted Therapy, Inc. expects all employees, contract workers, team members, volunteers, and clients to treat each other and those whom they may encounter while representing EAT with respect and integrity. Inclusion is a vital tenant of our organization.

Anyone who displays behavior that could be detrimental to any of the parties listed above, or endanger them in any way, will be asked to leave the premises immediately.

This code of conduct also applies to our property, horses, and other animals.

Name: _____ **Signature:** _____ **Date:** _____

(First parent/legal guardian OR Participant if 18 or older)

Name: _____ **Signature:** _____**Date:** _____

(Second parent/legal guardian)