VOLUNTEER/STAFF and APPRENTICE Application Package

EQUINE THERAPY ASSOCIATES
www.equinetherapyassociates.com
P.O. Box 59253 ■ Potomac, MD ■ 20859-9253 ■ USA
Phone: 301.972.7833 Fax: 301.972.7101
Emergency Phone: 301.651.6622

Thank you for applying to ETA! For your safety, NARHA's FREE one hour online safety course is required by all Volunteers, Staff members and or Apprentices, regardless of age, and regardless of parental or non-parental status. PLEASE DO THIS FIRST, AS IT TAKES 3-5 BUSINESS DAYS TO GET YOUR USER ID AND PASSWORD FROM NARHA!

Go to tmcchesney@narha.org, and ask for the online NARHA Volunteer course. Give our Premier Center number, 42967, so that you can take the course for FREE! Put your contact information and phone number in your e-mail, and NARHA will e-mail you the codes necessary to take the course. Thank you.

1. **ETA is unable to process incomplete forms.** Thus, if you need to update your tetanus shots (within five years) or your last TB test (within 12 months), please do not send your forms until those items are complete, and you can also forward proof of a negative TB. All forms and payment for lessons should be RECEIVED by ETA at least one week before the start of lessons or the date of your Farm Training session (see the Annual Calendar on ETA's website). For insurance reasons, and because of NARHA requirements, ETA is unable to train Volunteers, Staff, and or Apprentices until their paperwork, including shots and TB tests, are complete.

2. Please print out each of the four forms, sign and date it where appropriate and mail to ETA at P.O. Box 59253 in care of The Registrar.

3. Parents as well as teens under 18 must sign each Volunteer form.

4. Please do not forget to email to ETA your Course Completion Certificate just as soon as you finish the online NARHA course. It is necessary to meet ETA and insurance requirements.

5. Please print out your online NARHA course for your Volunteer Handbook, and bring it along to your Farm Volunteer Training. You will refer to it often.

Please include with your application package written documentation from your physician or clinic that you have received a tetanus shot (current within five years) and a NEGATIVE TB test (current within 12 months). Thank you!

ETA needs from EVERY potential rider, volunteer and or apprentice the "Participant's Consent for Release of Information." Without it, ETA is unable to comply with federal regulations requiring proof of your consent to hold any confidential data. If you will not be a rider, check "Other: Personal, contact, emergency medical, hospital and insurance data.

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Volunteer/Staff Information Form and Health History

General information

Name: ____ Date: ________________

Address: ____

Date of Birth: __________ Phone: (H)__________________ (W)______________________

Employer/School: ____

Address: ____

Parent/Legal Guardian/Caregiver Name/Address/Phone Number:_____________________

____

How did you learn about the program? ______________________________________

Recent medical tests: Last Tetanus Shot: __________ Tuberculosis Test + -- Date: __________

Tetanus must be current within five years; a negative tb test must be current within 12 months

Health History

Please describe your current health status, particularly regarding the physical/emotional demands of working in an equine assisted program. Address fitness, cardiac, respiratory, bone or joint function, recent hospitalizations/surgeries, or lifestyle changes.

____

____

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____

____

____

____

Allergies: ____

____

Medications: ____

____

____

Check which areas you are interested in:

Program	Special Events	Administration	
❑ Horse Handling	❑ Horse Show	❑ Public Relations	❑ Photography/Video
❑ Sidewalking with a Student	❑ Fundraising	❑ Grant Writing	❑ Budget & Finance
❑ Stable Management	❑ Special Olympics	❑ Newsletter	❑ Future Planning
❑ Facility Repairs	❑ Trail Rides	❑ Volunteer Recruitment	

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.

Signature: ____ Date: ________________

(volunteer/staff/caregiver; signed in presence of center staff)

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Volunteer/Staff Information Form and Health History - Page 2

Name: ____

Address: ____

Phone: ______________________ Date of Birth: ______________________

Photo Release
I ❑ DO
❑ DO NOT

consent to and authorize the use and reproduction by ________ Equine Therapy Associates ________
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: ______________

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

____

____

I, ______________________ (volunteer/staff), authorize ____ Equine Therapy Associates ____ 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 NARHA 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/staff)

CURRENT DRIVER'S LICENSE Y N LICENSE NUMBER ______________________ STATE ________

Confidentiality Agreement
I understand that all information (written and verbal) about participants at this NARHA 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: ______________
(volunteer/staff)

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Participant's Consent for Release of Information

I hereby authorize: ____ ______________________
(person or facility)

to release information from the records of: _____________________________ DOB: ____________
(participant's name)

The information is to be released to: Equine Therapy Associates

for the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below:

- ❑ Medical History
- ❑ Physical Therapy evaluation, assessment and program plan
- ❑ Occupational Therapy evaluation, assessment and program plan
- ❑ Speech Therapy evaluation, assessment and program plan
- ❑ Mental Health diagnosis and treatment plan
- ❑ Individual Habilitation Plan (I.H.P.)
- ❑ Classroom Individual Education Plan (I.E.P.)
- ❑ Psychosocial evaluation, assessment and program plan
- ❑ Cognitive-Behavioral Management Plan
- ❑ Other: ____

This release is valid for one year and can be revoked, in writing, at my request.

Signature: ____ Date: ____________

Print Name: ____

Relation to Participant: ______________________________________

Please send materials to: Equine Therapy Associates

(please see address above)

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Authorization for Emergency Medical Treatment Form

❑ Participant ❑ Staff ❑ Volunteer

Name: ______________________________ DOB: ____________ Phone: ______________

Address: ____ ____________________

Physician's Name: __________________________ Preferred Medical Facility: ______________

Health Insurance Company: ______________________ Policy #: __________________________

Allergies to medications: ____________________ ______________________________

Current medications: ________________________ ______________________________

Date of last tetanus shot: ________; Date of last TB test: _______; Are you positive for any infectious disease or are you "colonized" for any antibiotic resistant bacterium/fungus? _______, if so what: ________. If so, what precautions must you and ETA's staff and volunteers take to prevent contamination? ______________________________.

In the event of an emergency, contact:

Name: ______________________________ Relation: ___________ Phone: ______________

Name: ______________________________ Relation: ___________ Phone: ______________

Name: ______________________________ Relation: ___________ Phone: ______________

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 ______Equine Therapy Associates______ 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
Signed in presence of ETA staff

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid 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 will remain on site at all times during equine assisted activities
❑ In the event emergency treatment/aid is required, I wish the following procedure to take place:

____

____

____

Date: ___________ Non-Consent Signature: ______________________________________

Client, Parent or Legal Guardian
Signed in presence of ETA staff