CLOUD DANCERS
THERAPEUTIC HORSEMANSHIP

Volunteer Application

(Must be 14 yrs. old to Volunteer)

Please Email Completed Form to volunteer@clouddancersthp.org **OR**
Mail to PO Box 14058 Albuquerque, NM 87919

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phones: (H) _____ (C) _____ (W) _____ Email: _____

If volunteer is under 18 yrs. Parent/Legal Guardian's Name:_____

Phones: (H) _____ (C) _____ (W) _____ Email: _____

How did you hear about Cloud Dancers (CD)? _____

Names of friends/relatives employed by or volunteering at CD: _____

Why do you want to volunteer for CD? _____

Are you presently able to perform the duties of the volunteer position (s) you have identified as of interest to you with or without reasonable accommodation?

Have you ever been convicted of a felony? Conviction of a crime is not an automatic bar.

Please describe the nature of the offense: _____

Court: _____ Sentence and Place: _____

Education and Experience

◯ High School/GED ◯ Associates ◯ Bachelors ◯ Masters ◯ MD ◯ PhD

Present or Last Employer: _____ Start Date: _____End Date: _____

Title and Responsibilities: _____

If applicable, Reason for Leaving: _____

Present or Previous Volunteer Experience

Dates	Organization	Position/Responsibilities	Reason for Leaving

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References

Name	Capacity/Years Known	Phone

Applicant's Agreement

My answers to the questions on this application are true and complete. I authorize Cloud Dancers Therapeutic Horsemanship to investigate all references and information given. I agree that any false statement or misrepresentation on this application may be cause for refusal to appoint me to a volunteer position, or for immediate dismissal as a volunteer. I further understand that my work with Cloud Dancers will be subject to verification of legal age requirements or any applicable requirements for working with youth or adults with disabilities. I further understand that my relationship with Cloud Dancers may be terminated with or without cause at any time.

Applicant Name (Print): _____ **Signature:** _____ **Date:** _____

If Applicable, Parent/Legal Guardian (Print): _____

Parent/Legal Guardian Signature: _____ **Date:** _____

Office Use ONLY

Interviewer Name (Print): _____ Signature: _____ Date: _____

Applicant Start Date: _____ Position: _____

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Volunteer Release Agreement

I, _____, would like to participate in the Cloud Dancers Therapeutic Horsemanship Program as a Volunteer. I acknowledge the hazards and potential risks of equine activities. I hereby, intending to be legally bound, for myself, my heirs, my assigns, executors or administrators, waive and release forever all claims for damages against Cloud Dancers, its officers, directors, guarantors, instructors, therapists, aides, volunteers and/or employees or contractors for any and all injuries and/or losses I may sustain while participating in any Cloud Dancers lessons, programs or events, whether caused directly or indirectly by any negligence (active or passive) attributable to Cloud Dancers, its officers, directors, guarantors, instructors, therapists, aides, volunteers and /or employees or contractors.

Volunteer Signature: _____

If Applicable, Parent/Legal Guardian (Print): _____

Parent/Legal Guardian Signature: _____ **Date:** _____

Confidentiality Agreement

I, _____, understand that all information (written and verbal) about clients of Cloud Dancers Therapeutic Horsemanship program are confidential and will not be shared with anyone without the express written consent of the client and/or their parent or guardian, or order of the Court. Failure to comply with this policy could result in reprimand, loss of certain volunteer responsibilities, or termination.

Volunteer Signature: _____

If Applicable, Parent/Legal Guardian (Print): _____

Parent/Legal Guardian Signature: _____ **Date:** _____

Consent to Photography, Videotape, Televised Recordings and/or related Media Recordings

I, _____, hereby ◯ Consent ◯ Do not Consent to Cloud Dancers right to photograph, televise, film, videotape and/or sound record the acts, appearances, and utterance of the undersigned and to use any descriptive words or name of the undersigned in connection and without limit as to time, to produce and reproduce the same or any part thereof by any method and to use said photographs, films, videotapes and/or sound recordings for any purpose which Cloud Dancers deems proper in the interest of newspapers, television, media, website, brochures, pamphlets, flyers or instructional materials. All such photographs, films and/or sound recordings shall be exclusive property of Cloud Dancers, and hereby relinquish all right, title and interest therein. With respect to the foregoing, no inducements or promises have been made to me to secure my signature to this release other than the intention of Cloud Dancers to use or cause to be used such photographs, films and pictures for the primary purpose of promoting and aiding Cloud Dancers and its work.

Volunteer Signature: _____

If Applicable, Parent/Legal Guardian (Print): _____

Parent/Legal Guardian Signature: _____ **Date:** _____

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Volunteer Health History and Emergency Contact Form

Volunteer Name: _____Birthdate:_____

Parent/Guardian (if under 18 years old): _____

Phone: Cell_____Home_____Work_____

Health History – Please describe your current health status particularly regarding the physical/emotional demands of working in a therapeutic riding program. Address fitness, cardiac, respiratory, bone or joint function, recent hospitalizations/surgeries, special precautions (i.e. epi-pen, pacemaker, etc.).

_____

Allergies: _____

Medications Relative to Above: _____

If you want us to contact your doctor or send you to a particular hospital in the event of an emergency:

Physician: _____Phone: _____

Preferred Hospital: _____ Phone: _____

In Case of Accident or Injury Contact:

Name: _____ Relationship: _____Phone:_____ Email: _____

Name: _____ Relationship: _____Phone:_____ Email: _____

In the event emergency medical aid/treatment is required due to illness or injury during your volunteer activities or while being on Cloud Dancer property or at a Cloud Dancer event, I authorize Cloud Dancers to:

Initial: ____ Secure and retain medical treatment and transportation if needed.

Initial: ____ Release this form, upon request, to the authorized individual or agency involved in the medical emergency treatment.

Volunteer Signature: _____

If Applicable, Parent/Legal Guardian (Print): _____

Parent/Legal Guardian Signature: _____ Date: _____

It is within my rights to withhold this information and I choose to do so.

Volunteer Signature: _____

If Applicable, Parent/Legal Guardian (Print): _____

Parent/Legal Guardian Signature: _____ Date: _____