



# Volunteer Application

(Must be 14 yrs. old to Volunteer)

Please Email Completed Form to [volunteer@clouddancersth.org](mailto:volunteer@clouddancersth.org) OR  
Mail to PO Box 10489 Albuquerque, NM 87184

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?  No  Yes

Have you ever been convicted of a felony? Conviction of a crime is not an automatic bar.  No  Yes

Please describe the nature of the offense: \_\_\_\_\_

Court: \_\_\_\_\_ Sentence and Place: \_\_\_\_\_

### Education and Experience

High School/GED  Associates  Bachelors  Masters  PhD  Other

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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**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 and passing a background check. 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:** \_\_\_\_\_



## 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:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**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:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If Applicable, Parent/Legal Guardian (Print):** \_\_\_\_\_

**Parent/Legal Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Volunteer Health History and Emergency Contact Form

Volunteer Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Parent/Guardian (if under 18 years old): \_\_\_\_\_

Phone: Cell \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_

Current Health Insurance Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

**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: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**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 agencies authorized and involved in medical emergency treatment.

Volunteer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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: \_\_\_\_\_ Date: \_\_\_\_\_

If Applicable, Parent/Legal Guardian (Print): \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Confidentiality/Non-Compete Agreement

In light of my staff or volunteer service with Cloud Dancers Therapeutic Horsemanship, I agree to the following:

I will not publish, communicate, or use any Confidential information either during or after my service with Cloud Dancers, except as these matters relate to the business of Cloud Dancers or are within the written consent of Cloud Dancers. Confidential information may include, but is not limited to, such things as client personal and medical information; staff or other volunteer personal and medical information; financial matters; or confidential information related to donors or donations or strategic plans not communicated to the public. Confidential client information, with express permission of the parents or guardian, or order of the court, may be shared with volunteers or staff on a need to know basis, to ensure the safety and well-being of riders in our programs.

During my service with Cloud Dancers, I will not directly or indirectly compete with Cloud Dancers in the development, production, marketing or servicing of any product or service with which Cloud Dancers is involved, nor will I aid or become associated with others in such acts.

Failure to comply with this policy could result in reprimand, loss of certain volunteer responsibilities, or terminations.

**Volunteer/Staff Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If Applicable, Parent/Legal Guardian (Print):** \_\_\_\_\_

**Parent/Legal Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## Staff/Volunteer Acknowledgement of Risk

I, \_\_\_\_\_ (Print Name), am aware of the risks of contracting COVID 19 while working or volunteering for Cloud Dancers Therapeutic Horsemanship. I acknowledge that certain at-risk populations such as persons over age 60 and those with underlying medical conditions are more susceptible to the disease.

I am also aware that face-to-face services increase my risk of contracting and passing on COVID 19. Cloud Dancers cannot guarantee social distancing where support or assistance is needed to mount/dismount, balance or sit upright on a horse, address bodily fluid from the facial area, or in cases of emergencies or other unforeseen circumstances.

I have read Cloud Dancers Rider and Family Information and Volunteer packets relative to COVID 19, our Cleaning & Disinfecting Protocol for Prevention of the Spread of COVID 19 and agree to follow these guidelines, as well as, the Governor's, New Mexico Department of Health and CDC mandates as they relate to COVID 19.

I knowingly accept the additional risks stated above, despite reasonable precautions, and agree to release, acquit, discharge and hold harmless Cloud Dancers Therapeutic Horsemanship Program, Inc., its officers, trustees, agents, employees, contractors, representatives, staff, volunteers, successors and assigns, for all manner of claims, demands and damages of every kind and nature whatsoever, which the undersigned may now, or in the future, have against Cloud Dancers related to any matters associated with COVID 19.

**Volunteer/Staff Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If Applicable, Parent/Legal Guardian (Print):** \_\_\_\_\_

**Parent/Legal Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_