



214 Asbury Road
Egg Harbor Township, NJ 08234
(609) 703-9130
info@HeartsTRC.com

Volunteer Application

Name: _____

Date of Birth: _____ Gender (circle one) male female

Address: _____

Email address: _____

Best phone #: _____ Alternate #: _____

Are you attending school? Name? _____

Parent or guardian's names (if under 18 years): _____

Phone if different from above

Best phone #: _____ Alternate #: _____

Our hours of operation are:

Monday, Tuesday, Wednesday, Thursday 2:30 – 6:00 pm

Saturday 9:30 – 1:00 pm

Days you are available: _____ Times: _____

Are you available any mornings for school groups?: _____

Why do you want to volunteer with Hearts?: _____

How did you learn of our volunteer needs?: _____

Do you require community service hours? Yes _____ No _____

CONTINUE TO NEXT PAGE

Horse experience is not necessary but please describe if you have any: _____

Lesson volunteers are expected to be able to lift, bend, stand, walk and/or jog short distances for up to 30 minutes at a time. Sidewalkers may also be required to hold their arm above shoulder height for the duration of a lesson. Please be aware these activities may be conducted on days that are hot and/or humid or cold.

Areas of Interest:

- | | |
|---|--|
| <input type="checkbox"/> Horse leader | <input type="checkbox"/> Side walking with a student |
| <input type="checkbox"/> Administrative/office work | <input type="checkbox"/> Fundraising |
| <input type="checkbox"/> Grounds/maintenance | <input type="checkbox"/> Special Events |
| <input type="checkbox"/> Marketing | |

Do you have special skills that could be of benefit to Hearts?

- | | |
|--|--|
| <input type="checkbox"/> Videography | <input type="checkbox"/> Photography |
| <input type="checkbox"/> Computer skills | <input type="checkbox"/> Grant writing |

For grant application purposes:

Occupation _____

Place of work _____

Confidentiality Agreement

I agree what I see at HeartsTRC Inc, what I hear at HeartsTRC Inc, when I leave HeartsTRC Inc, will remain at HeartsTRC Inc in order to protect the privacy of the riders and their families.

Print name: _____

Signature: _____ Date _____

CONTINUE TO NEXT PAGE

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Name: _____ Date of Birth: _____

Address: _____

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. _____

Allergies: _____

Medications: _____

Physician's Name: _____ Phone: _____

In the event of an emergency contact:

Name: _____ Relation to you: _____ Phone: _____

Name: _____ Relation to you: _____ Phone: _____

Sign one or the other but not BOTH

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 property, I authorize Hearts TRC Inc to:

- 1. Secure and retain medical treatment and transportation if needed.*
- 2. Release client records or health history 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'.

Date: _____ Consent Signature: _____

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 property.

Parent or legal guardian will remain on site AT ALL TIMES during equine assisted activities. In the event of emergency treatment/aid is required, I wish the following procedure to take place:

Date: _____ Non Consent Signature: _____