



Offering Alternative Therapy with Smiles, Incorporated

~ horseback riding for the disabled ~



## Volunteer Registration Form

**You should be able to fill this out on your computer.  
If you are filling this out by hand, please print clearly & use black or blue ink.**

How did you learn about OATS?		Date:	
Name:		DOB:	Age:
Address:		City/Zip:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Email Address:		
Home Phone:	Cell Phone:		
Parent/Guardian (if under 18):			
Address, if different from above:			
Home Phone:	Cell:	Work:	

### My Participation as a Volunteer

**Please mark the boxes below next to the areas for which you would like to volunteer.**

**I am here as a one time event with (Group Name):**

<input type="checkbox"/> Horse Handling	<input type="checkbox"/> Volunteer Recruitment	<input type="checkbox"/> Public Relations	<input type="checkbox"/> Fund Raising
<input type="checkbox"/> Side Walking with a rider	<input type="checkbox"/> Leading Volunteer Groups	<input type="checkbox"/> Speakers Bureau	<input type="checkbox"/> Grant Writing
<input type="checkbox"/> Stable Management	<input type="checkbox"/> Photography/Video	<input type="checkbox"/> Special Events	<input type="checkbox"/> Website help
<input type="checkbox"/> Facility Repairs <input type="checkbox"/> Electrical <input type="checkbox"/> Plumbing <input type="checkbox"/> Carpentry <input type="checkbox"/> Landscaping & Grounds			<input type="checkbox"/> Help with Mailings/office
<input type="checkbox"/> You tell us how you would like to assist our organization:			

### I am available to help with classes during the times I've checked below:

<input type="checkbox"/> Mon 5-8 pm	<input type="checkbox"/> Tues a.m.	<input type="checkbox"/> Tues 5-8 pm	<input type="checkbox"/> Wed 5- 8 pm	<input type="checkbox"/> Thurs 5-8 pm	<input type="checkbox"/> Sat 8-12noon	<input type="checkbox"/> other
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### Do You Need Community Service Hours?

<input type="checkbox"/> No <input type="checkbox"/> Yes   How many hours?	For what organization do you need hours?
<p><b>If yes, you need to fill out and bring the included community service log with you, each time you volunteer. It is your responsibility to make sure it is signed when you arrive and again when you leave. OATS cannot document your hours, unless this log is completed. Thanks for your co-operation!</b></p>	

## Health & Activity Information

Do you have any allergies?

Are you allergic to any medications?

Physical limitations or Medical Conditions?

Last tetanus shot date:  
Positive

Latest TB test:

Result:  Negative

Can you walk for 60 minutes & jog short distances?

Can you support a rider by holding him by the waist or belt? (This may mean keeping your arm above shoulder height.)  yes  no

Are you comfortable working with horses & other animals?  Yes  No Please list any experience you've had with animals:

Do you have any experience working with people with disabilities?  Yes  No If yes, please explain:

## Personal Background & Information Release

Have you ever been **charged** with or **convicted** of a crime? No  Yes  If yes, please explain:

I, \_\_\_\_\_, authorize OATS 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 against children or animals. I understand that such access is for the purpose of considering my applications as an employee/volunteer and the I expressly DO NOT authorize O.A.T.S., its directors, officers, employees, or other volunteers to disseminate this information in any way to any other individual, group, agency, organization, or corporation.

Signature: (Parent or Guardian, if under 18):  
Printed Name:

Date:

Do you have a current Drivers License: YES  NO  License # & State:

## Confidentiality Agreement

I understand that all information (written and verbal) about O.A.T.S. participants 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).

Initials: (Parent or Guardian, if under 18):

Date:

## Liability Release

I, \_\_\_\_\_, would like to participate in the O.A.T.S.hrh riding program. I acknowledge the risks and dangers, together with potentials risks and dangers of horseback riding. However, I think that the possible benefits to myself/my son/my daughter/my ward are greater than the risks assumed. I have read the warning mandated by the Michigan Equine Activity Liability Act. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors, administrators or personal representatives, waive and release forever all claims for damages against O.A.T.S. hrh, its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses that I/my son/my daughter/my ward may sustain while participating in O.A.T.S.hrh activities or upon the O.A.T.S.hrh premises.

Signature: (Parent or Guardian, if under 18):  
Printed Name:

Date:

## Photo Release

I hereby consent to and authorize the use and reproduction by O.A.T.S.hrh of any and all photographs and any other audio/visual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities or any other use for the benefit of O.A.T.S.hrh programs.  Yes  No

Initials: *(Parent or Guardian, if under 18)*:

Date:

## Michigan Equine Activity Liability Act Warning

I understand that under the Michigan Equine Activity Liability Act, an equine professional is not liable for an injury to or the death of a participant in an equine activity resulting from an inherent risk of equine activity.

Initials: *(Parent or Guardian, if under 18)*:

Date:

## Authorization for Emergency Medical Treatment

*You **must** sign either "Consent Plan" or "Non-Consent Plan"*

In the event that emergency medical aid and/or treatment is required due to illness or injury, during the process of receiving services, while volunteering or while being on the premises of O.A.T.S.hrh, I authorize O.A.T.S.hrh :

- To secure and retain medical treatment and transportation, if needed.
- To release client records, upon request, to the authorized individual or agency involved in the emergency medical treatment.

Emergency Contact:

Phone:

Secondary Emergency Contact:

Phone:

Physician's Name:

Phone:

Preferred Medical Facility:

Health Insurance:

Policy Number:

CONSENT – I DO give my consent for emergency medical treatment. This authorization includes x-ray, surgery, hospitalization, medication and any treatment or procedure deemed "life saving" by the physician. This provision will only be invoked if the person listed below is unable to be reached.

Name:

Phone:

Address:

City, State, Zip

Signature: *(Parent or Guardian, if under 18)*:

Date:

Printed Name:

NON-CONSENT - I DO NOT give my consent for emergency medical aid and/or treatment in case of illness or injury during the process of receiving services, while volunteering or while being on the premises of O.A.T.S.hrh. In the event that emergency treatment or aid is required, I wish the following to take place: (please fill in your express directions:)

Signature: *(Parent or Guardian, if under 18)*:

Date:

Printed Name:

## Class Cancellation Notification

In the rare event that a class or event must be cancelled, for which you are scheduled to volunteer, we will text or eMail you.

Cell phone # & Cell company (i.e., AT&T, Sprint, T-Mobile, Verizon):

Email, if different from page one: