CENTRAL ILLINOIS RIDING THERAPY
A VOLUNTARY, NON-PROFIT ORGANIZATION PROVIDING RIDING THERAPY FOR PEOPLE WITH DISABILITIES.
305 Neumann Drive, East Peoria, IL 61611 309-699-3710 fax 309-699-4696 www.cirt.info

2025 VOLUNTEER/STAFF INFORMATION & HEALTH HISTORY

General Information

Name: _____ Gender: M F Home Phone: _____
Date of Birth: _____ Age: _____ T-shirt Size: _____ Cell Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
E-mail: _____
Employer/School: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
How did you hear about our program? _____
Any previous horse/riding experience? _____

If you are under the age of 18 please include:

Parent/Legal Guardian: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
E-mail: _____

CHECK THE AREAS YOUR ARE INTERESTED IN:

Program Volunteer
- ☐ Leading a Horse
- ☐ Side Walking with a Rider
- ☐ Stable Management
- ☐ Tack Management
- ☐ Photography/Video
- ☐ Facility Repairs
- ☐ Drill Team

Competition
- ☐ Horse Shows
- ☐ Barn Dance Fundraiser
- ☐ Special Olympics
- ☐ Pre-Show Preparation
- ☐ Concession Stand Crew

Administration
- ☐ Volunteer Recruitment
- ☐ Newsletter/Public Relations
- ☐ Budget & Finance
- ☐ Future Planning
- ☐ Fundraising
- ☐ Board Member
- ☐ Website

Special skills & talents (such as sign language, public speaking) that you would like to contribute to our program: _____
_____
I would like to commit to a regular day: _____ and time: _____. In addition to my regular day/time I can be on call: Y N
How many hours a week do you want to volunteer? _____ Indicate your availability:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

Health History

Describe your current health status in regards to the physical/emotional demands of working in a therapeutic riding program. Address fitness, cardiac, respiratory, bone or joint function, recent surgeries/hospitalizations, or lifestyle changes: _____
_____
Allergies: _____
Medications (name only): _____
Date of Last Tetanus Shot: _____ Date of Last Tuberculosis Test: _____ + -

Become a CIRT "Spur Sponsor". For a minimum donation of **$25** you will receive a ***FREE t-shirt*** and your name will be included in CIRT's newsletter. If you wish to become a *Spur Sponsor*, please include your check, payable to CIRT, with this form.

☐ Yes, I wish to become a Spur Sponsor. My check, in the amount of $_____ is enclosed.

I understand that the information provided on these forms is accurate to the best of my knowledge; I know of no reason I should not participate in the Central Illinois Riding Therapy program.

Signature: _____ Date: _____
*(Staff/Volunteer/Parent or Legal Guardian if a minor - **To be signed in the presence of CIRT Staff**)*

LIABILITY RELEASE

I would like to participate in the Central Illinois Riding Therapy Program. Under the Equine Activity Liability Act, each Participant who engages in an equine activity expressly assumes the risks of engaging in and legal responsibility for injury, loss, or damage to person or property resulting from the risk of equine activities, except in specific situations as set forth in the Act. (745 ILCS 47/1 et. seq).

I acknowledge the risks and potential for risk of horseback riding. I hereby acknowledge receiving notice of the risks of engaging in equine activities, including (1) the propensity of equine to behave in dangerous ways that may result in injury to the Participant, (ii) the inability to predict an equine's reaction to sound, movements, objects, persons, or animals, and (iii) the hazards of surface or subsurface conditions. However, I feel the possible benefits to myself/my son/my daughter/my ward are greater than the risks assumed. I hereby, am intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release all claims for damages and liabilities against Central Illinois Riding Therapy, its Board of Directors, instructors, therapists, aids, volunteers and/or employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in Central Illinois Riding Therapy.

I certify that I have the legal authority, on behalf of the participant to execute this Release. This release shall remain valid until expressly revoked by the Participant or if a minor, the parent or guardian.

Signature : _____ Date: _____

If a minor, Parent or Guardian Signature: _____ Date: _____

CONFIDENTIALITY STATEMENT

This document confirms that I am recognized as a volunteer of Central Illinois Riding Therapy. I understand that their purpose is to provide quality therapeutic riding classes and other horse related activities in a safe environment to their participants.

Volunteers are a valuable part of the Central Illinois Riding Therapy Program and as a volunteer of Central Illinois Riding Therapy; I have completed available and appropriate training. I understand and agree that in the performance of my duties as a volunteer I must hold personal, medical, financial, and other sensitive information regarding riders/families confidential. Failure to do so may result in loss of privileges. Participant issues may be discussed with the CIRT Director, Instructors, and Therapists.

I will endeavor to keep my standard of conduct high in order to uphold the quality of the Central Illinois Riding Therapy program.

Signature: _____ Date: _____

If a minor, Parent or Guardian Signature: _____ Date: _____

BACKGROUND

Do you have a current driver's license? Y N License Number _____ State _____

For youth volunteers (Age 18 and under): Social Security Number: _____

Have you ever been charged with or convicted of a crime? _____ YES _____ NO If yes, explain

_____

_____

I, _____(volunteer/staff) authorize Central Illinois Riding Therapy 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 PATH Intl. center, its directors, officers, employees, or other volunteers, to disseminate this information in any way to any other individuals, groups, organizations, or corporations.

Signature _____ Date: _____

PHOTO RELEASE

I ____ Do _____ Do Not

Consent to and authorize the use and reproduction by Central Illinois Riding Therapy of any and all photographs and any other audio/visual material taken of me/participant for promotional material, educational activities, exhibitions or any other use for the benefit of the program, including but not limited to CIRT's website, facebook and/or twitter accounts.

Signature: _____ Date: _____

Central Illinois Riding Therapy

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PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

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EMERGENCY MEDICAL TREATMENT INFORMATION

___ Rider ____ Staff ___ Volunteer

Name: _____ Date of Birth: _____ Phone: _____

Address: _____ City: _____ State: _____ County: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Co: _____ Policy Number: _____

Allergies to Medications: _____

Current Medications (name only): _____

IN THE EVENT OF AN EMERGENCY, CONTACT:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

FOR OFFICE USE ONLY

Date Received: _____

Signature Witnessed By: _____

Volunteer Mandatory Training: _____

Signature of Training Instructor: _____

Advanced Volunteer Training: _____

Horse Handling: _____

CPR: _____ First Aid: _____ Sign Language: _____

Other: _____

Volunteered in Areas: _____

Total Annual Hours: _____

Additional Comments: _____

_____