VOLUNTEER APPLICATION

Name: ____ Date of Birth: ____________________

Address: ____

Phone Number: ________________________ Cell phone: ___________________________________

Email Address: ____

Parent/Legal Guardian/Caregiver Name, Address and Phone Number:

____

How did you hear about PSEAT? ____

Health:

Allergies/Health concerns we should be aware of? _______________________________________

Areas of Interest?

☐ Horse Handling	☐ Horse Shows	☐ Grant Writing
☐ Side Walking with a Student	☐ Fundraising	☐ Volunteer Recruitment
☐ Stable Management	☐ Trail Rides	☐ Photography/video
☐ Facility Repairs	☐ Public Relations	☐ Budget/Finance

Photo Release:

I, the undersigned ☐ Do ☐ Do not consent and authorize Prairie Sky Equine Assisted Therapy Association of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or any other use for the benefit of the program.

Signature: ____ Date: ____________________

I agree that the above information provided by me is true and correct. I agree to provide a criminal record check and a child intervention check as a condition of acceptance as a volunteer with the Prairie Sky Equine Assisted Therapy Association.

Signature: ____ Date: ____________________

Confidentiality Agreement

I, _______________________________, agree that I will keep confidential anything I hear or see in regards to personal information as it pertains to any activity related to Prairie Sky Equine Assisted Therapy. This confidentiality agreement is held for an indefinite period of time. I realize that by breaking this agreement I may subject myself to legal action on behalf of Prairie Sky Equine Assisted Therapy or the person/persons affected by a confidentiality breach.

Signature: ____ Date: ____________________

VOLUNTEER APPLICATION

Consent for Medical Treatment

I, ________________________________, the undersigned ☐ Do ☐ Do Not
Consent to medical treatment given to me by any member of Prairie Sky Equine Assisted Therapy Association, or Emergency Medical Services being called for me, in the event I cannot giver verbal consent or am incapacitated and cannot make the decision for myself. In exchange for being given medical care, for myself, my heirs, guardians, and legal representatives, I release and agree not to make or bring any claim of any kind against the Prairie Sky Equine Assisted Therapy Association and/or the property owners, officials, servants, employees, representatives, officers, and directors for any injury (including death) arising out of the medical care given to me.

Signature:____Date:____________________

Emergency Contact:

Name: ____
Phone Number:____
Relationship: ____
Email: ____

Parent/Guardian Information (if applicable)

Name: ____
Phone Number:____
Relationship: ____
Email: ____

Name: ____
Phone Number:____
Relationship: ____
Email: ____