



10861 N US HWY 31 Seymour, IN 47274  
812-350-4864  
Email: [reinstorecovery@gmail.com](mailto:reinstorecovery@gmail.com)

Trained on: _____
Started on: _____
Received by: _____ Date: _____

Today's Date: \_\_\_\_\_

## VOLUNTEER APPLICATION

Name: \_\_\_\_\_ Date of Birth (mm/dd/yy): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer/Occupation: \_\_\_\_\_ Does employer have matching donation program? \_\_\_\_\_

May we call you at work? Yes  No  If yes, phone: \_\_\_\_\_

Preferred method of communication: home  cell  work  email  text

If you are a student, school name: \_\_\_\_\_

Community Affiliations (civic clubs, service organizations, etc.): \_\_\_\_\_

Availability: \_\_\_\_\_ Daytime \_\_\_\_\_ Evenings \_\_\_\_\_ Saturdays (feeding)

Spring  Summer  Fall  Winter

Areas you are interested: Side walker  Horse Leader  Maintenance  Office  fundraising  other \_\_\_\_\_

Describe your horse experience: \_\_\_\_\_

Explain your experience with individuals with special needs: \_\_\_\_\_

List any special skills/talents/certifications: \_\_\_\_\_

Have you ever been arrested or convicted of a crime other than a minor traffic offense? Yes  No  If yes,

Explain: \_\_\_\_\_

List any languages spoken other than English: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Describe any physical/health limitations: \_\_\_\_\_

### Authorization for Emergency Medical Treatment

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

In case of an emergency, I consent  or I do not consent  for Reins to secure medical treatment including x-rays, surgery, hospitalization, transportation and medication as recommended by the attending emergency medical personnel.

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

(Must be Parent/Legal Guardian signature if under 18 years of age)

**\*\*Please continue and complete the next side\*\***

How did you hear about Reins?

Radio  TV  Newspaper  Friend/Family member   
Website  Facebook  Other \_\_\_\_\_

**Confidentiality Policy**

Reins to Recovery, Inc. staff and volunteers will protect the rights and confidentiality of all participants. Medical and personal information regarding participants will be shared with volunteers only for the purpose of providing safe and effective services. No information regarding a participant is to be shared with others outside of the therapeutic environment at Reins to Recovery, Inc. discovery of such disclosure may result in the termination of said volunteer. As a Reins to Recovery volunteer I hereby agree to abide by the above stated confidentiality policy.

**Photo & Media Release**

I consent and authorize  or I do not consent and authorize  the use of any and all promotional, educational, or program photos, videos, or other audio-visual materials of myself while participating at the facility or engaged in an authorized Reins to Recovery activity for promotional material, educational activities, exhibitions, website, or any other use for the benefit of the program.

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

(Must be Parent/Legal Guardian signature if under 18 years of age)

**Waiver Agreement & Liability Release**

My signature below denotes that I agree to all the following as a condition for myself/child/family as it pertains to Reins to Recovery, Inc. (hereafter referred to as the "Center") as a condition for participation in activities at/on/near the Center's premises and property or associated with any Center activity including but not limited to equine-assisted activities, trail riding, arena instruction, barn & pasture activities, demonstrations and public events. Under Indiana law, an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities. As the legal representative of the participant (myself/child/family) I acknowledge the risks and potential for risks of equine related activities. I understand not all risks can be foreseen nor prevented. I understand these risks and assume responsibility for them. I hereby, intending to be legally bound for myself/child/family, heirs and assigns, executors or administrators, waive and release forever all claims for damages (present or future) against Reins to Recovery, Inc., its Board of Directors, Executive Director, Instructors, Staff, Therapists, Volunteers and/or other authorized persons for any and all injuries/losses sustained while participating or visiting at Reins to Recovery, Inc. As consideration for the Center to allow myself/child/spouse/family members to engage in Center related activities, I agree to assume full responsibility for any and all bodily injuries, losses, or damages, which I or they might sustain. It is mutually understood and agreed that the waiver and liability release set forth in this document constitutes a waiver of liability beyond the provisions of the Indiana Equine Activity Liability Act. I further agree to indemnify and hold harmless the Center or persons/entities associated with the Center and to not bring any claim or suit against them on the basis of any exception to the IN Equine Act. Should I breach any part of this waiver/liability release, I agree to pay all the Center's attorney's fees or other legal costs that may occur. I attest that I am at least 18 years of age, of sound mind, not suffering from shock or under the influence of alcohol, drugs or intoxicants. I have read this ENTIRE waiver and application and fully understand it. I intend for this waiver, agreement and liability release to be valid and binding today and at ALL FUTURE TIMES. I attest that all the information I have provided in this application/medical history is true and accurate. My signature denotes agreement with ALL the information on both sides of this form.

**Your signature denotes agreement to abide by the above policies and information.**

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

(Must be Parent/Legal Guardian signature if under 18 years of age)

Please return completed form to the Reins to Recovery office

	Date _____	Initials _____	Date _____	Initials _____
Application				
Renewal:	Date _____	Initials _____	Date _____	Initials _____