



Barn Volunteers Call: 707-781-9455
Event/Office Volunteers Call: 707-769-8900

Please send completed forms to:
P.O. Box 4855, Petaluma, California 94955-4855
Email: volunteer@giantstepsriding.org
Fax: (707) 769-4770

Staff Use Only	
Orientation	Date Completed _____
Instructor Training	Date Completed _____
Training	Date Completed _____
<input type="checkbox"/> Tina Received <input type="checkbox"/> Entered in Raiser's Edge	

Giant Steps Volunteer Application
(Please print clearly or type)

Name: _____ Date of Birth: ____/____/____ Age: _____ Height ____' ____" Male / Female
(Circle One)

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ Email Address: _____

School or Place of Employment: _____ School/Work Address: _____

Spouse/Partner: _____ Spouse/Partner's School or Place of Employment: _____

Are you: First Aid Certified? _____ Date: _____ CPR Certified? _____ Date: _____

Have you ever been convicted of a criminal offense? _____ Yes _____ No If yes, When? _____

Where? _____ Please Explain: _____

The above information may be verified, and I give permission for inquiry to be made as to my suitability to act as a volunteer at Giant Steps.

SIGNATURE: _____ DATE _____

SIGNATURE OF PARENT/GUARDIAN: _____ DATE _____

LIABILITY RELEASE: I acknowledge the risks and potential for risks of horseback riding and activities in and around a facility where horses are kept and farm machinery operated. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. Intending legally to bind myself, my heirs and assigns, executors or administrators, I hereby waive and release forever all claims for damages against Giant Steps Therapeutic Equestrian Center, Inc., its Board of Directors, Instructors, Therapists, Aides, Volunteers, Employees for any and all injuries and losses I/my son/my daughter/my ward may sustain while participating in Giant Steps' therapeutic riding program. This release includes without limitation the risk of negligent instruction and supervision. I engage in activities at Giant Steps Therapeutic Equestrian Center, Inc. voluntarily with knowledge of the risks and I assume all risks of injury, death, and property damage that may result. I agree to bear any loss myself. I acknowledge that Giant Steps Therapeutic Equestrian Center, Inc. and the property owners are materially relying on this waiver and assumption of risk in allowing me or my son/my daughter/my ward to participate in activities at Giant Steps Therapeutic Equestrian Center, Inc.

PHOTO RELEASE: _____ I consent to and authorize
_____ I do not consent to nor do I authorize

the use and reproduction by Giant Steps Therapeutic Equestrian Center, Inc. of any and all photographs and any other audiovisual materials taken of me for promotional printed material, educational activities, exhibitions, or for any other use for the benefit of the program.

POLICY OF CONFIDENTIALITY: Confidentiality is defined as "told in secret or private relations; trusted." Any information in regards to the participants (clients) at Giant Steps must be held in strict confidentiality. It is critical that we respect each individual. Confidentiality is considered one of the most basic responsibilities of our facility. In failure to abide by this policy, the quality of the services we provide may diminish and result in legal ramifications. I have read and understand Giant Steps' Policy of Confidentiality and agree to abide by same.

The undersigned acknowledges that he/she has read this Volunteer Application in its entirety; that he/she understands the terms of this release and has signed this release voluntarily and with full knowledge of the effects thereof.

SIGNATURE: _____ DATE _____

SIGNATURE OF PARENT/GUARDIAN: _____ DATE _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury while being on the property of the agency, I authorize Giant Steps to:

1. Secure and retain medical treatment and transportation, if needed.
2. Release records upon request to the authorized individual or agency involved in the medical emergency treatment.

Volunteer's Name: _____ Today's Date: _____

In case of Emergency, contact*: _____ Relationship: _____ Phone: _____

Physician's Name: _____ Phone: _____

Preferred Medical Facility: _____ Health Insurance Carrier: _____ Policy #: _____

Medical conditions, medications or allergies we should know about: _____

Date of last Tetanus shot: _____ We recommend Tetanus shots every ten years.

*Emergency contact person needs to be a local resident

CONSENT PLAN: (to be invoked in the event that your emergency contact cannot be reached.) I give consent for emergency medical treatment/aid (including x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician) in the event of illness or injury while on the property of the agency.

Date: _____ Consent Signature: _____
(Parent or Guardian if volunteer is under 16 years of age)

NON-CONSENT PLAN: I do not give consent for emergency medical treatment/aid in the event of illness or injury while on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedure(s) to take place:

Date: _____ Non-Consent Signature: _____
(Parent or Guardian if volunteer is under 16 years of age)

GENERAL INFORMATION

Please tell us of your experience with:

- A. Horses: _____
- B. People With Disabilities: _____

I am interested in being involved in the following way(s):

A. Therapeutic Riding Program

- Horse Leading
- Sidewalking
- Instructor

B. Horsemanship

- Schooling Horses
- Tack Cleaning

C. Facility Projects and Maintenance

- Gardening
- Building
- Repairs and Maintenance

D. Special Events and Public Awareness

- Special Events
- Public Outreach
- Phoning or Emailing

E. Office Administration

- Data Entry
- General Office
- Phoning or Emailing

F. Special Skills

- Graphic Design
- IT Support
- Grant Writing
- Bilingual
- Sign Language

How did you learn about Giant Steps? _____

For Program Volunteers:

I understand that I need to make a commitment for a minimum of one 10-week session. ___YES ___NO

I cannot commit to a regular day/time right now, but would like to serve as a substitute: ___YES ___NO

In addition to my regular hours, I would like to act as a substitute on the following day(s)/time(s): _____

Does your employer give time off to volunteer? ___YES ___NO

Does your employer have a donation-matching program? ___YES ___NO

Do you belong to a group that would like to hear more about Giant Steps? ___YES ___NO