Phone: 301-351-2669
Email: volunteer-training@spirittherapies.org
Website: spirittherapies.org/volunteers.html

WHAT IS SPIRIT THERAPIES?

Spirit Therapies is a place where riders with Down's Syndrome, Angelman's Syndrome, MS, Autism, Muscular Dystrophy, spinal cord injuries, emotional distress, and other disabilities experience the expansion of their worlds through the magic of connecting with horses.

Our horses are really four legged therapists, who help our riders improve their lives through physical contact, exercise, and interaction with others which increases communication and social skills.

As our rider's skills increase, so does their self-esteem and general well being. Research has proven that exercise and interpersonal interaction produces profound benefits for individuals with special needs working to reach their full physical, mental and social potential.

Spirit Therapies is dedicated to helping our riders discover their dreams and goals—to help them expand their physical and mental horizons, so they can free their true Spirit and be the best that they can be!

Spirit Therapies is a 501 (c) 3 non-profit organization. Someday through support of our friends, riders, volunteers, sponsors and the public, we will be able to offer our services free of charge through our Pegasus Program.

For more information, please visit our website at www.spirittherapies.org or call Laurie Willmott, Executive Director (702) 219-1728.

VOLUNTEER COVER SHEET

Name: _________________________________Cell phone:_________________________

DOB: ______________________ Alternate Phone #:_______________________________

Age: _______________________

Address: ____

Street City State Zip

Email: ____

Emergency Contact: ___________________________________

Phone #:__________________________

Experience with horses: Yes ____ No____

Explain:

____

____

Experience with mentally/physically challenged children/adults: Yes____ No ____

Explain:

____

Health Issues: (diabetic, physical limitations, etc.)

____

____

____

____

Date Accepted: __________________________ Staff: _____________________________

VOLUNTEERING: WHAT CAN I DO?

We are excited to have you join our team!
Please help us find you the perfect position.

We want you to feel comfortable in your volunteer position. Spirit Therapies has volunteer opportunities for many kinds of skills, so we want to determine the best fit between your skills/experience and our organizational needs.

VOLUNTEER POSITION DESCRIPTIONS

Please note for the safety of riders and volunteers: to work directly with the horse and rider, a volunteer must be able to see, hear and understand instructions well and be able to stand and walk for 1/2 hour to 2 hours at a time sometimes in hot and cold weather.

Horse Leader: Leads horse during mounted lessons. You must be comfortable around horses and know how to read their body language.

Side Walker: Walks with mounted riders. Assists with lessons at the instructor's direction.

Lesson Volunteer: Assists rider at arrival, fits rider's helmet and visits with parents/guardians.

Barn Volunteer: Cleans stalls and tackroom, grooms and feeds horses.

Office Volunteer: Filing, typing, data entry and works on mail outs.

Spirit Therapies reserves the right to dismiss any volunteer who violates the organization's rules, its confidentiality policies and/or any involvement that would reflect negatively on the organization's reputation.

Printed Name:____ Date:_________________

Signature:____

VOLUNTEER PREFERENCE SHEET

Volunteer's Printed Name:____

Spirit Team Preference:

- ☐ Horse Leader
- ☐ Side Walker
- ☐ Lesson Volunteer
- ☐ Barn Volunteer
- ☐ Office Volunteer
- ☐ Other

If you selected "Other" describe what you would like to do:

____
____
____
____

Days and times you are able to volunteer:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

☐ Mornings ☐ Afternoons ☐ Nights

Remarks:

____
____
____
____
____
____

VOLUNTEER/STAFF INFORMATION FORM AND HEALTH HISTORY

General Information:
Printed Name: ____ Date: ___________
Address: ____
City: ______________________________ State: ________________ Zip Code: __________
Date of Birth: ____________ Cell Phone: _________________ 2nd Phone: _____________
E-mail Address: ____
Employer/School: ____
Address: __________________________ City/State: ________________ Zip Code: _______
Print Parent/Legal Guardian/Caregiver Name: ______________________________________
Address: __________________________ City/State: ________________ Zip Code: _______
Cell Phone: _____________________________ 2nd Phone: __________________________
Recent Medical Tests: Last Tetanus Shot Date: ____________________
Tuberculosis Test Date: ____________________

(Consult your physician or local health department if you are not up to date with these shots/ tests.)

Health History:
Describe your current health status with regards to working in an equine assisted program, i.e.: physical and emotional demands. Please address fitness, cardiac, respiratory, bone or joint function and list any recent hospitalizations, surgeries or lifestyle changes.
____
____
____
____
____
____
____
____
Allergies: ____
____
Medications: ____
____

I understand that the information provided above is accurate to the best of my knowledge. I know of no reason why I should not participate in this center's program.

Signature: ____ Date: _______________
Volunteer, Parent or Legal Guardian
Signed in presence of center staff

Photo Release: □ I DO □ I DO NOT consent to and authorize Spirit Therapies to use any and all photographs, audio or visual materials taken of me, to be used for the benefit of the organization.

Signature: ____ Date: ________________

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

I, ________________________________ (volunteer/staff), authorize Spirit Therapies 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 NARHA center, its directors, officers, employees, or other volunteers to disseminate this information in any way to any other individual, group, agency, organization, or corporation.

Signature: ____ Date: _________________

Current Driver's License No. : ________________________________ State: ______________

Confidentiality Agreement
I understand that all information (written and verbal) about participants at this NARHA center 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.

Signature: ____ Date: _________________

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

□ Participant □ Staff □ Volunteer

General Information:
Printed Name: ____
Date of Birth:____Phone: __________________________
Address: ____
City/State: ____ Zip Code: ________________
Physician's Name: ____
Preferred Medical Facility: ____
Health Insurance Company: ______________________________ Policy #: ________________________
Allergies to Medications: ____
Current Medications: ____

In the event of an emergency, contact:
Name: __________________________________ Relation: ________________ Phone: ______________
Name: __________________________________ Relation: ________________ Phone: ______________
Name: __________________________________ Relation: ________________ Phone: ______________

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services or while being on the property of the center, I authorize Spirit Therapies to: 1. Secure and retain medical treatment and transportation if needed. 2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Consent Plan
This authorization includes x-rays, surgery, hospitalization, medication, and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person(s) above are unable to be reached.

Printed Name: ____

Consent Signature: ____ Date: ___________
Volunteer, Parent or Legal Guardian
Signed in presence of center staff

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. ☐ Parent or legal guardian will remain on site at all times during equine assisted activities. ☐ In the event emergency treatment/aid is required, I wish the following procedure to take place:

____
____
____
____
____

Printed Name: ____

Signature: ____ Date: _____________

Volunteer, Parent or Legal Guardian

Signed in presence of center staff

RELEASE OF LIABILITY

The undersigned is a business guest and/or patron and/or visitor, or is the owner of a horse(s) kept upon the premises at 9140 La Madre Way, Las Vegas, Nevada, 89149 and fully understands that there is a certain amount of inherent danger in the keeping, handling, owing, riding, and being in the presence of horses, and in consideration of the owner/renters/guests, Jeff and Laura Willmott, permitting the undersigned to keep, board, ride, or train a horse(s) on said premises, or in consideration of permission granted to the undersigned and guests to visit upon said premises, or to receive any and all types of equestrian instruction upon said premises, the undersigned and guests, do hereby agree to assume all risk to loss, injury, or illness to all horses belonging to the undersigned, and to assume all loss, damage, or injury to any equipment or personal property to the undersigned.

Furthermore, the undersigned does hereby agree to assume all risk of personal injury to the undersigned, or guests of the undersigned, at any time while at the location of 9140 La Madre way, and does hereby release owners/renters/guests/Jeff and Laura Willmott, agents, employees, and staff, from any and all liability occurring from damage to or loss of property or equipment, or injury to or illness of any horse(s) or animals of the undersigned while at/on said property, facility and premises. The undersigned does hereby waive any and all claims of any and every kind of nature growing out of or based upon the operation of the aforementioned property, owners/renters/guests, and Jeff and Laura Willmott, agents, employees, and staff.

THE UNDERSIGNED HAS READ AND FULLY UNDERSTANDS THE CONTENTS OF THIS RELEASE OF LIABILITY AND BY SIGNING BELOW AGREES TO COMPLY AND BE BOUND BY THE CONTENTS STATED WITHIN.

Dated this _______ Day of ________________________ 20____

Volunteer Printed Name: ______________________________

Signature of Volunteer or Parent/Legal Guardian: __________________________________

Printed Name of Parent/Legal Guardian (if applicable): ______________________________

Address: ____

City/State: ____ Zip Code: __________

Cell Phone: ___________________________ 2nd Phone: ____________________________

Witness Printed Name: ____

Witness Signature: ____