



Physical Therapy, Occupational therapy, Speech Therapy
Equine Assisted Counselling

15 Hands & Hearts Inc.
928.310.0947
15handsandhearts@gmail.com

Volunteer Form

[PLEASE PRINT]

First Name: _____ Last Name: _____

DOB: _____ Email: _____ Phone: _____

Address: _____ City: _____ State: Zip: _____

If Student, name of School: _____ City: _____

Skills & Interests:

Previous volunteer experience: _____

Hobbies & Interests: _____

Educational Background: _____ Current Occupation: _____

Equine Background: _____

Other Experience (please check all that apply): Horse Care ___ Sign Language ___ Computer Skills ___

Bi-lingual ___

Do you have experience working with a particular Disability? If so, please describe _____

Volunteer Jobs: I would like to apply for the following volunteer positions (circle the ones you may be interested in): NOTE: There are certain criteria and skills required for some of these positions:

Horse Handler Side-Walker Tack Cleaner Special Projects Housekeeping
Stall/Barn Help Horse Care Arena Care Tech help/support

Weekly Commitment:

| | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|--------------|--------|---------|-----------|----------|--------|----------|
| Times: _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| | Am/Pm | Am/Pm | Am/Pm | Am/Pm | Am/Pm | Am/Pm |

Background Verification:

1. Have you ever been convicted of a criminal offense? Yes _____ No _____

2. Have you ever been charged with neglect, abuse or assault? Yes _____ No _____

If yes to questions 1 and/or 2, please explain: _____

3. Are you currently under physician care or taking medication that will alter performance?

Yes _____ No _____

If yes, _____

Please list (2) non-family references that we might contact:

Name: _____ Phone: () _____

Name: _____ Phone: () _____

Medical History and Emergency Treatment Release Information:

In Case of Emergency, please contact:

Name: _____ Phone/w: _____ Phone/cell: _____

Primary Physician: _____, Address: _____

Phone: () _____

Hospital Preference: _____ Town: _____

Medical Insurance Company: _____ Phone: () _____

Policy ID#: _____

2nd Emergency Contact: Name: _____ Phone: () _____

In case of emergency, I give permission to 15 Hands & Hearts to secure medical treatment to include x-rays, surgery, hospitalization, and/or medication.

Signature: _____ Date: _____

Medical History

Allergies (medications, insect bites, etc) _____

Pertinent Medical Conditions: _____

Useful Medical History: _____

Physical Requirements:

I realize that many of the volunteer jobs at 15 Hands & Hearts require me to be in good health, physically active and mentally alert and focused for the 2 – 3-hour long work sessions. I have reviewed the job descriptions for which activities I am participating in. I also acknowledge that I must be able to walk briskly, occasionally trot, and be able to tolerate times when there may be severe weather and dust.

Please initial to acknowledge: _____

I have reviewed all policies and procedures and will abide by the Rules of 15 Hands & Hearts.

Print Name: _____ Date: _____

Signature: _____

Statement of Confidentiality

I understand that all information, both written and verbal, regarding clients at 15 Hands & Hearts, and confidential business matters shall be held in strict confidence at all times except as needed within the facility for therapy and/or business purposes.

I understand that a breach of confidentiality is grounds for dismissal and may also result in legal prosecution.

Volunteer Signature

Date