



DATE: _____

COMOX VALLEY THERAPEUTIC RIDING SOCIETY

VOLUNTEER APPLICATION / REGISTRATION FORM

Volunteers are encouraged to attend an introductory workshop

1st Thursday each month @ 12:00 to 2:00pm



Yes I have taken a workshop..... Year 20__

NAME _____

MAILING ADDRESS _____

CITY _____ POSTAL CODE _____

PHONE: home _____ work _____ cell _____

e-mail _____

STUDENT yes _____ no _____ SCHOOL _____

OCCUPATION _____

PLEASE DESCRIBE YOUR EXPERIENCE

WITH THE DISABLED _____ WITH MENTAL HEALTH _____

WITH HORSES _____

PLEASE LIST YOUR INTERESTS, HOBBIES & SKILLS

FUNDRAISING SKILLS _____

ALL VOLUNTEERS ARE INSURED BY OUR PROGRAM

You are expected to commit a minimum of 1 or 2 hours per week for the duration of the 8 or 10 week session. If you are unable to come you must call as soon as possible, 338-1968 so that we can arrange a substitute for you.

PHOTO RELEASE

I consent to authorize the use and reproduction by The Comox Valley Therapeutic Riding Society of any and all photographs and any other audiovisual materials taken of me for promotional materials, educational activities, exhibitions, or for any other use for the benefit of the program.

SIGNATURE _____

IN CASE OF EMERGENCY CONTACT

NAME _____

ADDRESS _____ CITY _____

PHONE: Home _____ Work _____ Cell _____

PHYSICIAN _____ CITY _____

In case of emergency, I give permission to the Comox Valley Therapeutic Riding Society, 4839 Headquarters Rd., Courtenay, B.C. to secure medical treatment including X-ray, surgery, hospitalization and medication.

SIGNED _____ DATE _____

VOLUNTEER LIABILITY RELEASE

As a volunteer with The Comox Valley Therapeutic Riding Society at 4839 Headquarters Rd., Courtenay, B.C. I acknowledge the risks and potential for risks of the horseback riding program.

I feel that the possible benefits to myself and clients I work with, are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever, all claims for damages against The Comox Valley Therapeutic Riding Society, its Board of Directors, Instructors, Therapists, Volunteers and/or Employees and The Comox Valley Therapeutic Riding Society for any and all injuries and/or losses I may sustain with participation in The Comox Valley Therapeutic Riding Society.

SIGNED _____ DATE _____

VOLUNTEER STANDARD OF CONFIDENTIALITY

I _____ recognize that my role as a volunteer with The Comox Valley Therapeutic Riding Society will entitle me to certain information about riders which should be treated as confidential. All information given to me by a parent/instructor/rider in regard to a rider will be discussed only with the personnel of The Comox Valley Therapeutic Riding Society. At no time will I discuss any information about riders with other parents or any other individuals. I recognize that all material and papers pertaining to the rider's care are legal documents and that all information contained therein is confidential.

SIGNED _____ DATE _____

**THANK YOU FOR YOUR INTEREST IN CVTRS
WE HOPE YOU ENJOY YOUR TIME HERE**