

VOLUNTEER INFORMATION UPDATE FORM
TO BE COMPLETED ANNUALLY

Date: _____ Date of Birth: _____ Cell phone: (____) _____
Legal Name: _____ Nickname: _____
Address: _____
City _____ St: _____ Zip: _____
E-mail address _____
Employer: _____ Your supervisors name: _____
Work phone: (____) _____ May we call you at work? Yes No
If you are a student, school name: _____
What is the best way to get in touch with you in case of a class cancellation?
E-Mail FaceBook Post Cell Work

Emergency Information

In case of emergency I give permission to Therapeion Therapeutic Riding Center to secure medical treatment, including but not limited to, x-ray, emergency surgery, hospitalization, emergency transportation, CPR, and medication.

Emergency Contact Information:

Name: _____ Relationship: _____
Home phone: (____) _____ Cell phone: (____) _____

Your Doctor Information:

Name: _____ Phone: (____) _____
City: _____ State: _____

Preferred Hospital: _____ City: _____

Consent Signature: _____ Date: _____

Non-Consent Signature: _____ Date: _____

Consent for Mandatory Background Check

I hereby authorize Therapeion Therapeutic Riding Center, Inc. to conduct a limited criminal history check on me that will include sex offender and criminal history information. I understand that this confidential information will be kept in the locked files at Therapeion. In addition, I may request a copy of the report that is produced through this check. **(this is mandatory in order to volunteer during riding classes, per Federal Law)**

Consent Signature: _____

Volunteer Liability Release: *As a volunteer at Therapeion TRC, I acknowledge the risks and potential for risks of a horseback riding program. However, I feel that the possible benefits to myself and the clients I work with are greater than the risk assumed. I hereby, intending to be legally bound, for myself and my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Therapeion Therapeutic Riding Center Inc., its board of directors, instructors, therapists, volunteers, riders, and/or employees, or barn owners or managers for any and all injuries and/or losses I may sustain while participating at Therapeion Therapeutic Riding Center, Inc..*

Indiana State Equine Laws states: “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”.

Your signature below indicates that you have read and understand the above liability release and have voluntarily agreed to participate in this program.

Signature: _____ Date: _____

Please Print Your Name: _____

HIPPA CONFIDENTIALITY AGREEMENT

Confidential information is defined as any information found in a participant’s medical record, personal information, and information provided verbally by the participant, his/her family, or their caregiver or guardian. All information relating to a participant’s care, treatment, or condition constitutes confidential information. Confidential information also includes information regarding research studies and teaching methods developed by Therapeion.

- Employees shall never discuss a participant’s medical condition with any non-employee of Therapeion, friends, or family members. Confidential matters involving participants will not be discussed in areas where they might be overheard by other participants or other non-staff members, either volunteer or paid staff. All staff members are to be aware at all times that conversations regarding participants are not to be overheard by others and take appropriate steps to ensure this confidentiality.
- Any unauthorized disclosure of confidential information by paid or volunteer staff could render Therapeion liable for damages. Any staff member who violates the confidentiality of the center is subject to disciplinary action up to and including termination.

I have received a copy of, read, understand, and agree to uphold this written policy on matters of confidential information.

I also understand that in my daily job duties, I will have free access to confidential information and any violation of confidentiality, in whole or in part, could result in disciplinary action up to and including termination and/or legal action.

I recognize that this signed document of my agreement to uphold the provisions of this policy will be kept on file in my personnel file.

Date: _____

Staff Member Signature: _____

Staff Member Printed Name: _____