



Volunteer Registration Form

Quarter Moon Acres, Inc. Equine Therapy
1347 55th Avenue, Amery, WI 54001
qtrmoonacres@yahoo.com
715-554-0748
www.qmaequinetherapy.com

Patti – 715-554-0748 Karole – 651-491-5945

Date of Application: _____

Name: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ DOB _____

Parent/Legal Guardian Name: *(if under 18)* _____

What is the best way to contact you? Home Phone Cell Phone Email

Volunteer Interests: (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Facility maintenance | <input type="checkbox"/> Office work |
| <input type="checkbox"/> Horse feeding | <input type="checkbox"/> Barn gang (age 10 and above) |
| <input type="checkbox"/> Fundraising events | <input type="checkbox"/> Side walker (age 12 and above) |
| <input type="checkbox"/> Committees | |
| <input type="checkbox"/> Horse handler (age 13 and above with previous horse experience) | |

Please explain your experience with horses (if any): _____

Can you walk for 40 minutes and jog for short distances? Yes No

Given a chance to change sides frequently, can you hold your arm at shoulder height and support a modest weight? Yes No

Appearance Release Form

I give Quarter Moon Acres, Inc. permission to record my voice, physical likeness and appearance by any means for use in promotion, educational or other related uses.

∞ _____
(Date) (Printed name of volunteer) Signature of adult (at least 18) Parent/Guardian of Volunteer

Consent for Background Check to Volunteer *(mandatory to complete the following)*

Full Legal Name: _____

Maiden Name: _____ Date of Birth: _____

Have you ever been charged or convicted of a crime? Yes No

If yes, please explain: _____

I hereby authorize Quarter Moon Acres, Inc. Equine Therapy Center to conduct a search of the Wisconsin Sheriff's Sex and Violent Offender Registry, to release any information on the Registry to Quarter Moon Acres, Inc. Equine Therapy Center. I understand the misrepresentation or omission of facts requested is just cause for non-appointment as a Quarter Moon Acres Inc. Equine Therapy Center volunteer.

∞ Signature _____ Date: _____

Office Use Only: Date _____ Initials _____

Confidentiality Statement

I understand that all information (written or oral) about participants at this PATH 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.

Initials: _____

Parental Consent *Must be completed if volunteer is under 18*

I understand that my child wishes to be considered for volunteer work and I hereby give my permission for them to serve in that capacity. I understand that they will be provided with orientation and training necessary for the safe and responsible performance of their duties and that they will be expected to meet all the requirements of the position, including regular attendance and adherence to agency policies and procedures.

∞ Signature of Parent/Guardian: _____ Date: _____

In Case of Emergency

In case of emergency, I give permission to Quarter Moon Acres, Inc. Equine Therapy to secure medical treatment including x-ray, emergency surgery, hospitalization and medication.

Physician Name: _____ Phone: _____

Hospital Name: _____ City: _____ Child's DOB: _____

I agree that should emergency medical treatment be required, I and/or my own accident/medical insurance company shall pay for all such required expenses. My accident/medical insurance company is:

_____ Policy Number: _____

Do you have any medical limitations relating to your ability to complete your volunteer duties?

Yes No If yes, please explain: _____

∞ Consent Signature (if under 18 parent or guardian): _____

Volunteer Pledge

As a volunteer at Quarter Moon Acres, Inc. Equine Therapy, (QMA) I agree to follow the rules and guidelines in this or any following editions of the QMA volunteer handbook (found on webpage or office). I have read or have had the handbook explained to me and I will keep the current edition for reference. I will attend continuing education training/volunteer classes once a year throughout my volunteer service. I understand that violating the rules and guidelines at QMA may result in my dismissal from the program. I understand that the staff at QMA are in control of the activities that I participate in and I will follow their direction.

Name: _____ Printed: _____

Parent/Guardian (if under 18): _____

Liability Release

_____ (volunteer) is agreeing to work with and around horses at Quarter Moon Acres, Inc., Equine Therapy. I acknowledge the risks and potential for risks of a horseback riding program. **I understand that under Wisconsin law (statute 895.481), Quarter Moon Acres, Inc. is not liable for an injury to, or the death of a participant in equine activities resulting from the inherent risks of equine activities.** I accept the risk assumed and 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 Quarter Moon Acres, Inc., its board of directors, instructors, therapists, and employees for any and all injuries and/or losses I/my child/ward may sustain while volunteering at Quarter Moon Acres, Inc.

∞ Signature of Volunteer: _____ Date: _____

∞ Parent/Guardian Signature (if under 18): _____ Date: _____