



## VOLUNTEER REGISTRATION FORM - 2012

P: 817-379-5717 F: 817-431-6100

[www.rockytoptherapy.org](http://www.rockytoptherapy.org)

<b>I. Personal Information</b>			
TODAY'S DATE		ORIENTATION DATE	
E-MAIL ADDRESS (PRINT CLEARLY)			
NAME	D.O.B.	RACE	GENDER
ADDRESS		CELL #	
CITY	STATE	ZIP	HOME #
EMPLOYER NAME OR SCHOOL NAME		WORK #	
OCCUPATION (IF STUDENT LIST CURRENT GRADE)			
EMERGENCY CONTACT NAME		EMERGENCY CONTACT PHONE #	
EMERGENCY CONTACT RELATIONSHIP			
HOW CAN YOUR FAMILY CONTRIBUTE TO ROCKY TOP THERAPY CENTER?			
HORSE EXPERIENCE: <input type="checkbox"/> NONE <input type="checkbox"/> BEGINNER <input type="checkbox"/> EXPERIENCED [explain]			

Do you have any medical conditions/limitations/allergies? (If so, please specify) \_\_\_\_\_

Can you walk for 60 minutes and jog for short distances?      [check one]     Yes     No

### II. Volunteer Interests (check all that would apply)

- Program Volunteer (helping on a regular basis with our therapy riders and horses)
- Do you have a preference of days or times? \_\_\_\_\_
- Special Activities (Booths at Health Fairs, Community Events, Party Planning, etc.)
- Office Work (data entry, filing, general office administration, writing newsletter articles, photography)
- Fund Raising Events (The Great Trail Drive, Golf Tournament)

### III. Background/Interests

Why do you wish to volunteer in this program? \_\_\_\_\_

Special talents/skills: \_\_\_\_\_

Where did you hear about Rocky Top?     Friend     Radio     TV     Newspaper     Website     Social Media (Facebook, Twitter, etc.)  
[explain below]:

( ) Friend (name) \_\_\_\_\_

( ) Other (please specify) \_\_\_\_\_

**IV. Confidentiality Statement**

As a volunteer of the Rocky Top Therapy Center's riding program, I understand that all client information is confidential. I understand and agree not to discuss or make any written reports or take any pictures without prior approval from the Executive Director and at no time will I use the client's last name.

Signature: \_\_\_\_\_  
(If under 18, Parent or Guardian must sign)

Date: \_\_\_\_\_

**V. Liability Release (You must be 14 years old to volunteer & 12/13 years old to be in the Junior Horsemanship Program)**

As a volunteer at Rocky Top Therapy Center, 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 risks assumed. I, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Rocky Top Therapy Center, its Board of Directors, instructors, therapists, volunteers and/or employees for any and all injuries and/or losses I may sustain while participating in programs or services at Rocky Top Therapy Center.

Signature: \_\_\_\_\_  
(If under 18, Parent or Guardian must sign)

Date: \_\_\_\_\_

**VI. Photo Release**       **I do not consent (mark with a check if you do not consent)**

I hereby consent to and authorize the use and reproduction by Rocky Top Therapy Center of any and all photographs and any other audio-visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: \_\_\_\_\_  
(If under 18, Parent or Guardian must sign)

Date: \_\_\_\_\_

**VII. Background Check Release**

I hereby give my permission to Rocky Top Therapy Center and/or Mental Health and Mental Retardation of Tarrant and Denton Counties to perform a criminal background check on me in compliance with the open enrollment contract requirements for organizations providing service to MHMR clients.

Signature: \_\_\_\_\_  
(If under 18, Parent or Guardian must sign)

Date: \_\_\_\_\_

**VII. Volunteer's Authorization for Emergency Medical Treatment Form**

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 agency, I authorize Rocky Top Therapy Center to secure and retain medical treatment and transportation if needed.

**Consent Plan**

This authorization includes x-rays, surgery, hospitalization, medication and any procedure deemed "life saving" by the physician. This provision will only be invoked if the person on the reverse side is unable to be reached.

Signature: \_\_\_\_\_  
(If under 18, Parent or Guardian must sign)

Date: \_\_\_\_\_

**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. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Signature: \_\_\_\_\_  
(If under 18, Parent or Guardian must sign)

Date: \_\_\_\_\_