

# Gaitway of Salmon, Inc.



## Volunteer Application and Agreement Form

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

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

\*Name of Parent or Guardian if under 18 years: \_\_\_\_\_

\*If volunteer is under 18 years, the parent or guardian must also complete a volunteer application and agreement form.

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: (home) \_\_\_\_\_ (cell) \_\_\_\_\_

EMAIL: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Driver's License No. \_\_\_\_\_

**Allergies:** \_\_\_\_\_

If allergic to bees, do you carry an epi pen or the like? Yes \_\_\_\_\_ No \_\_\_\_\_

Emergency Contact:

\_\_\_\_\_  
(Name) (Phone no.; Indicate Home, Work or Cell) (Relationship)

\_\_\_\_\_  
(Name) (Phone no.; Indicate Home, Work or Cell) (Relationship)

When are you available to volunteer (specify hours of availability)?

Monday \_\_\_\_\_ Tuesday \_\_\_\_\_ Wednesday \_\_\_\_\_ Thursday \_\_\_\_\_ Friday \_\_\_\_\_  
Saturday \_\_\_\_\_ Sunday \_\_\_\_\_ Holidays only \_\_\_\_\_

Types of volunteer work you think you'd be most comfortable with:

\_\_\_ Leading for therapeutic horseback riding                      \_\_\_ Sidewalking for therapeutic riding  
\_\_\_ Helping with volunteer recruitment                              \_\_\_ General grounds maintenance  
\_\_\_ Horse care    \_\_\_ Other activities \_\_\_\_\_

List Your Past Volunteer Experiences:

Organization: \_\_\_\_\_ Duties: \_\_\_\_\_ Mo/Yr. to Mo./Yr. \_\_\_\_\_  
Organization: \_\_\_\_\_ Duties: \_\_\_\_\_ Mo/Yr. to Mo./Yr. \_\_\_\_\_

Have you ever been adjudged civilly or criminally liable for abuse of an individual with disabilities?  
No\_\_\_ Yes\_\_\_; Have you been convicted of a crime? No\_\_\_ Yes\_\_\_ If yes, please describe:

REFERENCE CHECK: Gaitway requires volunteers working with individual consumers to submit to a reference check. Criminal conviction does not necessarily bar an applicant from volunteering. The nature of the offense will be taken into consideration before a decision is made. There is no fee on the part of the volunteer for the reference check. Screening must be completed before volunteers begin working with participants.

\_\_\_\_\_ I agree to have a reference check.

HEALTH: Gaitway requires that all volunteers be physically able to perform their duties at Gaitway.

Please list any limitations, physical restrictions, medical conditions or medications we should be aware of:

\_\_\_\_\_  
\_\_\_\_\_

REFERENCES: List two people, not related to you, who have knowledge of your qualifications.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone No.: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone No.: \_\_\_\_\_

**Confidentiality:** Please remember that all medical or therapeutic information pertaining to participants discussed or released during Gaitway activities are subject to confidentiality laws, policies and procedures.

**General:** As a volunteer for Gaitway of Salmon, Inc., I agree to abide by all applicable rules, regulations, policies and procedures. I understand that I will receive no monetary benefits in return for my volunteer service.

I certify that my answers on this application are true and complete and that I have not knowingly withheld any information that might, if disclosed, affect my application unfavorably. I understand that any misrepresentation or omission of facts on this application could be cause for rejection of this application or dismissal.

I understand that after I submit my application, it will be reviewed and my eligibility for volunteer work will be determined. I agree to an interview with the on site manager and on site orientation to perform my volunteer role.

I hereby Release and Waive liability against Gaitway of Salmon, Inc., a non-profit corporation, its directors, officers, employees and agents, its successors and assigns, for any injuries or illness that I myself or my dependent may suffer in connection with any volunteer work for Gaitway of Salmon, Inc. Further, I agree that Gaitway of Salmon, Inc., is not liable for any damage to my property or my dependent's property resulting from volunteer work for Gaitway. I agree that this release is as broad and inclusive as permitted by the laws of the State of Idaho.

**Volunteer Signature:** \_\_\_\_\_

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

**Authorization for Emergency Medical Treatment Form  
Gaitway of Salmon, Inc.**

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 **Gaitway of Salmon** to:

- 1) Secure and retain medical treatment and transportation if needed.
- 2) Release client records upon request to authorized individual or agency in the medical emergency treatment.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physician's name: \_\_\_\_\_ Preferred Medical Facility: \_\_\_\_\_

Health Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

Current medications: \_\_\_\_\_

In the event of an emergency, contact:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ (cell) \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ (cell) \_\_\_\_\_

**Consent Plan**

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

Consent Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Participant, Volunteer, Parent or Guardian

**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 Gaitway of Salmon.

Non-Consent Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Participant, Volunteer, Parent or Guardian

## Photo Consent Form

I consent to have my photo and/or video taken during my duties at Gaitway and these media to be posted in public forums including the newspaper and on Facebook as well as on location at the arena.

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Signature

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Date