



Reins of Life, Inc.

55200 Quince Road,
South Bend, IN 46619
Phone: 574/232-0853

9375 W. 300 N.
Michigan City, IN 46360
Phone: 219/874-7519

Fax: 574/232-1104
Website: www.reinsolife.org

VOLUNTEER REGISTRATION

Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Height ___ ft ___ in Phone: Home: _____ Cellular/Other: _____

Work: _____ May we call you at work? _____

Email: _____

Employer or School: _____ If school: What year? _____

How did you hear about Reins of Life? _____

Do you have horse experience? Please explain _____

Do you have experience working with people with disabilities? Please explain _____

Please specify any other experience and/or skills you feel could be useful to the program _____

Please check your area(s) of interest

- _____ Side-walker
- _____ Horse Leader
- _____ Cleaning equipment/tack
- _____ Cleaning stalls and paddocks
- _____ Maintenance
- _____ Feeding (requires a commitment of once per week, approx. 2 hours)
- _____ Administrative duties (filing, publicity, fundraising, newsletter)
- _____ Being a member of the Board of Directors
- _____ Serving on a committee (mark any areas of interest)

- | | |
|-------------------------|-------------------------|
| _____ Development | _____ Reins Of Life Day |
| _____ Program | _____ Benefit Dinner |
| _____ Facilities | _____ Golf Outing |
| _____ Horse Care | _____ Horseshow |
| _____ Policy/Procedures | _____ Ride-a-Thon |

Days and Times available to work (please be specific)

Sunday:	_____	A.M.	_____	P.M.
Monday:	_____	A.M.	_____	P.M.
Tuesday:	_____	A.M.	_____	P.M.
Wednesday:	_____	A.M.	_____	P.M.
Thursday:	_____	A.M.	_____	P.M.
Friday:	_____	A.M.	_____	P.M.
Saturday:	_____	A.M.	_____	P.M.

Volunteer's Authorization for Emergency Medical Treatment

In the event emergency medical aid/treatment is required due to illness or injury while volunteering for Reins of Life, I authorize Reins of Life to secure and retain medical treatment and transportation if needed.

Signed _____ Date _____
Signature (parent/guardian if volunteer is under 18 years of age)

Person(s) to be contacted in case of an emergency:

1. Contact _____ Phone: _____

2. Contact _____ Phone: _____

Physician's Name: _____

Preferred Medical Facility: _____

Health Insurance Company: _____ Policy # _____

Consent Plan

This authorization includes X-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the contact persons above are unable to be reached.

Consent Signature _____ Date _____
Signature (parent/guardian if volunteer is under 18 years of age)

Print Name _____

OR

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury while volunteering for Reins of Life. In the event emergency treatment/aid is required, I wish the following procedure to be followed: _____

Non-Consent Signature _____ Date _____
Signature (parent/guardian if volunteer is under 18 years of age)

Print Name _____

Volunteer Liability Release

As a volunteer with Reins of Life, I acknowledge the risks and potential for the risks of a horseback riding program. However, I feel 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, my heirs and assigns, executors or administrators, waive and release forever all claims for damage against Reins of Life, Inc., its Board of Directors, Instructors, Therapists, Volunteers and/or Employees, Operating Site for any and all injuries and/or losses I may sustain while participating in Reins of Life, Inc.

Signed _____ Date _____
Signature (parent/guardian if volunteer is under 18 years of age)

Photo/Media Release/Website

I consent to and authorize the use and reproduction by Reins of Life, Inc. of any and all photographs and any other audiovisual material taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Photo Release

Do Not Photograph

Signed _____ Date _____
Signature (parent/guardian if volunteer is under 18 years of age)

Volunteer Confidentiality Statement

I understand that any and all activity and information that may be disclosed to me during my activities as a volunteer are deemed confidential and are not to be discussed with anyone other than Reins of Life staff.

Signed _____ Date _____
Signature (parent/guardian if volunteer is under 18 years of age)

Release Authorization

Name _____ Date of Birth _____

Gender _____ Race _____ SSN _____

Drivers License/State and # _____

I hereby authorize the South Bend Police Department to furnish Reins of Life, Inc. any information concerning Criminal and/or Traffic Convictions that they may have on Record or otherwise, and do hereby release the City of South Bend, the South Bend Police Department, and all individuals connected therewith from all liability for damage whatsoever incurred in furnishing such information.

Signed _____ Date _____

Reins of Life Signature _____ Date _____