



CHAMPLAIN ADAPTIVE MOUNTED PROGRAM
 A volunteer, non-profit tax-exempt corporation
 57 East Shore Road
 South Hero, VT 05486
 802-372-4087
 www.vtchamp.org

Volunteer/Staff: GENERAL INFORMATION

Volunteers must be 14 years old or older. Parent or Guardian signature required for anyone under 18

NAME _____

ADDRESS _____

CITY/STATE/ZIP _____

PHONE: (H) _____ (W) _____ E-MAIL: _____

HOW LONG HAVE YOU LIVED IN VERMONT? _____

EMPLOYER/SCHOOL _____

WORK/SCHOOL ADDRESS _____

PARENT/LEGAL GUARDIAN (IF UNDER 18): _____

ADDRESS _____

CITY/STATE/ZIP _____

PHONE: (H) _____ (W) _____ E-MAIL: _____

ARE YOU FULFILLING A COMMUNITY SERVICE REQUIREMENT? _____

FOR WHICH SCHOOL OR AGENCY? _____

HOW DID YOU HEAR ABOUT CHAMP? _____

CURRENT DRIVER'S LICENSE? NO YES - LICENSE NUMBER _____ STATE _____

Volunteer Opportunities: Horse leader Sidewalker Hosting Lesson Prep

These are suggested hours, we are flexible and will adjust hours to fit your availability.

AVAILABLE TIMES	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	
9:00-11:00							ABLE TO JOG NEXT TO THE HORSE? <input type="checkbox"/> YES <input type="checkbox"/> NO
11:00-1:00							PREVIOUS HORSE TRAINING/EXPERIENCE <input type="checkbox"/> YES <input type="checkbox"/> NO
1:00-3:00							
3:00-5:00							

Other Opportunities (check all that apply)

- Dust Busters Yard Hand/Posey Posse
- Event Extras Horse Shows Special Olympics Trail Rides
- Paper Jockeys Fundraising Grant Writing Budget/Finance Future Planning
- Writing/Editing Photography/Video Public Relations Volunteer Recruitment
- General Office Help other _____



NARHA
 North American Riding for the
 Handicapped Association, Inc.
 PREMIER ACCREDITED CENTER

All CHAMP instructors are
 NARHA certified

A member agency of the
 Franklin-Grand Isle United Way.



Call for more
 information about the
 CHAMP VOLUNTEER PROGRAM



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Volunteer/Staff Authorization for Emergency Medical Treatment

NAME _____ DOB _____

ADDRESS _____

CITY/STATE/ZIP _____

PHONE: (H) _____ (W) _____ E-MAIL: _____

PHYSICIAN'S NAME _____ PREFERRED MEDICAL FACILITY _____

HEALTH INSURANCE CO. _____ POLICY # _____

IN CASE OF EMERGENCY CONTACT

NAME _____	Relation _____	Phone _____
NAME _____	Relation _____	Phone _____
NAME _____	Relation _____	Phone _____

These forms must be signed in the presence of a member of the CHAMP Staff.

CONSENT PLAN: In the event emergency medical aid/treatment is required due to illness or injury during the process of volunteering services or working for the Champlain Adaptive Mounted Program (CHAMP), or while on the property I authorize CHAMP at Good Hope Farm to:

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

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 person(s) above is unable to be reached.

SIGNATURE _____ DATE _____

PRINT NAME BELOW IF SIGNATURE ABOVE IS BY A PARENT OR GUARDIAN FOR A VOLUNTEER UNDER 18 _____

RELATIONSHIP _____

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 volunteering or working while being on the property of CHAMP at Good Hope Farm

- Parent or legal guardian will remain on site at all times during equine assisted activities.
- In the event emergency treatment/aid is required I wish the following procedure to take place:

SIGNATURE _____ DATE _____

PRINT NAME BELOW IF SIGNATURE ABOVE IS BY A PARENT OR GUARDIAN FOR A VOLUNTEER UNDER 18 _____

RELATIONSHIP _____



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Volunteer/Staff: **RELEASES**

NAME _____

Photo Release I do **do not** consent to and authorize the use and reproduction by the Champlain Adaptive Mounted Program (NARHA 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 _____ DATE _____

PRINT NAME BELOW IF SIGNATURE IS BY A PARENT OR GUARDIAN FOR A VOLUNTEER UNDER 18 _____

RELATIONSHIP _____

Confidentiality Agreement I understand that all information (written or verbal) about participants at this NARHA center is confidential and will not be shared with anyone without express written consent of the participants and/or their parent or guardian in the case of a minor

SIGNATURE _____ DATE _____

PRINT NAME BELOW IF SIGNATURE IS BY A PARENT OR GUARDIAN FOR A VOLUNTEER UNDER 18 _____

RELATIONSHIP _____

Volunteer Liability Release As a volunteer at the Champlain Adaptive Mounted Program, I acknowledge the risks and potential for risks of a horseback riding program. However, I feel the possible benefits to myself and the clients worked 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 damages against Champlain Adaptive Mounted Program (CHAMP), its board of directors, instructors, therapists, volunteers and/or employees of CHAMP at Good Hope Farm and the North American Riding for the Handicapped Association for any and all injuries and/or losses I may sustain while participating in the CHAMP activities. I also understand that under Vermont Law, an equine activity sponsor is not liable for an injury to, or the death of a participant in equine activities resulting from the inherent risks of equine activities that are obvious and necessary, pursuant to 12 V.S.A. 1039.

SIGNATURE _____ DATE _____

PRINT NAME BELOW IF SIGNATURE ABOVE IS BY A PARENT OR GUARDIAN FOR A VOLUNTEER UNDER 18 _____

RELATIONSHIP _____

Background Information Have you ever been charged with or convicted of a crime? yes no . If yes please explain:

I authorize Champlain Adaptive Mounted Program to file the form on page 5 with the Vermont Criminal Information Center or other law enforcement agencies. I understand that such access is for the purpose of considering my application for volunteering or employment. I do not authorize CHAMP, its directors, officers employees or volunteers to discriminate this information in any way to any other individual, group, agency, organization or corporation.

SIGNATURE _____ DATE _____

PRINT NAME BELOW IF SIGNATURE ABOVE IS BY A PARENT OR GUARDIAN FOR A VOLUNTEER UNDER 18 _____

RELATIONSHIP _____

**VERMONT CRIMINAL INFORMATION CENTER
VULNERABLE POPULATIONS PROGRAM
VERMONT RELEASE FORM**

Qualified Entity	Champlain Adaptive Mounted Program (CHAMP)		
Applicant	Last	First	Middle
Maiden or Alias Names			
Social Security #	- -		
Place of Birth	City/Town	State	Country
Date of Birth	Month	Day	Year
Applicant's Telephone #	Include Area Code and Number - -		

RELEASE

I, _____, hereby acknowledge and agree to a check of any criminal record of convictions which may be maintained by the Vermont Criminal Information Center. I understand that the results of that check will be made available to CHAMP for use in reviewing my suitability for employment. I further understand that I have the right to appeal the results of the criminal record check to the Vermont Criminal Information Center, Department of Public Safety, 103 South Main Street, Waterbury, Vermont, 05671-2101.

Signature of Applicant	Date
Identity verified by:	Date

NOTARY

_____ personally appeared before me and satisfied me that s/he is the person named in and who signed this Release Form. Thereupon s/he acknowledged the signing of this Release Form as his/her act and deed for the uses and purposes expressed in this document.

Printed Name of Notary	Notary Signature
Commission Number	Commission Expires

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