



5325 Harrison Road  
Fredericksburg, VA 22407  
HazlewildTRP@gmail.com

## HAZELWILD FARM THERAPEUTIC RIDING PROGRAM VOLUNTEER APPLICATION

Thank you for your interest in volunteering with Hazelwild Farm's Therapeutic Riding Program. Whatever your reason for volunteering, the relationships you form with our riders, horses, fellow volunteers and staff is sure to leave a lasting impression. No matter what your horse experience, your willingness to give of yourself and your time is much appreciated.

Hazelwild Farm's Therapeutic Riding Program meets on Tuesday evenings from 4:30-8:30. The riding ring is outside so we are weather dependent – that means we may cancel a week here or there due to thunderstorms and we take a short break in the hottest part of Summer and the coldest part of Winter. Please contact HazlewildTRP@gmail.com for additional information.

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ AGE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

E-Mail Address \_\_\_\_\_

PLACE OF EMPLOYMENT OR SCHOOL \_\_\_\_\_

PARENT/GUARDIAN NAME \_\_\_\_\_ PHONE \_\_\_\_\_

(If volunteer is under 16 years of age)

REFERENCE NAME \_\_\_\_\_ PHONE \_\_\_\_\_

Relationship \_\_\_\_\_

Driver's License # \_\_\_\_\_ State \_\_\_\_\_

Has your driver's license ever been suspended or revoked in any state? \_\_\_\_\_ No \_\_\_\_\_ Yes If yes, when? \_\_\_\_\_

Where? \_\_\_\_\_ Why? \_\_\_\_\_

Have you ever been convicted of a criminal offense? \_\_\_\_\_ No \_\_\_\_\_ Yes If Yes, When? \_\_\_\_\_

Where? \_\_\_\_\_ Please explain \_\_\_\_\_

*(Upon request, you can be asked to submit an application for a criminal background check.)*

The information that I have provided may be verified, and I give permission to Hazelwild Farm Educational Foundation to make inquiry of others concerning my suitability to act as a volunteer at Hazelwild.

Date \_\_\_\_\_ Signature \_\_\_\_\_

(Parent or Guardian if volunteer is under 16 years of age)



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**GENERAL INFORMATION**

Please tell us of your experience with the following:

Horses:

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Leading horses and/or sidewalking:

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People with disabilities:

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**PHOTO RELEASE:** \_\_\_\_\_ I consent to and authorize  
\_\_\_\_\_ I do not consent to nor do I authorize

The use and reproduction by the Hazelwild Farm Therapeutic Riding, of any and all photographs and any other audiovisual materials taken of me for promotional printed material, educational activities, exhibitions, or for any other use for the benefit of the program.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_

SIGNATURE OF PARENT OR GUARDIAN \_\_\_\_\_

(If volunteer is under 16 years of age, **both** signatures are needed)

**POLICY OF CONFIDENTIALITY:** Confidentiality is defined as “told in secret or private relations; trusted.” Any information in regards to the participants (clients) at Hazelwild must be held in strict confidentiality. It is critical that we respect each individual. Confidentiality is considered one of the most basic responsibilities of our facility. In failure to abide by this policy, the quality of the services we provide may diminish and result in legal ramifications. I have read and understand Hazelwild’s Policy of Confidentiality and agree to abide by the same.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_

SIGNATURE OF PARENT OR GUARDIAN \_\_\_\_\_

(If volunteer is under 16 years of age, **both** signatures are needed)



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**AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FOR VOLUNTEERS**

In the event emergency medical aid/treatment is required due to illness or injury while being on the property of the Hazelwild Farm, I authorize HAZELWILD to:

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

In case of Emergency, contact \_\_\_\_\_ Phone \_\_\_\_\_  
 Or \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Name \_\_\_\_\_ Town \_\_\_\_\_ Phone \_\_\_\_\_

Preferred Medical Facility \_\_\_\_\_

Health Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

Medical conditions and/or medications we should know about: \_\_\_\_\_

Allergies \_\_\_\_\_ Other \_\_\_\_\_

Date of last Tetanus shot \_\_\_\_\_

**CONSENT PLAN** (To be invoked in the event that you Emergency contact cannot be reached) I give consent for emergency medical treatment/aid (including x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician) in the event of illness or injury while on the property of Hazelwild Farm.

Date \_\_\_\_\_ Consent Signature \_\_\_\_\_  
 (Parent or Guardian if volunteer is under 16 years of age)

**NON-CONSENT PLAN** – I do not give consent for emergency treatment/aid in the event of illness or injury while on the property of Hazelwild Farm. In the event emergency treatment/aid is required, I wish the following procedures to take place: \_\_\_\_\_

\_\_\_\_\_

Date \_\_\_\_\_ Non-consent Signature \_\_\_\_\_  
 (Parent or Guardian if volunteer is under 16 years of age)