Back In The Saddle Equine Therapy Center

334 College Hill Rd. / Hopkinton, NH 03229

(603) 746-5681 fax: (603) 746-3522

bitsetc2003@gmail.com

www.bitsetc.org

Hello,

Thank you for your interest in BITS ETC. We depend on volunteers to help us provide quality services to our clients, and a good life-style for our therapy herd of horses. Page two describes some of the jobs which volunteers fill here at the farm. You may keep this page for your records, and to contact us in future.

By filling out the all pages completely, we can get to know what it is you would like to do here. Our focus is safety; for our clients, our volunteers and our horses. It is your responsibility to learn the methods we use to safely interact with our horse. In the interest of safety, we require background checks on **all Volunteers/Staff over 18 years of age**. The fee for this is $10.00. **Please take the enclosed background check application form, and the 'reduced fee' paperwork to a notary for your signature to be notarized, and then send it into the State Police along with a check for $10.00.** They will return the results to us.

We offer Volunteer Training days on an ongoing basis and specialty training throughout the season at BITS. You are encouraged to participate in any of these free trainings to develop your skills in working with our clients and horses.

We will contact you when all paperwork has been received to schedule your volunteer training. This and a clear background check will confirm your volunteer status. We depend on your help with astride lessons and horse care. If you are unable to fulfill your commitment, please inform your instructor ahead of time. Inclement weather may cancel classes, Hopkinton school closure results in BITS ETC closure.

Thank you again for your support, and we look forward to working with you as we help others get "Back in the saddle."

Sincerely,

Jaryn Hall-Haines
Executive Director

VOLUNTEER OPPORTUNITIES

Everyone is welcome to participate in volunteer opportunities. Liability insurance requires that those directly working with our clients and horses be at least 14 years old. We have a program for junior volunteers 10-13 who are welcome to come with a parent or other adult for direct supervision. Some of the opportunities include:

Side walker: Directly participates in riding sessions by assisting the rider with grooming and tacking up their horse. During the ride, the side walker is responsible for walking/jogging beside the rider to ensure safety. A minimum commitment of 120 minutes per week is required for each monthly term. Side walkers must attend a volunteer training before participating in a riding session.

Leader: May also assist the rider before astride lessons begin. During the lesson, the leader is responsible for leading the horse and or walking/jogging next to the horse ti ensure horse safety. Leaders must make a commitment of a minimum of 120 minutes per week, for a four week session and attend volunteer training prior to participating in a riding session.

Barn Mate: "Adopt" one of our therapy horses for your own, and take responsibility for his or her care on an ongoing basis---grooming, training, feeding, etc. We welcome your consistent interaction. This does NOT include riding independently. (Must demonstrate ability to safely handle equines, and be knowledgeable in BITS ETC methods of horse interaction.)

Barn Help: Assists in the barn with daily care of our horses. Tasks include feeding, turning out, cleaning stalls, grooming, and other miscellaneous barn tasks.

Builders/Handy Persons: Use your special talents to build fences, paint, do yard work, landscaping, manure management, and miscellaneous maintenance necessary about the property.

Office Assistant: Filing, data entry, mailings, photocopying, phone calls, research, and other office tasks.

Board of Directors: We welcome e qualified individuals to become members of the Board of Directors, or to sit on various committees such as budget, policy, fundraising, or equine management. Please speak with Pauline Meridien if you have an interest in serving BITS in this manner.

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VOLUNTEER CHOICE AND AVAILABILITY

Name_____ **Phone** _____

E-Mail_____ **Cell** _____

Address [street] _____ [town/zip] _____

I AM AVAILABLE AT THE FOLLOWING TIMES (Please indicate AM and/or PM):

- ❑ Monday (_____)
- ❑ Tuesday (_____)
- ❑ Wednesday (_____)
- ❑ Thursday (_____)
- ❑ Friday (_____)
- ❑ Saturday (_____)
- ❑ Sunday (_____)

My main interest lies in the following:

CLASSES: Direct support of clients during lessons. This is approximately a 2 hour commitment, minimally once per week)

- ❑ Astride lessons
- ❑ Vocational Education lessons

DIRECT HORSE CARE/TRAINING: Barn chores, horse grooming, exercising, training. This is approximately a 1 hour commitment minimally once a month, (usually once a week.)

- ❑ Barn Chores/ Horse grooming, training

ADMINISTRATIVE/OTHER DUTIES

- ❑ OFFICE HELP (Copying, organizing office, phone calls, etc.)
- ❑ SPECIAL PROJECTS (Fundraisers, pr, advertising, fence repair, etc.)
- ❑ BOARD OF DIRECTORS (Meets 6-8 X per year. Please submit a letter of intent and resume)

VOLUNTEER LIABILITY STATEMENT

A Parent or legal Guardian must sign in addition, for all minors

Volunteers are a valuable part of Back in the Saddle Equine Therapy Center (BITSETC). This document confirms that I am recognized as a volunteer at BITS ETC, which exists to provide quality therapeutic riding services in a safe environment. As a volunteer, it is my duty to help ensure the safety of all clients, as well as myself while on the property. This document follows the provisions of New Hampshire RSA 508.17, the Volunteer Immunity Law.

As a volunteer, I will complete available and appropriate training offered to me. I understand and agree that, in the performance of my duties as a volunteer, I must only engage in those activities for which I have been trained, and with which I am comfortable in my ability to accomplish in a safe manner.

Furthermore, I understand that by engaging in equine activities, I am involved in an inherently dangerous activity, and agree to hold BITS ETC, its Board of Directors, its Executive Director, employees, other volunteers, and the owner of the property upon which BITS ETC's business is conducted, harmless in the event of personal injury while volunteering at this facility.

PLEASE NOTE:

> **Therapy Horses are in the program to provide lessons and interaction to our clients. Riding to "train" therapy horses shall only be engaged in by instructors, and volunteers who have completed a course of riding instruction, and passed a rigorous riding test.**

Name [please print clearly] _____**Date**_____

Signature_____**Date**_____
Parent or Guardian if under 18

RELEASE OF LIABILITY

A Parent or legal Guardian must sign in addition, for all minors

Although every effort will be made to avoid accident or injury, NO LIABILITY can be accepted by BITS ETC, it's officers, board of directors, agents, employees, and any of its members, associates, or the property owners upon whose land the therapeutic riding sessions are conducted.

According to RSA 508:19:

"…an equine activity sponsor, an equine professional, or any other person engaged in an equine activity, shall not be liable for any injury or the death of a participant resulting from the inherent risks of equine activities and, except as provided in paragraph III of this section, no participant's representative shall make any claim against, maintain an action against, or recover from any other person for injury, loss, damage, or death of a participant resulting from any other inherent risks of equine activities. Each participant in an equine activity expressly assumes the risk of and legal responsibility for any injury, loss or damage to person or property which results from participation in an equine activity. Each participant shall have the sole responsibility for knowing the range of his or her ability to manage, care for, and control a particular equine or perform a particular equine activity, and it shall be the duty of each participant to act within the limits of the participant's own ability, to maintain reasonable control of the particular equine at all times while participating in an equine activity, to heed all posted warnings, and to refrain from acting in a manner which may cause or contribute to the injury of any person…"

I, [print name] _____, have read and understand the legal limits of liability of BITS ETC, and request to participate in therapeutic riding activities as a

❑ Student ❑ Volunteer ❑ Visitor/Clinic Participant

I understand the inherent risks and potential for risk of equine activities, and agree to accept them. I hereby, intending to be legally bound for myself, my heirs, and assigns, executors, and administrators, waive and release forever all claims for damages against BITS ETC. its board of directors, instructors, therapists, aides, volunteers, and /or employees for any and all injuries and or losses I (my child, ward) may sustain while participating in the Program from whatever cause including but not limited to the negligence of these released parties. The undersigned acknowledges that he / she has read this Liability Release in its entirely; that he / she understands the terms of this release and has signed this release voluntarily and with full knowledge of the effects thereof.'

Signature_____**Date**_____
Participant

Signature_____**Date**_____
Parent or Guardian if under 18

CONFIDENTIALITY POLICY

It is the policy of BITS ETC to hold absolutely confidential all charts, communications, (oral or written) made by and between or about Therapeutic Riding Center staff, board members, volunteers, and clients. It is required that all staff, board members, and volunteers sign this confidentiality agreement. All of these persons are accountable for maintaining the confidentiality of therapy which occurs here. We shall treat all communications regarding therapy as protected health information, and will be guided by the Federal Health Insurance Portability and Accountability Act (HIPAA) in all dealings with outside agencies, or interested persons.

Confidential Communication:

Is any information that is either written or spoken, and shared between client, and/or family-guardian, and staff, volunteers, and /or the board of directors in the course of service delivery of Equine Assisted Therapy and Equine Assisted Learning Activities. The information that is exchanged is considered confidential and is to be kept as such by all involved, and disclosed only to those people who are:

1. Present at the time the information is shared and working to further the interests of the client.
2. Working for BITS ETC maintaining records of clients for informational purposes to aid in evaluation, and facilitate communications between staff/volunteers, as well as for medical and psychological documentation.
3. Not associated with BITS ETC, but working on behalf of the client, such as an attorney, counselor, housing worker, or other social service agent.
4. Maintenance of Records:

BITS ETC shall maintain all records in a strictly confidential manner. Only staff members have access to these records, kept in a locked cabinet. Clients/guardians may access their records at any time, and copies are available for a nominal copying fee.

In cases where information must be disclosed to others, BITS ETC shall have a signed release form on file from the client or guardian before said information is disclosed.

Exception for the Release of Information:

1. Where a staff member or volunteer has reason to suspect a person has been either physically or sexually abused, a report must be made to the appropriate authority. If a volunteer suspects abuse, they should notify a staff member who will be responsible for reporting such. If the client is willing to report the abuse themselves, BITS ETC will have complied with the requirements for reporting. If they assist that individual with making the report.
2. In criminal proceedings, when the court has determined, through the procedure explained in RSA 173-c, that the information contained in the record or testimony is admissible under chapter 173-c, where medical emergency exists and the information from the file is required and the client/family/guardian is unable to authorize the release, information limited to the medical emergency will be disclosed to any emergency personnel, and/or the medical institution treating the client.

I HAVE READ AND AGREE TO ABIDE BY THE CONFIDENTIALITY POLICY OF BITS ETC.

Name [please print clearly] _____

Signature_____ **Date**_____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

❑ **Participant** ❑ **Staff** ❑ **Volunteer**

Name:_____

MD Name: _____

Health Insurance: _____Policy #_____

Allergies: _____

Current Medications: _____

In the event of an emergency, contact:

Name: _____Relation_____Phone_____

Name: _____Relation_____Phone_____

Consent Plan: This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "lifesaving" by my physician. This provision will only be invoked if the person above is unable to be reached.

Signature_____**Date**_____
(Parent or Legal Guardian if under 18)

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 BITS ETC.

_____Parent or legal guardian will remain on site at all times.

_____In the event of an emergency, I wish the following procedure to take place:

_____

_____

_____

_____

VOLUNTEER / STAFF INFORMATION AND HEALTH HISTORY

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GENERAL INFORMATION

Name: _____Date of Birth_____

Preferred Phone: _____E-Mail_____

Employer/ School_____

Address: _____

Parent / Legal Guardian Name (and address if different:)

_____

_____

How did you learn about the program? _____

Last Tetanus Shot: _____ Tuberculosis Test + / - Date: _____
Please consult your local health department if you are not up to date with these shots/tests.)

HEALTH HISTORY

Please describe your current health status, particularly regarding the physical/emotional demands of working in an equine assisted program. Address fitness, cardiac, respiratory, bone or joint function, recent hospitalizations/surgeries, or lifestyle changes.

_____

_____

_____

_____

_____

_____

I understand that the information provided above is accurate to the best of my knowledge. I know of no reason why I should not participate in this center's program.

Signature_____**Date**_____

VOLUNTEER / STAFF INFORMATION AND HEALTH HISTORY

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PHOTO RELEASE:

I ❑ DO ❑ **DO NOT** consent and authorize the taking and use / reproduction of any and all photographs, and or other audiovisual materials taken of me by BITS ETC for promotional, (printed, or web-based), exhibitions, educational activities, or for any other use for the benefit of BITS ETC.

Signature_____Date_____
(Parent or Guardian if under 18)

Background Information
Have you ever been charged with or convicted of a crime? ❑ NO ❑ YES

If yes, please explain:_____
_____
_____
_____

I [print name] _____ authorize Back In The Saddle Equine Therapy Center to receive information from any law enforcement agency, including police departments and sheriff's departments, of this state or any other state, or federal government, to the extent permitted by state and federal law, pertaining to any convictions I may have had for violations of state or federal criminal laws, including but not limited to convictions for crimes committed upon children or animals.

I understand that such access is for the purpose of considering my application as an employee/volunteer, and that I expressly DO NOT authorize any dissemination of this information in any way to any other individual, group, agency, organization, or corporation.

Signature_____**Date**_____
(Parent or Legal Guardian if under 18)

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

Signature_____**Date**_____
(Parent or guardian if under 18)

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New Hampshire Department of Safety
DIVISION OF STATE POLICE
Central Repository for Criminal Records
33 Hazen Drive, Concord, NH 03305

CRIMINAL RECORD RELEASE AUTHORIZATION FORM

SECTION I

PLEASE TYPE OR PRINT CLEARLY, ALL INFORMATION IN THIS SECTION **MUST BE COMPLETED**

NAME_____
LAST (MAIDEN/ALIAS) FIRST MI

ADDRESS_____
STREET CITY STATE ZIP CODE

DATE OF BIRTH_____ **HAIR COLOR**_____ **EYE COLOR**_____ **SEX**_____

DRIVER LICENSE NUMBER_____ STATE_____

PURPOSE FOR RECORD: ☐ Housing ☐ Employment ☐ Annulment/Expungement ☐ Other _____

My below signature certifies I am the individual listed above and that the information provided is true.

YOUR SIGNATURE:_____ DATE_____
Signed under penalty of unsworn falsification pursuant to NH RSA 641:3

SECTION II

IF RECORD IS TO BE MAILED **TO YOU, OR** RECEIVED BY SOMEONE OTHER THAN YOURSELF,

ALL OF SECTION II MUST BE COMPLETED

I hereby authorize the release of my criminal record conviction(s), if any, to the following individual:

BACK IN THE SADDLE EQUINE THERAPY CEN
NAME OF PERSON / FIRM TO RECEIVE RECORD

ADDRESS 334 College Hill Rd Hopkinton NH 03229
STREET CITY STATE ZIP CODE

YOUR SIGNATURE_____ DATE_____

NOTARY'S SIGNATURE_____ DATE_____
(Affix Seal) (Comm. Exp.)

Pauline Meridien Director BITS ETC DATE_____
SIGNATURE OF PERSON / FIRM TO RECEIVE RECORD

NOTE: A $25.00 fee is required for each request- make checks payable to: State of NH – Criminal Records.

New Hampshire Department of Safety
DIVISION OF STATE POLICE
Central Repository for Criminal Records
33 Hazen Drive, Concord, NH 03305

REDUCED FEE REQUEST FORM

SECTION 5703.07 **Fee Exemption** of the *Rules and Regulations for the Operation of the Central Repository*: (d) Volunteers for public or private not-for-profit agencies that provide services to the elderly, the disabled or children shall be charged $10.00 for each criminal record check requested.

PLEASE PRINT OR TYPE CLEARLY

NAME Pack In The Saddle Equine Therapy Center
ORGANIZATION OR AGENCY

ADDRESS 334 College Hill Rd. Hopkinton NH 03229
STREET CITY STATE ZIP CODE

TELEPHONE NUMBER 603-746-5681 **FAX NUMBER** 603-746-3522

IS AGENCY OR ORGANIZATION NON-PROFIT? YES ✓ NO ____

IS THE REQUESTED PERSON(S) A VOLUNTEER? YES ✓ NO ____

WILL THE SERVICES BE TO THE ELDERLY, THE DISABLED, OR CHILDREN? YES ✓ NO ____

The Identity of the volunteer for whom this reduced fee is requested:

_____
NAME OF VOLUNTEER (please print)

who will be working with:

- ☐ Elderly
- ☒ Disabled
- ☒ Children

THE ABOVE INFORMATION IS ACCURATE AND TRUE:

Authorized Signature Pauline Meridien **Date** _____
FOR THE AGENCY OR ORGANIZATION
Signed under penalty of unsworn falsification pursuant to RSA 641:3

NOTE: This form *must* be accompanied by a completed Criminal Record Release Authorization Form.

Effective 1/01/2009