Back In The Saddle Equine Therapy Center

334 College Hill Rd. / Hopkinton, NH 03229

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

info@bitsetc.org

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 lifestyle for our therapy herd of horses. The following page will describe some of the jobs which volunteers perform here at the farm. Please keep this page for your records.

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 training sessions to develop your skills in working with our clients and horses.

We kindly request you fill out all pages completely, to help us better understand which volunteer opportunities you would like to partake in here at BITS ETC. Our focus is safety; for our clients, our volunteers, and our horses. It is the volunteer's responsibility to learn the methods we use to safely interact with our horses. In the interest of safety, we require Background Checks on all Volunteers and Staff over 18 years of age. Please take the enclosed background check application form, and the 'reduced fee' paperwork to a notary for your signature to be notarized. Banks often notarize free of charge for their members. Lastly, bring your authorization form to the State Police located at 33 Hazen Drive, Concord, NH 03305 (there is a $10.00 processing fee) and deliver the results to the BITS administration office. Alternatively, you can mail your authorization form along with a check for $10.00 to the State Police. They will return the results to us, but this will delay the application process.

We will contact you when all paperwork has been received to schedule your volunteer training. Completing your volunteer training along with a clear background check will confirm your volunteer status. We depend on your help with astride lessons, horse care, and more. If you are unable to fulfill your commitment, please inform the volunteer coordinator with as much notice as possible. 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. Below are some of the opportunities available.

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. 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 to ensure horse safety. Leaders must attend volunteer training prior to participating in a riding session.

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 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 Jaryn Hall-Haines if you have an interest in serving BITS in this manner.

GENERAL INFORMATION

Name: _____Date of Birth_____

Preferred Phone: _____E-Mail_____

Address [street] _____ [town/zip] _____

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

_____

How did you learn about the program? _____

VOLUNTEER AVAILABILITY

I am available at the following times (Please circle AM and/or PM):

❑ Sunday	AM	PM	❑ Thursday	AM	PM
❑ Monday	AM	PM	❑ Friday	AM	PM
❑ Tuesday	AM	PM	❑ Saturday	AM	PM
❑ Wednesday	AM	PM			

I am interested in participating in the following (see prior page for description):

- ❑ Side Walker
- ❑ Leader
- ❑ Barn Help
- ❑ Builder/Handy person
- ❑ Office Assistant
- ❑ Fundraising

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:_____

_____

_____

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 (BITS ETC). 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 volunteer.

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

Name:_____

MD Name: _____

Allergies: _____

Current Medications: _____

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

In the event of an emergency, contact:

Name: _____Relation_____Phone_____

Name: _____Relation_____Phone_____

☐ I give my consent for emergency medical treatment/aid in the case of illness or injury during the process of providing or 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 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_____

State of New Hampshire

Department of Safety
DIVISION OF STATE POLICE

Criminal Records Unit
33 Hazen Drive, Concord, NH 03305

CRIMINAL HISTORY RECORD INFORMATION RELEASE AUTHORIZATION FORM

INSTRUCTIONS

NH RSA 106-B:14 and Administrative Rule Saf-C 5700 authorizes the dissemination of NH Criminal History Record Information (CHRI) for non-criminal justice purposes. In NH, all CHRI is confidential and released only upon the knowledge and permission of the individual of whom the request is made. Individuals requesting their own record in person need only to complete Section I. If the CHRI is to be released to a third party, both Section I and Section II must be completed. All requests by mail must have both sections completed and Section II notarized.

SECTION I (PLEASE PRINT CLEARLY)

Last Name_____ **First Name** _____ **Maiden** _____ **MI**____

Address_____ **City**_____ **State**_____ **Zip**_____

Date of Birth _____ **Hair Color**_____ **Eye Color**_____ **Male** ☐ **Female** ☐

Driver's License Number_____ **State**_____

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

Signature _____ **Date** _____
Signed under penalty of unsworn falsification pursuant to RSA 641:13

PURPOSE OF RECORD

☐ **Housing** ☐ **Employment** ☐ **Annulment/Expungement** ☐ **Other**_____

SECTION II

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

Person or Entity to Receive Record BACK IN THE SADDLE EQUINE THERAPY CENTER

Address 334 COLLEGE HILL ROAD **City** HOPKINTON **State** NH **Zip** 03229

Your Signature_____ **Date**_____

Notary's Signature _____ **Date**_____

Signature of person/entity to receive record Joyce Hall-Haines (Affix seal) **Date** _____

RECORD CHALLENGE

Saf-C 5703.12 Procedure for Correcting a CHRI (a) Persons or their attorneys desiring access to their CHRI for the purpose of challenge or correction shall appear at the central repository. (b) A copy shall be provided to a person if after review he/she indicates he/she needs the copy to pursue the challenge. (c) Any person making a challenge shall identify that portion of his/her CHRI which he/she believes to be inaccurate or incorrect, and shall also give a correct version of his/her record with an explanation of the reason that he/she believes his/her version to be correct. (d) The director shall take the following actions within 30 days of receipt of challenge: (1) Review the records and contact the law enforcement agency or court which submitted the record to compare the information to determine whether the challenge is valid; (2) If the challenge is valid, which means there is a discrepancy between the information submitted and the information maintained by the law enforcement agency or court, the record shall be corrected and the person and appropriate CJAs shall be notified; and (3) If the challenge is invalid, the person shall be informed and advised of the right to appeal pursuant to RSA 541 (e) When a record has been corrected, the division shall notify all non-criminal justice agencies, to whom the data has been disseminated in the last year, of the correction (f) The person shall be entitled to review the information that records the facts, dates, and results of each formal stage of the criminal justice process through which he passes, to ensure that all such steps are completely and accurately recorded.

WARNING: The Division of State Police is the Criminal Record Repository for the State of New Hampshire. The record you have received is based only on what has been reported to the Repository and may not be a complete Criminal History Record of the named individual.

☐ **To prevent a delay in processing, I have enclosed a self-addressed envelope.**

☐ **Prepaid Acc't Number**_____

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

DSSP256

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 BACK IN THE SADDLE EQUINE THERAPY CENTER
ORGANIZATION OR AGENCY

ADDRESS 334 COLLEGE HILL ROAD, 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 X NO ____

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

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

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

_____
NAME OF VOLUNTEER (please print)

who will be working with:
- [X] Elderly
- [X] Disabled
- [X] Children

THE ABOVE INFORMATION IS ACCURATE AND TRUE:

Authorized Signature Joryn Hall-Haines **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