

# CHEFF THERAPEUTIC RIDING CENTER

8450 North 43<sup>rd</sup> St, Augusta, MI 49012

Tel: 269-731-4471 Fax: 269-731-2990

[www.cheffcenter.org](http://www.cheffcenter.org)

## Welcome New Volunteer!

Thank you for your interest in volunteering at Cheff Therapeutic Riding Center. Our program depends on volunteers to make equine-assisted activities available for individuals with disabilities.

In order to begin volunteering at Cheff, complete the following steps:

- ❖ Fill out the volunteer packet included with this cover sheet.
- ❖ Call Cheff Center at 269-731-4471 or email our volunteer coordinator at [volunteer@cheffcenter.org](mailto:volunteer@cheffcenter.org) for orientation information or to answer any questions you may have. NOTE: Orientations are scheduled once a month.
- ❖ Bring completed paperwork with you, including the last page of the Volunteer Manual, acknowledging you have read the manual.

We're looking forward to having you join our team of dedicated staff, volunteers and horses whose mission is to make life a little better for those with special needs.



# VOLUNTEER INFORMATION & SIGN UP SHEET

## OFFICE USE ONLY

Sign-In \_\_\_\_\_ TricTrax \_\_\_\_\_  
Email \_\_\_\_\_ Newsletter \_\_\_\_\_  
PPW \_\_\_\_\_ BkGrd Ck \_\_\_\_\_  
Orientation \_\_\_\_\_

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

Male \_\_\_ Female \_\_\_

Date of Birth: \_\_\_\_\_ Parent/Guardian (if under 18): \_\_\_\_\_

Address: \_\_\_\_\_

Street City ST ZIP  
Phone (Primary) \_\_\_\_\_ (Other) \_\_\_\_\_ EMAIL: \_\_\_\_\_

Preferred method of contact (circle one): Phone ☎ or Email ☒

Employer: \_\_\_\_\_ School & Grade: \_\_\_\_\_

Do you have prior experience with horses and/or people with disabilities? Yes \_\_\_ No \_\_\_ Please explain: \_\_\_\_\_

Race/Ethnicity: *American Indian/Alaska Native* \_\_\_; *Asian* \_\_\_; *Black/African American* \_\_\_;  
*Hispanic/Latino* \_\_\_; *Native Hawaiian/Other Pacific Islander* \_\_\_; *White*; \_\_\_; *Other* \_\_\_

**This information is optional**

## **Background Information**

Have you ever been charged with or convicted of a crime? Yes \_\_\_ No \_\_\_. If yes, please explain \_\_\_\_\_

I, \_\_\_\_\_ (volunteer), authorize the Cheff Therapeutic Riding 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.

I understand that such access is for the purpose of considering my application as an employee/volunteer, and that I expressly DO NOT authorize the Cheff Therapeutic Riding Center, its directors, officers, employees, or other volunteers to disseminate this information in any way to any other individual, group, agency, organization, or corporation.

Current Driver's License: Yes \_\_\_ No \_\_\_ License # \_\_\_\_\_ State \_\_\_\_\_

## **Photo Release**

**I DO** \_\_\_ or **I DO NOT** \_\_\_

Consent to and authorize the use and reproduction of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibits, social media, or for any other use for benefit of the program.

## **Emergency Treatment Release**

Physician's name: \_\_\_\_\_ Ph: \_\_\_\_\_

Physician's address: \_\_\_\_\_ Preferred Medical Facility: \_\_\_\_\_

Health Insurance: \_\_\_\_\_ Policy # \_\_\_\_\_

In the event of a medical emergency, please provide emergency contact information:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_ **I GIVE MY CONSENT**, in the event of a medical emergency, for the Cheff Therapeutic Riding Center to provide such medical assistance as deemed to be necessary. I authorize any licensed physician and/or medical facility to provide medical surgical care and/or hospitalization for the above-named volunteer, including anesthetic, which they determine to be necessary or advisable, pending receipt of a specific consent from the undersigned.

**OR:** \_\_\_ **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 the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place: \_\_\_\_\_

**List any medical-related allergies (latex, drug allergies, etc) here:** \_\_\_\_\_

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

Volunteer or Parent/Guardian (if under 18)



Cheff Therapeutic Riding Center  
8450 North 43<sup>rd</sup> Street, Augusta MI 49012

**Liability Release Form**

I agree to the following agreement with the CHEFF THERAPEUTIC RIDING CENTER, a Michigan nonprofit corporation (hereafter referred to as "Center") as a condition for allowing me, and the persons identified below, to enter the Center's premises and surrounding land, be near horses, participate in equine-assisted activities, work near horses, handle horses, use equipment, work with staff and volunteers, and/or receive instruction or guidance in riding, grooming, or handling of horses (these activities will hereafter be referred to in this document as "The Activities").

CONTRACTING PARTY (Volunteer if 18 or Parent/Guardian) \_\_\_\_\_

OTHER CONTRACTING PARTY (Spouse or Other Parent) \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
Street City ST ZIP

PHONE (Home) \_\_\_\_\_ (Business) \_\_\_\_\_ (Cell/Other) \_\_\_\_\_

I also make this agreement on behalf of the following, who is/are my child/ren or court appointed legal ward(s):

1. \_\_\_\_\_ Age \_\_\_\_\_ 2. \_\_\_\_\_ Age \_\_\_\_\_

Child's DOB: \_\_\_\_\_ Child's DOB: \_\_\_\_\_

All parts of this agreement shall apply to me and shall also apply to the children/legal wards listed above. This Release is intended to be valid and binding at all times – now and in the future – when Center permits me (directly or indirectly) to engage in any or all of The Activities.

**IT IS HEREBY AGREED AS FOLLOWS:**

1. I have requested to engage in any or all of The Activities, now and/or in the future.
2. **Risks.** I understand that anyone engaging in The Activities can suffer bodily and other injuries. Participation in The Activities involved certain inherent risks and, regardless of the care that is taken, it is impossible to ensure the safety of the participant. I understand the risks/dangers inherent in The Activities, and I agree to assume them. I am not relying on the Center to list all possible risks for me.
2. **Waiver and Liability Release.** As consideration for Center allowing me to engage in The Activities at any time and at any location, I agree to assume full responsibility for any and all bodily injuries, losses, or damages that I may sustain. I, for my heirs, administrators, personal representatives, or assigns, release and discharge the CHEFF THERAPEUTIC RIDING CENTER, Cheff Therapy Services, and their employees, assistants, directors, volunteers, land owners, and owners of horses from any and all claims, demands, damages, actions, omissions, suits, or causes of action (present or future).

**WARNING**

Under the Michigan Equine Activity Liability Act [1994 P.A. 351], an equine professional is not liable for an injury to or the death of a participant in an equine activity resulting from an inherent risk of the equine activity.

IT IS MUTUALLY UNDERSTOOD AND AGREED THAT THE WAIVER AND LIABILITY RELEASE SET FORTH IN THIS DOCUMENT CONSTITUTES A WAIVER OF LIABILITY BEYOND THE PROVISIONS OF THE MICHIGAN EQUINE ACTIVITY LIABILITY ACT, 1994 P.A. 351. BY SIGNING THIS RELEASE, I AGREE NOT TO BRING ANY CLAIM OR SUIT AGAINST CENTER OR PERSONS OR ENTITIES WORKING ON BEHALF OF OR AFFILIATED WITH CENTER ON THE BASIS OF ANY EXCEPTION IN THAT LAW.

3. **Indemnification.** I also agree to indemnify and hold harmless the CHEFF THERAPEUTIC RIDING CENTER, Cheff Therapy Services, and persons or entities working on behalf of or affiliated with the Center against all damages which are sustained or suffered by any third persons. The indemnification shall include reimbursement of Center's attorney fees.
4. **ASTM/SEI Headgear.** CHEFF THERAPEUTIC RIDING CENTER will provide me with an equestrian safety helmet that is ASTM-standard and SEI-certified for use when riding, handling, or being near horses. I understand that neither CHEFF THERAPEUTIC RIDING CENTER or its assistants or agents can guarantee the suitability of any helmet provided.
5. **Health and Disabilities.** I understand that Center always recommends that I seek the advice of a physician, and many of The Activities pose special physical risks to the participant and even to the volunteer. I want Center to be aware of the following physical conditions I have that may affect my ability to handle, ride, and/or be near an equine:  
\_\_\_\_\_
6. Should I breach this Release (or any part of it) I agree to pay the attorney's fees and court costs related to such breach incurred by Center and/or persons directly affiliated with Center. It is also mutually agreed that any disputes arising under this Release, or any activities that are undertaken pursuant to this document, shall be litigated in a court of proper jurisdiction located in or nearest to Kalamazoo County, Michigan.

SIGNATURE OF CONTRACTING PARTY \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE OF OTHER CONTRACTING PARTY \_\_\_\_\_ DATE \_\_\_\_\_



## Volunteer Interest Form

**Volunteers at Cheff have the opportunity to help with a wide range of activities, enabling staff to provide our program to our clients.**

**Please indicate which of the following activities you are interested in:**

**1=most interest**

**2= some interest**

**3=least interest**

\_\_\_ Classes (lead and/or sidewalk)      \_\_\_ Summer Camp (assist in all activities)

\_\_\_ Barn (clean stalls, sweep, groom, feed horses)      \_\_\_ Tack Maintenance

\_\_\_ Hippotherapy (assist P.T. as a side-walker; requires special training)

\_\_\_ Grounds/Maintenance (gardening, lawn maintenance, landscaping, painting)

\_\_\_ Special Events (usually weekends)      \_\_\_ Committee member for fundraisers

\_\_\_ Office work (mailings)

List any special skills you have: \_\_\_\_\_

**Check days and times you are available:**

Day	Morning	Afternoon	Evening
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Weekends / Special Events			

Are you interested in being on-call? If yes, list available days/times: \_\_\_\_\_

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
E-mail address

\_\_\_\_\_  
Phone



## **CONFIDENTIALITY AGREEMENT**

As a volunteer at the Cheff Therapeutic Riding Center (Cheff Center), I acknowledge that I will have access to and there will be made available to me certain knowledge belonging to the Cheff Center which is confidential information. Such confidential information may include, but not be limited to, student symptoms and/or diagnoses. I will hold in trust and confidence such information and will not disclose or use such information for any purpose other than to participate in my volunteering experience. I will not use the confidential information for my personal use or for the use of any other party.

The undersigned understands and agrees that the Cheff Center may apply for and have granted an injunction restraining any breach or threatened breach of any of the covenants contained herein.

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Volunteer Signature

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Date

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Volunteer Printed Name