CHAKOTA
Therapeutic Riding Center

6248 Wesclin Rd, Germantown, IL 62245
618-334-0885 Chakota-trc.org

Dear Prospective Volunteer,

Chakota Therapeutic Riding Center, founded June 14, 2005, is a community-based human service organization which provides Therapeutic Horseback Riding for children and adults with disabilities. Chakota Therapeutic Riding Center is the only facility within an 80-mile radius to offer Therapeutic Horseback Riding. Our Board of Directors consists of individuals from the community who care about the program and have graciously volunteered their time, expertise and enthusiasm to help maintain and grow the program. Chakota Therapeutic Riding Center is a 501(c)3 non-profit organization and a Professional Association of Therapeutic Horsemanship, Int'l (PATH, Int'l) center member.

Thank you for your interest in Chakota Therapeutic Riding Center. Our volunteer program is an ongoing effort to meet the needs of our clients enrolled in therapeutic riding. Within the program, we have 2 levels of skill: side-walkers and leaders. Each level builds on the previous one. We will train you! No previous horse experience is necessary. Our volunteers also help out in the office, around the barn, and in the garden.

Our entry level volunteer position is a Sidewalker. This volunteer walks along the side of the horse and provides safety and stability to the riders as they work toward their therapeutic goals. We require a minimum of a one-two hour time commitment, same day each week. This is very different from most volunteer programs, where the volunteer is not necessarily tied down to a specific day and time. Here, if a volunteer does not show up...the client does not ride. Therefore, we require and greatly appreciate as much advance notice for any volunteer absence that may occur. Is this something you think you can do? Please let me know if you have any questions. Our beginning age for volunteering is 14...needless to say, it becomes a family commitment to make sure a volunteer who doesn't drive can follow through on the commitment to Chakota Therapeutic Riding Center.

Your next step is to fill out a Chakota Therapeutic Riding Center application and either mail it or bring it with you when you come for training. I have attached the application packet for your convenience. Be sure to include your e-mail address on the application. We hold required Orientation and Sidewalker training sessions on various days. Please call me at 618-334-0885 to reserve your spot. Dress code is for a barn environment…shoes that cover your feet (no sandals!) and no short shorts! I'll eventually need to know what day and time you can volunteer on a regular basis. Below are the hours during which we offer therapy classes:

Again, thank you for your interest in Chakota Therapeutic Riding Center. We are always in need of volunteers!

Sincerely,

Kay Langenhorst

Kay Langenhorst
Executive Director

CHAKOTA Therapeutic Riding Center

Personal Information

(Use the exact name you registered with the Department of Children and Family Services for the background check.)

Mr. ☐ **Mrs.** ☐ First Name _____ MI _____ Last Name _____
Ms. ☐ **Dr.** ☐

Current Age: _____ (Must be at least 14 years old) Birth Date: _____

Veteran: Military Branch _____

Have you ever been convicted of a felony or other crime? (Circle one) Yes No If Yes, please explain:

_____

_____

Employment Information

Employer's Name _____

Occupation/Title _____

Street _____ Suite # _____

City _____ State _____ Zip Code _____

Mailing Address

(circle one) Home Work School Other

Street _____ Apartment # _____

City _____ County _____ State _____ Zip Code _____

Is anyone at this address already a volunteer here? (circle one) Yes No

If yes, what is his/her name? _____ What is his/her relationship to you? _____

Home Address

(if different from above)

Street _____

Apartment # _____

City _____ County _____ State _____ Zip Code _____

Contact Information

Preferred Phone: (circle one) Home Mobile Work Preferred E-Mail: (circle one) Work Personal

Home Phone: ( ) _____ Work E-mail: _____

Mobile/Cell: ( ) _____ Personal E-mail: _____

Work Phone: ( ) _____

Be sure that your contact information is legible!

About You…

Nick Name: _____

(This name will appear on your nametag!)

I am available to volunteer on the following days: (Please circle day and time at which you are available.)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning	Morning	Morning	Morning	Morning	Morning	Morning
Afternoon	Afternoon	Afternoon	Afternoon	Afternoon	Afternoon	Afternoon
Evening	Evening	Evening	Evening	Evening		

How did you hear about Chakota Therapeutic Riding Center? _____

Do you have experience with horses? (circle one) Yes No Please explain: _____

_____

Do you have experience with people with disabilities? (circle one) Yes No Please explain: _____

_____

In which areas of our program would you like to volunteer? (Please circle all that apply.)

Administration Facility/Grounds Care Horse Handler Public Relations
Barn Work Fundraising Leader Side Walker

What are your skills and interests? _____

_____

Highest level of Education *completed*: (circle one) High School Tech School College Graduate School

Names of Schools: _____

What school do you currently attend, if any? _____

Do you have previous volunteer experience? (circle one) Yes No

If yes, where? _____ For how long? _____

Do you have training in CPR or First Aid? (circle one) Yes No If yes, please bring a copy of your card(s).

Have you volunteered with us before? (circle one) Yes No If so, when and where? _____

Why do you want to become a Chakota Therapeutic Riding Center volunteer? _____

_____

I certify that the statements made in this volunteer application are true and correct and have been given voluntarily. I understand that this information may be disclosed to any party with legal and proper interest, and I release Chakota Therapeutic Riding Center from any liability whatsoever for supplying such information. I understand that I will not be paid for my services as a volunteer.

Applicant's Signature _____ **Date** _____

Legal Guardian's Signature _____ **Date** _____

(The Legal Guardian of the Applicant must sign if the Applicant is less than 18 years old.)

General Liability Release

The undersigned is aware that all activities involving horses including but not limited to riding, driving, grooming, leading or events involving horses pose many inherent dangers, risks and hazards including but not limited to bodily injury and physical harm to rider, groomer, leader, handler, side walker, photographer, spectator and/or helper. I (the undersigned) freely assume all such risks, dangers, and hazards. I hereby agree as follows

(Initial each number to indicate that you have read, understand and agree):

_____1) To assume and accept all risks, dangers and hazards in connection with my use or my minor child's or ward's use of the facilities and activities at Chakota Therapeutic Riding Center, hereinafter ("Chakota") or any off site activities sponsored by Chakota.

_____2) To waive any and all claims that I may have against Chakota and the property owners as a result of my, my minor child or ward's use of the facility or participation in any off site activity sponsored by Chakota.

_____3) To release Chakota, its employees, board of directors, agents, volunteers, spectators, clients, guests, property owners and all people involved with Chakota from any and all liability, rights of action, or causes of action arising out of contract, tort or otherwise for any loss, damage, injury or expense that I, my minor child or ward, or next of kin of myself may suffer or incur as a result of use of the facilities and activities or participation in offsite activities sponsored by Chakota due to any cause whatsoever.

_____4) The undersigned agrees to hold harmless Chakota, and any employees, volunteers, board of directors, agents, spectators, clients and or property owners form any and all liability for personal injury, property damage or death suffered by myself, my minor child or ward or by a third party as a result of use and/or presence at the facility or activities or off site activities sponsored by Chakota.

_____5) That, in the event of my, my minor child or ward's injury or death, this release and indemnity agreement shall be effective and binding upon mine and my minor child or ward's heirs, next of kin, executors, administrators and assigns in relation to Chakota, it's property owners and any and all people involved.

Adult:

I acknowledge that I have read and understood this release. I am at least 18 years of age and am aware that by signing this document, I am releasing legal rights for myself, my heirs, next of kin, executors, administrators, and assigns or in relation to Chakota, its property owners and any and all people involved.

Date:_____Name:_____(print legibly)

Signature:_____

Witness:_____

Minor or ward:

I acknowledge that I have read and understood this release and indemnity. I am 18 years of age or older. I have the authority as the parent or legal guardian or legal representative of _____ (Please print legibly) to sign and release on behalf of the minor/ward so that the minor/ward may participate and use the facilities and activities offered by Chakota. I am waiving legal rights and liabilities of the minor/ward, his/her heirs, next of kin, executors, administrators, and assigns in relation to Chakota, its property owners and any and all people involved.

Date:_____Name:_____(print legibly)

Signature:_____

Witness:_____

Photo Release

In consideration for being accepted into the Chakota Therapeutic Riding Center volunteer program and for the valuable personal benefits I receive from participating in the program and promoting the program, I, (please print)_____, hereby AUTHORIZE Chakota Therapeutic Riding Center, its advertising agencies or the news media to have photographs, films or other audio-visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the Chakota Therapeutic Riding Center program. I hereby indemnify and hold Chakota Therapeutic Riding Center harmless against any and all claims of damages arising out of the use of any such photographs or films of me or audio-visual materials containing my image.

Applicant's Signature: _____ Date: _____

Legal Guardian's Signature:_____Date: _____
(The Legal Guardian of the Applicant must sign if the Applicant is less than 18 yrs old.)

~~~OR~~~

I, (please print)_____, hereby DO NOT AUTHORIZE Chakota Therapeutic Riding Center, its advertising agencies or the news media to have photographs, films or other audio-visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the Chakota Therapeutic Riding Center program.

Applicant's Signature: _____ Date: _____

Legal Guardian's Signature:_____Date: _____
(The Legal Guardian of the Applicant must sign if the Applicant is less than 18 yrs old.)

WARNING

Under Illinois law, an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities pursuant to the Revised Statutes of Illinois.
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CFS 689
6/2001

State of Illinois
Department of Children and Family Services

AUTHORIZATION FOR BACKGROUND CHECK

Child Abuse and Neglect Tracking System (CANTS)

For Programs NOT Licensed by DCFS

NOTE: Do not use this form if you are an applicant for licensure or an employee/volunteer of a licensed child care facility. Please contact your licensing representative.

Name: _____
Last First Middle

Date of Birth: _____ Gender (circle): Male Female Race: _____

Current Address: _____
Street/Apt #

_____
City State Zip Code

List all addresses at which you have resided in the past five years:

_____

_____

_____

_____

_____

List maiden name and/or all other names by which you have been known: (last, first, middle)

_____ _____

_____ _____

_____ _____

_____ _____

I hereby authorize the Illinois Department of Children and Family Services to conduct a search of the Child Abuse and Neglect Tracking system (CANTS) to determine whether I have been a perpetrator of an indicated incident of child abuse and/or neglect or involved in a pending investigation. I further consent to the release of this information to the agency listed below.

_____
Signed Date

Please type, use bold letters or label:

Mail this request to:
Department of Children and Family Services
406 E. Monroe – Station # 30
Springfield, IL 62701

Chakota Therapeutic Riding Center (Agency Name)
Kay Langenhorst 618-334-0885 KayL@chakota-trc.org (Contact Person)
6248 Wesclin Rd (Address)
Germantown, IL, 62245 (City/State/Zip)
N/A (Submitting Agency Fax Number)

Volunteer Pledge and Commitment

I understand as a volunteer I am agreeing to help and support Chakota Therapeutic Riding Center and their needs, whatever they may be.

I understand that a student's right to privacy and a parent's right to privacy must be respected. Therefore I understand I am to hold such information in confidence and not to divulge the information to any person.

I have filled out the background check form and understand that I may be asked to refrain from volunteering at Chakota Therapeutic Riding Center if the check comes back with any questionable information.

I will honor my schedule and commitment. I will try to be an appropriate model for my clients in my dress, language, and behavior. I will abide by the smoking policy and refrain from discussing my concerns with those who are not directly involved with the situation. I understand I am to bring my concerns to the Volunteer Coordinator or Program Director.

Date:_____

Signature:_____

Phone Number: ( ) _____

Authorization for Emergency Medical Treatment Form

(circle one) Participant Staff Volunteer

Name:_____ DOB:_____
Phone: _____

Address:_____

Physician's Name:_____
Medical Facility:_____

Health Insurance Company:_____
Policy#:_____

Allergies to medications:_____

Current medications:_____

Epi-pen (circle) Yes No Inhaler (circle) Yes No

In the event of an emergency, contact:

Name:_____ Relation:_____ Phone:_____

Name:_____ Relation:_____ Phone:_____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Chakota Therapeutic Riding Center (Operating Center's Name)
To:

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

Do you have any medical conditions you wish us to be aware of for safety reasons? (Please note this form is accessible to Chakota staff and volunteers.)

_____

_____

CONSENT PLAN
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.

Date:_____
Consent Signature:_____
Client, Parent or Legal Guardian

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

_____

_____

Date:_____ Consent Signature:_____
Client, Parent or Legal Guardian