



2019 E. Harvest Circle  
Perryville, Mo 63775  
573-517-6004

Dear Prospective Volunteer,

Thank you for your inquiry about the volunteer opportunities at The Hope Center. We are a not-for-profit organization that uses horses to encourage physical and mental development in people with disabilities.

Next to our horses, our volunteers are the most critical element in the success of this program. We rely on volunteers in every aspect and could not exist without their support, dedication and abilities.

Enclosed are the necessary forms each volunteer must fill out and return before entering the volunteer training session at the Hope Center. Please notice the Child Abuse and Neglect Check Form. We cannot accept any applicant with a history of abusing or neglecting a child. Meanwhile, the volunteer application/ information, emergency medical treatment and release forms need to be sent to our mailing address.

Lisa Best,  
Program Director  
573-517-6004

Jim Best,  
Facilities Manager  
573-517-1674

Krystal Evans,  
Certified Riding  
Instructor  
573-768-0848

Rick Schemel, Sr.  
Executive Director  
573-547-6057

Please feel free to contact us if you have any questions. We look forward to working with you in this challenging yet rewarding program.



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VOLUNTEER APPLICATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Mr. \_\_\_ Mrs. \_\_\_ Ms. \_\_\_ Other: \_\_\_ preferred nickname: \_\_\_\_\_

Address:

Street: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Phone:

Home: \_\_\_\_\_

Work: \_\_\_\_\_

Cell: \_\_\_\_\_ Do you prefer text messages? Yes No

E-mail: \_\_\_\_\_ (please provide an e-mail that you check regularly. We promise not to spam you!)

Birth date: \_\_\_\_\_ (participants working directly with horses must be at least 14)

Is anyone at this address a volunteer at The Hope Center? \_\_\_\_\_

If yes, what is his/her name? \_\_\_\_\_

What is his/her relationship to you? \_\_\_\_\_

Employment:

Employed: full time \_\_\_\_\_ part time \_\_\_\_\_

Retired: \_\_\_\_\_ Other: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_



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How did you find out about The Hope Center?

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What are the reasons you would like to volunteer with The Hope Center?

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For which areas of the program would you like to volunteer?

- |   |  |
|---|--|
| <input type="checkbox"/> Administrative /office | <input type="checkbox"/> horse handler             |
| <input type="checkbox"/> fund raising           | <input type="checkbox"/> side walker               |
| <input type="checkbox"/> public relations       | <input type="checkbox"/> leader                    |
| <input type="checkbox"/> groundskeeper          | <input type="checkbox"/> Barn Buddy Horse Care     |
| <input type="checkbox"/> lesson organizer       | <input type="checkbox"/> other/wherever I'm needed |

If Volunteer is under 18 years of age:

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

Parents Home and Work phone numbers: \_\_\_\_\_

Availability: The Hope Center is open Monday – Saturday and will be making class times according to the clients need. Please consider your schedule and check a time that you could be regularly available.

Monday: AM \_\_\_\_\_ PM \_\_\_\_\_

Tuesday: AM \_\_\_\_\_ PM \_\_\_\_\_

Wednesday: AM \_\_\_\_\_ PM \_\_\_\_\_

Thursday: AM \_\_\_\_\_ PM \_\_\_\_\_

Friday: AM \_\_\_\_\_ PM \_\_\_\_\_

Saturday: AM \_\_\_\_\_ PM \_\_\_\_\_

Daytime special events: \_\_\_\_\_



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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 The Hope Center, Inc. from any liability whatsoever for supplying such information.

I understand that I will not be paid for my services as a volunteer.

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

Legal Guardians Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(If applicant if less than 18 years of age)



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## Authorization for Emergency Medical Treatment Form

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while on the property of the agency, I authorize The Hope Center, Inc. to:

1. secure and retain medical treatment and transportation if needed
2. release client records upon request to authorized medical personnel

Participant's name: \_\_\_\_\_ phone: \_\_\_\_\_

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

In the event I cannot be reached contact: \_\_\_\_\_ phone: \_\_\_\_\_

Physician's name: \_\_\_\_\_ phone: \_\_\_\_\_

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

Health Insurance Co.: \_\_\_\_\_ Policy #: \_\_\_\_\_

### Consent Plan

This authorization includes x-rays, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician. The provision will only be invoked if the person below is unable to be reached.

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

Volunteer if 18 or older, parent or guardian

Print name: \_\_\_\_\_ phone: \_\_\_\_\_

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

### Non-Consent Plan

I do not give my consent for emergency medical aid/treatment in the case of illness or injury during the process of receiving services or while on the property of the agency. In the event emergency aid/treatment is required, I wish the following procedures to take place:

\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Non-consent signature: \_\_\_\_\_

Volunteer if 18 or older, parent or guardian

Print name: \_\_\_\_\_ phone: \_\_\_\_\_

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



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## Volunteer Release and Indemnification Agreement

I acknowledge and understand the inherent risks of equine activities and that horsemanship experiences can result in injury and even death. In consideration for being accepted into the Hope Center Program and for the benefits I receive from participating in the program, I, \_\_\_\_\_, (volunteer if 21 or older, parent or guardian) hereby consent to assume the risks of \_\_\_\_\_, (volunteer's) participation in the horsemanship program sponsored by The Hope Center, Inc.

Accordingly, I hereby, intending to be legally bound, for myself, my heirs and assigns, executors, or administrators, waive and forever release, acquit, discharge and hold harmless, The Hope Center, Inc., the owners of the facilities and properties on which The Hope Center, Inc. conducts its therapeutic horseback riding program, including, but not limited to Rick and Claire Schemel, the officers, directors, agents, employees, representatives, therapists, instructors, and volunteers, of The Hope Center, Inc. and any other person associated with The Hope Center, Inc. therapeutic horseback riding program, and the successors and assigns of each of them, from all manner of claims, demands and damages of every kind and nature whatsoever I may now or in the future have against these parties on account of any losses or personal injuries, physical or mental condition, known or unknown to myself and the treatment thereof, as a result of, or in any way connected with the Hope Center, Inc. therapeutic horseback riding program, or growing out of acts of omission or caused by negligence or in any way incidental to The Hope Center, Inc. therapeutic horseback riding program.

**WARNING: Under Missouri law, an equine professional is not liable for any 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 Missouri.**

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

Signed: \_\_\_\_\_  
Volunteer if 21 or older, parent or guardian

Witnesses: \_\_\_\_\_  
\_\_\_\_\_



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## Photo Release

In consideration for being accepted into the Hope Center, Inc. therapeutic horseback riding program and for the valuable benefits I receive from participating in the program and promoting the program I, \_\_\_\_\_, hereby authorize The Hope Center, Inc., its advertising agencies or the news media to have photographs, films or other audio-visual materials taken of the participant for promotional material, educational activities, exhibitions or for any other use for the benefit of the Hope Center therapeutic horseback riding program. I hereby indemnify and hold the Hope Center, Inc. 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 the participants' image.

### WARNING

**Under Missouri law, an equine professional is not liable for any 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 Missouri.**

Date: \_\_\_\_\_ Signed: \_\_\_\_\_  
Volunteer if 21 or older, parent or guardian

Witnesses: \_\_\_\_\_  
\_\_\_\_\_

**REQUEST FOR CHILD ABUSE OR NEGLECT/CRIMINAL RECORD**

TYPE OF SERVICE (Check only one) See reverse side for further instructions

- (1) Name Search - \$5.00 (Criminal Record and Child Abuse Search)
- (2) Fingerprint Search - \$14.00 (Criminal Record and Child Abuse Search)
- (3) DFS Central Registry Child Abuse Search Only – No Charge

**IDENTIFYING DATA (Please type or print information legibly in ink.) The subject of the request must complete the next section and sign.**

APPLICANT'S NAME (Last, First, MI, Jr., Sr., III)

MAIDEN NAME		DATE OF BIRTH (MM/DD/YY)	STATE OF BIRTH	SEX	RACE
ALIAS NAME(S)		SOCIAL SECURITY NUMBER		DRIVER'S LICENSE NUMBER / STATE /	
ADDRESSES FOR PAST 5 YEARS STREET	CITY	STATE	STREET	CITY	STATE

Have you ever been charged / pled guilty to or been convicted of any criminal act in this state or any state?

- YES (Complete section below)
- NO, I have not been charged / pled guilty to or been convicted of any criminal offense in this state or any state.

DATE	CITY	STATE	COUNTY	CIRCUMSTANCES (Identify charges, attach separate page, if necessary.)

Have you ever been substantiated as a perpetrator in any child abuse or neglect report made to the Division of Family Services in this state or any state?

- YES (Complete section below)
- NO, I have not been substantiated as a perpetrator in any child abuse or neglect report.

DATE	CITY	STATE	COUNTY	CIRCUMSTANCES (Attach separate page, if necessary.)

The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant permission to the Department of Social Services to obtain any and all information needed to process my request and to use the information as permitted by law.

SIGNATURE OF APPLICANT (REQUIRED IN INK)		DATE
SIGNATURE OF CHILD CARE PROVIDER (Required in ink)		DATE
TITLE OF CHILD CARE PROVIDER		TELEPHONE
STATE AGENCY		STATE VENDOR OR CONTRACT NO. (If applicable)
CHECK APPROPRIATE BOX <input type="checkbox"/> CHILD CARE RELATED EMPLOYMENT <input type="checkbox"/> CHILD CARE RELATED VOLUNTEER <input type="checkbox"/> DFS LICENSURE		
<input type="checkbox"/> DOH / CCB CHILD CARE BUREAU <input type="checkbox"/> DMH / DMH VENDOR <input type="checkbox"/> HEALTH CARE		
<input type="checkbox"/> SCHOOLS / PUBLIC AND PRIVATE <input type="checkbox"/> DYS <input type="checkbox"/> OTHER _____		

RETURN ADDRESS (REQUIRED ON EACH APPLICATION)  
Complete your mailing label below  
Confidential Mail

AGENCY NAME
ATTENTION
ADDRESS
CITY, STATE, ZIP CODE