



WELCOME VOLUNTEER!

A note from our Executive Director...

Bon Cheval is a not-for-profit organization that strives to improve the quality of life and health for people living with mental, physical, social and cognitive disabilities through therapeutic activities with the horse. We rely on volunteers in every aspect and could not exist without their support, dedication and abilities.

*If you love animals and people, you will find yourself at home at Bon Cheval. Our volunteers are so very vital to our participants and our organization. **We hope you will have fun but take this responsibility seriously. Without you our riders cannot ride!***

Enclosed are the necessary forms each volunteer must fill out and return before entering the volunteer training session at Bon Cheval Riding Therapy. Please do not overlook the Child Abuse and Neglect Check Form. We cannot accept any applicant with a history of abusing or neglecting a child.

Welcome to our Bon Cheval family and I look forward to meeting you in person!

*Kim Culver
Executive Director*

Here's how to volunteer

- 1. Fill out application completely.** If completing the digital version in Microsoft Word, type your responses in the grey form areas. After completing typed responses, print the form and sign where needed. **NOTE:** *You must be at least 14yrs old to volunteer with Bon Cheval*
- 2. Return the completed application to our Napoleon/Bates City facility** (9969 Hwy D - Napoleon, MO 64074).
Email or fax the completed application boncheval@yahoo.com
- 3. We will contact you** as soon as your application has been processed. We will discuss what volunteer role you would like, what times work best for you, and then get you going just as soon as we can.



VOLUNTEER APPLICATION

Date	
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CONTACT AND PERSONAL INFORMATION		
Last Name:	First Name:	I Prefer to be called:
Sex: Male Female	Date of Birth: <i>(You must be at least 14yrs old to volunteer)</i>	
Email:	Home Phone:	Cell Phone:
Street:		Apt:
City:	State:	ZIP Code:
Want to receive Quarterly *eNewsletter? Yes No <i>*eNewsletters are also available via our website</i>		

AVAILABILITY																								
<p>I am regularly available:</p> <table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">Mon</td> <td style="text-align: center;">AM</td> <td style="text-align: center;">PM</td> <td style="text-align: center;">Tue</td> <td style="text-align: center;">AM</td> <td style="text-align: center;">PM</td> <td style="text-align: center;">Wed</td> <td style="text-align: center;">AM</td> <td style="text-align: center;">PM</td> </tr> <tr> <td style="text-align: center;">Thur</td> <td style="text-align: center;">AM</td> <td style="text-align: center;">PM</td> <td style="text-align: center;">Fri</td> <td style="text-align: center;">AM</td> <td style="text-align: center;">PM</td> <td style="text-align: center;">Sat</td> <td style="text-align: center;">AM</td> <td style="text-align: center;">PM</td> </tr> </table> <p>I'd like to help with:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Side-walking in classes</td> <td style="width: 50%;">Groundskeeping</td> </tr> <tr> <td>Horse leading in classes</td> <td>Fundraising/Grant Writing</td> </tr> <tr> <td>Assist with Groups</td> <td>Wherever I'm needed</td> </tr> </table>	Mon	AM	PM	Tue	AM	PM	Wed	AM	PM	Thur	AM	PM	Fri	AM	PM	Sat	AM	PM	Side-walking in classes	Groundskeeping	Horse leading in classes	Fundraising/Grant Writing	Assist with Groups	Wherever I'm needed
Mon	AM	PM	Tue	AM	PM	Wed	AM	PM																
Thur	AM	PM	Fri	AM	PM	Sat	AM	PM																
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Horse leading in classes	Fundraising/Grant Writing																							
Assist with Groups	Wherever I'm needed																							

HOW DID YOU HEAR ABOUT US?
Flyer TV Service Group Corporate Service Day School Tour Volunteer Match Chamber of Commerce Special Event Other _____

<input type="checkbox"/> Agreement <input type="checkbox"/> Release/Indemnification <input type="checkbox"/> Medical completed	OFFICE USE ONLY <input type="checkbox"/> Background Check <input type="checkbox"/> Outreach/ Video _____ <input type="checkbox"/> In Contacts	<input type="checkbox"/> Scheduled _____ <input type="checkbox"/> Start Date _____ NO Photos Allowed <input type="checkbox"/> {
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VOLUNTEER AGREEMENT



VOLUNTEER APPLICATION

I certify that the information provided in this volunteer application is true and correct and has been given voluntarily.
 I understand that this information may be disclosed to any party with legal and proper interest and I release Bon Cheval Riding Therapy, Inc. from any liability whatsoever for supplying such information.
 I understand that I will not be paid for my services as a volunteer.

Volunteer Applicant's Name (please print):	
Signature:	Date:
Complete if Volunteer is less than 18 years of age	
Parent or Legal Guardian's Name (please print):	
Signature:	Date:
Main Phone:	

WARNING: UNDER MISSOURI LAW, AN EQUINE PROFESSIONAL OR ANY EMPLOYEE THEREOF, 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 MISSOURI. R.S.Mo. §537.325

MORE ABOUT YOU
Why would you like to volunteer with us?
What do you consider your strengths?
Do you have experience with people with disabilities? Yes No
If yes, please explain:
Do you have experience with horses? Yes No
If yes, please explain:
If you have previous volunteered in the past, please describe where and your role:

Volunteer Authorization for Emergency Medical Treatment

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 Bon Cheval Riding Therapy, Inc. to:

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

Volunteer's Name:	
In the event of an emergency contact:	Phone:
Or contact:	Phone:



VOLUNTEER APPLICATION

Physician's Name:	Phone:
Preferred Medical Facility:	
Health Insurance Company:	Policy #:

Consent

Consent is given 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 Bon Cheval. This authorization includes x-rays, surgery, hospitalization, medication, and any treatment procedure deemed "lifesaving" by the physician. The provision will only be invoked if the volunteer is not responsive and the emergency contact is unable to be reached.

Date:	
Consent Signature:	<i>(Volunteer if 18 or older OR parent or guardian)</i>

Non-Consent

Consent is NOT given 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 Equine-Assisted Therapy, Inc. In the event emergency aid/treatment is required, I wish the following procedures to take place:

Date:	
Non-consent Signature:	<i>(Volunteer if 18 or older OR parent or guardian)</i>

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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 Bon Cheval Riding Therapy Program and for the benefits I receive from participating in the program, I, _____, (volunteer if 18 or older, parent or guardian) hereby consent to assume the risks of _____, (volunteer's) participation in the horsemanship program sponsored by Bon Cheval Riding Therapy, Inc.

Accordingly I hereby, intending to be legally bound, for myself, my heirs, assigns, executors, and/or administrators, waive and forever release, acquit, discharge and hold harmless, Bon Cheval Riding Therapy, Inc.; the owners of the facilities and properties on which Bon Cheval Riding Therapy, Inc. conducts its therapeutic and equine-related programs and activities, including but not limited to, the City of Napoleon and the City of Bates City; the officers, directors, agents, employees, representatives, therapists, instructors, and volunteers of Bon Cheval Riding Therapy, Inc.; and any other person associated with Bon Cheval Riding Therapy, Inc. therapeutic and equine-related programs and activities, and the successors and assigns of each and all of the above-mentioned parties, 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 due to any loss or personal injury, physical or mental condition, whether known or unknown to myself, and the treatment thereof, as a result of, or in any way connected with Bon Cheval Riding Therapy, Inc. therapeutic and equine-related programs and activities,



VOLUNTEER APPLICATION

or growing out of acts or omissions or caused by negligence or in any way incidental to Bon Cheval Riding Therapy, Inc therapeutic and equine-related programs and activities. I have asked, or have had the opportunity to ask, any and all questions that I may have relating to the risks involved in therapeutic and equine-related programs and activities. I fully understand and accept these risks.

Volunteer if 18 or older		
Name:	Signature:	Date:
Witness		
Name:	Signature:	Date:
Parent(s) or Legal Guardian(s) if volunteer is less than 18 years of age		
Name:	Signature:	Date:
Name:	Signature:	Date:
Witness		
Name:	Signature:	Date:

Photo Release

In consideration for being accepted as a volunteer into the Bon Cheval Riding Therapy, Inc. therapeutic horseback riding program and for the valuable benefits I receive from participating in the program and promoting the program I hereby authorize Bon Cheval Riding Therapy, Inc., its advertising agencies and/or the news media to have photographs, films or other audio-visual materials taken of myself for promotional material, educational activities, exhibitions or for any other use for the benefit of the Bon Cheval Riding Therapy, Inc. therapeutic horseback riding program. **I hereby indemnify and hold Bon Cheval Riding Therapy, Inc. harmless against any and all claims of damage arising out of the use of any such photographs or films of me or audio-visual materials containing my image.**

Participant if 18 or older Parent(s) or Legal Guardian(s) if participant less than 18 years of age		
Name:	Signature:	Date:
Witness		
Name:	Signature:	Date:

I choose **NOT** to allow photographs, films, or other audio-visual material of myself/ my child to be used.

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VOLUNTEER APPLICATION

Bon Cheval Riding Therapy, Inc.
Kim Culver
9969 Hwy D
Napoleon, MO 64074



VOLUNTEER APPLICATION

Missouri State Highway Patrol/Missouri Department of Social Services
REQUEST FOR CHILD ABUSE OR NEGLECT/CRIMINAL RECORD

TYPE OF SERVICE (Check only one) See reverse side for further instructions <input type="checkbox"/> (1) Name Search - \$5.00 (Criminal Record and Child Abuse Search) <input type="checkbox"/> (2) Fingerprint Search - \$14.00 (Criminal Record and Child Abuse Search) <input type="checkbox"/> (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		CITY	STATE	STREET	CITY	STATE
STREET						
Have you ever been charged / pled guilty to or been convicted or any criminal act in this state or any state? <input type="checkbox"/> YES (Complete section below) <input type="checkbox"/> NO, I have not been charged / pled guilty to or been convicted or 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? <input type="checkbox"/> YES (Complete section below) <input type="checkbox"/> 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



VOLUNTEER APPLICATION