



**PIONEER VALLEY THERAPEUTIC
RIDING ASSOCIATION, INC.**

PVTRA ♦ P.O. Box 944 ♦ Belchertown, MA 01007 ♦ Telephone (413)668-8260 ♦ A non-profit corporation with tax-exempt status

VOLUNTEER REGISTRATION

Name: _____ Date: _____

Street: _____

City: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Date of Birth: _____ Email Address: _____

Occupation: _____

If under age 18: Parent/Guardian: _____

Street: _____

City: _____ Zip: _____

How did you hear about PVTRA?

Have you had experience with horses? If so, please explain:

Have you had experience working with disabled people? If so, please explain:

What days and times would you be available to volunteer?

Do you have any physical limitations that would prevent you from jogging or performing other volunteer required tasks? i.e. Cardiac issues, recent surgeries, severe allergic reactions etc.

OVER

Please read this document carefully and do not sign it unless you fully understand it.

Release

I recognize the inherent risks of injury involved in working around horses. I assume any such risks of injury and further, I voluntarily release PVTRA, its instructors, employees and agents from any responsibility on account of any injury I (my child/ward) may sustain while volunteering, and I agree to indemnify and hold harmless PVTRA, its instructors, employees and agents on account of any such claim. **I understand that all information about participants at PVTRA is confidential and will not be shared with anyone.**

Volunteer: _____ Date: _____

Parent/Guardian: _____ Date: _____
(If under 18)

Medical Authorization

In the event that the above-named volunteer requires emergency medical treatment on account of any accident or injury which may occur in connection with any activities with PVTRA, the authorities at PVTRA are hereby given full authorization to provide all such necessary emergency medical treatment for the above-named volunteer.

Volunteer: _____ Date: _____

Parent/Guardian: _____ Date: _____
(If under 18)

Physician's Name: _____

Health Insurance Co.: _____ Policy #: _____

In case of an emergency, please contact:

Name: _____ Telephone: _____

Do you have any allergies, medical conditions, or medications that emergency officials should be informed of?

Photo Release:

I do
I do not

consent to and authorize the use and reproduction by PVTRA for any and all photographs and any other audio-visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Volunteer: _____ Date: _____

Parent/Guardian *(If under 18)*: _____ Date: _____