Medicine Horse

Promoting Physical Wellness and Emotional Healing
in Partnership with Horses

FORMS

38 Lizzies Lane ≈ Morrisonville, NY 12962 ≈ (518) 566-7217

Medicine Horse

Promoting Physical Wellness and Emotional Healing
in Partnership with Horses

GUIDELINES FOR PARTICIPATION

Medicine Horse Farm Corp. is a not for profit organization in Morrisonville, NY committed to offering the proven benefits of therapeutic riding and equine activities to physically, developmentally, and emotionally challenged children and adults.

Medicine Horse offers a variety of innovative programs that provide educational and therapeutic equestrian activities. We offer weekly therapeutic riding lessons throughout the year, unmounted stable management lessons, and vocational education.

Application, enrollment, attendance and payment are administered according to the following policies:

APPLICATION

Upon request, Medicine Horse provides the information and forms required for the application. Once all forms have been completed and returned to Medicine Horse, prospective clients are assessed by staff for eligibility. We reserve the right to decide that we are unable to serve an applicant. If accepted, clients are enrolled into the program when a time slot becomes available.

ENROLLMENT

1. NO ONE MAY PARTICIPATE IN MEDICINE HORSE CLASSES UNTILL THE FOLLOWING MANADATORY FORMS ARE FILLED OUT, RECEIVED AND ACCEPTED AS COMPLETED BY THE MEDICINE HORSE OFFICE: Registration and Release, Emergency Medical Treatment, and Medical History forms. Each form must be signed and dated by the appropriate party (in particular, the *Medical History* form **must** be signed and dated by a physician.)

2. Clients are notified of scheduled enrollment 4 weeks prior to the start of a session. Confirmation of intent to participate must be made to the office at least 2 weeks prior to each session to guarantee participation.

Please Note: The Medicine Horse staff is available for consultation throughout the application and enrollment process, as well as during the program session. Call with any questions, concerns, suggestions or comments: 518-566-7217

Medicine Horse

Promoting Physical Wellness and Emotional Healing
in Partnership with Horses

ATTENDANCE

1. Medicine Horse farm expects regular attendance from all participants. Refunds are not given for missed lessons.

2. Participants who must be absent should notify the office by calling 518-566-7217 at least 24 hours prior to their scheduled lesson time. Two absences without notification may result in a participant losing their scheduled time slot.

3. The Medicine Horse class schedule is subject to change. In the event of unforeseen circumstances, all reasonable attempts will be made to notify clients at least 2 hours prior to a schedule change. In the event Medicine Horse must cancel a lesson, the client will receive a credit for a make-up lesson, or a credit will be applied to a lesson in another session.

Medicine Horse

Promoting Physical Wellness and Emotional Healing
in Partnership with Horses

REGISTRATION AND RELEASE FORM

Participant's Name:_____ Date of Birth:___/___/___ Age:_____

Weight:_____ Height:_____ Disability: _____

School or Institution Presently Attending:_____ Teacher's Name:_____

Primary Contact Name:_____

Check One: ( ) Parent ( ) Guardian ( ) Executor ( ) Residential Mgr. ( ) Other: Specify_____

Mailing Address:

Street:_____ City:_____ State:____ Zip_____

Home Phone: ( )_____Cell Phone: ( )_____E-Mail_____

Business Name:_____Address:_____Bus. Phone:( )_____

PHOTO RELEASE: _____ I hereby consent to and authorize
_____ I do not consent to, nor do I authorize

The use and reproduction of any and all photographs and other audiovisual material taken of me/participant by Medicine Horse Therapeutic Riding, Inc. for promotional printed material, education activities, exhibitions, or for any other use for the benefit of the program.

Date: _____ Signature: _____

LIABILITY RELEASE (Required): _____ (Name) would like to participate in the Medicine Horse Program. I acknowledge the risks and potential for risks of horseback riding and related equine activates, including grievous bodily harm. However, I feel that the possible benefits to myself/my child/my ward are greater than the risk assumed. I hereby, intending to be legally bound for myself, my heirs and assigns, executors, and administrators waive and release forever all claims for damages against Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses I/my child/ ward may sustain while participating in the Program from whatever cause including but not limited to the negligence of these release parties.

The undersigned acknowledges that he/she has read this Registration and Release Form in it entirety; that he/she understands the terms of this release and has signed this release voluntarily and with full knowledge of the effects thereof:

Date:_____ Signsture:_____

TESTING RELEASE (*NEW RIDERS ONLY*): I have read the letter to prospective Medicine Horse participants, parents and/or teacher. I understand the importance of pre- and post-testing of new participants. I give permission for _____ to be tested by Medicine Horse

Date:_____ Signature:_____

/Forms/Participant forms/Registration and Release Form 06/07

Medicine Horse

Promoting Physical Wellness and Emotional Healing in Partnership with Horses

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

_____ Participant _____ Staff _____ Volunteer

Name_____ DOB:_____ Phone:_____

Physician's Name:_____ Preferred Medical Facility:_____

Health Insurance Co.:_____Policy #:_____

Current Allergies, Medications, and Health Concerns:_____

_____

_____**In the event of an emergency:**

Emergency Contact 1:_____Relation:_____

Home Phone:_____ Work Ph.:_____ Cell Ph.:_____

Emergency Contact 2:_____Relation:_____

Home Phone:_____ Work Ph.:_____ Cell Ph.:_____

In the event that 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 Medicine Horse 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.

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) listed cannot be reached.**

Date:_____ Consent Signature:_____

(Client Parent or Legal Guardian)

NON-CONSENT PLAN

I do not give consent for emergency medical treatment/aid in the case of illness of injury during the process of receiving services of while being on the property of the agency. In the event emergency treatment/aid is required, I wish for the following procedure to take place (please give details below):

_____

_____

_____

Date:_____ Non-Consent Signature:_____

(Client Parent or Legal Guardian)

/Forms/Participant forms/Authorization for Emergency Medical Treatment 06/07

Medicine Horse

Promoting Physical Wellness and Emotional Healing
in Partnership with Horses

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize _____
Person(s) or Place(s) releasing information

To release information from the records of _____
Participant's name

DOB: _____.

The information is to be released to Medicine Horse Farm for the purpose of developing an equine activity program for the above named participant. The information release is marked below.

_____ Medical History
_____ Physical Therapy evaluation, assessment and program plan
_____ Occupational Therapy evaluation, assessment and program plan
_____ Speech Therapy evaluation, assessment and program plan
_____ Psychosocial evaluation, assessment, program plan and discharge summary
_____ Classroom Individual Education Plan (I.E.P)
_____ Cognitive-Behavioral Management Plan
_____ Other _____

Date:_____ Signature:_____
(Client Parent or Legal Guardian)

Please send the indicated material to the address below. Thank you.

Medicine Horse Farm
38 Lizzies Lane
Morrisonville, NY 12962

Medicine Horse

Promoting Physical Wellness and Emotional Healing in Partnership with Horses

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Participant's Name: _____DOB:_____ Height:_____Weight:_____
Address: _____
Diagnosis: _____Date of Onset:_____
Past/Prospective Surgeries: _____
Seizure Type: _____ Controlled: Y N Date of Last Seizure:_____
Shunt Present: Y N Date of last revision: _____
Special Precautions, Diets/Needs: _____
_____ May participate in all activities _____ May participate except for: _____
Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N
Braces/Assistive Devices Comments:_____
***For those with Down Syndrome: AtlantoDens Interval X-rays, date _____ Result: + -**
Neurologic Symptoms of AtlantoAxial Instability: _____

This participant is up-to-date on all the following routine childhood immunizations:

	Y	N	Date:
Measles			
Rubella			
Tetanus			
Pertussis			
Polio			
Diphtheria			
Other			

Please indicate current or past difficulties in the following systems/areas, including surgeries:

	Y	N	Comments:
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

IMPORTANT NOTE TO DOCTOR / MEDICAL FACILITY
If you prefer to provided the requested information on your own medical form, we will accept that only when the below release section is completed, signed and dated and your form is stapled to our form.

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a referral of the patient to a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

Name/Title _____ MD DO Other: _____
Signature: _____ Date: _____
Address: _____
Phone: _____ License/UPIN Number: _____

Medicine Horse

Promoting Physical Wellness and Emotional Healing in Partnership with Horses

Date: _____

Dear Physician:

Your patient _____is interested in participating in supervised equine activities.

In order to safely provide this service, our center requests that you complete/update the Medical History and Physician's Statement Form on the back of this letter. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic
Atlantoaxial Instability- include neurological symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Spinal Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation
Tethered Cord/Hydromyelia

Other
Age- usually under 4 years
Indwelling Catheters
Medications- i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine activities, please feel free to contact the center at the address/phone indicated below.

Sincerely,

Marie Postiglione-Dupell
Program Director
(Over)

Medicine Horse

Promoting Physical Wellness and Emotional Healing in Partnership with Horses

ATTENTION:
MEDICINE HORSE FARM PARTICIPANTS WITH DOWN SYNDROME

As a member of NARHA (North American Riding for the Handicapped Association), we require the following medical clearance be updated by the participant's physician annually. See reverse side for further information.

I certify that _____ has a **negative** Atlantoaxial
(Participant's name)

Instability (AAI) and therefore authorized to continue Therapeutic Horseback Riding at Medicine Horse.

Physician's Name: _____ Date: _____

License/UPIN Number: _____

Medical Facility Name, Address and Phone number:

_____
_____
_____
_____
_____

If you have any questions, feel free to contact us. **Please return this completed form to Medicine Horse Farm by mail at address indicated below**. Thank you.

Atlantoaxial Instability (AAI) in Down Syndrome

Atlantoaxial instability (AAI) has been described as instability, subluxation or dislocation of the joint between the first and second cervical vertebrae (atlantoaxial joint). Instability of the joint is generally due to poor muscle tone and ligament laxity that is common with **Down Syndrome**, less common with other disorders such as rheumatoid arthritis. The problems that may arise with a lax joint is that there can begin to be pressure on the spinal cord, resulting in neurologic changes (see listing below). This is symptomatic AAI, and will always require evaluation by an MD and restriction of high risk activities such as riding or driving. This is a potentially paralyzing or life threatening condition. Incidence of non-symptomatic AAI among persons with Down Syndrome is reported to be 10 to 20 percent. Symptomatic AAI is much less frequently seen.

X-ray, CT or MRI is needed to determine if AAI is present. An accurate measurement by X-ray is not easy to obtain and should be done by a radiologist familiar with this examination. It should be noted that X-rays done prior to the age of 2 can be unreliable, therefore, these children may not participate in mounted activities. For the child from 2-4 years, please refer to the section on Age Related Considerations, and always consult with the participant's pediatrician. A group of individuals with Down Syndrome have been reported to demonstrate neurologic abnormalities with no visual AAI. The cause of these abnormal neurologic signs is unclear. **Neurologic signs always supercede radiographs and the presence of the neurologic disorder must be evaluated by a physician and is a contraindication for mounted equine activities.**

Note that it is not just a fall that is potential for injury. For a participant with low muscle tone and laxity in the joints of the neck, the repeated movement of the equine or a sudden quick movement of the equine as with a spook or a mis-step, could be enough to cause problems. Please also see the section on Head/Neck control.

NARHA requires that all participants with Down Syndrome have:

Prior to starting mounted activities:

A. A recent medical examination with special reference to neurologic function.

B. Lateral or side view X-rays or other appropriate imaging studies to determine presence of AAI. Suggested to be within the past 5 years. X-rays are of the upper cervical region in:

   1. Full flexion
   2. Extension

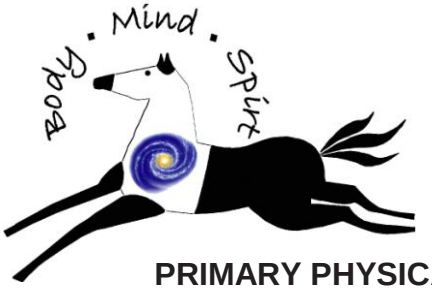
C. Certification by a physician that an examination did not reveal atlantoaxial instability or focal neurologic disorder

With continuation of mounted activities:

A. Annual certification from a physician/qualified medical professional that the participant's physical examination reveals no signs of AAI or decrease in neurologic function.

B. Following the initial radiograph, indication for repeated imaging studies (X-ray or CT) should be made at the discretion of the participant's physician.

38 Lizzies Lane ≈ Morrisonville, NY 12962 ≈ (518) 566-7217



Medicine Horse

Promoting Physical Wellness and Emotional Healing
in Partnership with Horses

PRIMARY PHYSICAL THERAPIST—PHYSICAL THERAPY EVALUATION

Name of Patient: _____ Date: _____

General Information (Brief history and muscle evaluation) _____
_____
_____

Joint Evaluation: _____
_____
_____

Behavior: _____
_____
_____

Functional Ability and Limitation Imposed by Reflexes: _____
_____
_____

Capable of Independent Sitting: ( ) Yes ( ) No

Physical Therapy Program: _____
_____
_____

Goals: _____
_____
_____

Primary Physical Therapist's Signature: _____

Print Name/Address/Telephone of Primary Physical Therapist:

_____
_____
_____
_____

Please return to Medicine Horse at the address listed below. Thank you.

38 Lizzies Lane ≈ Morrisonville, NY 12962 ≈ (518) 566-7217

Medicine Horse

Promoting Physical Wellness and Emotional Healing in Partnership with Horses

Primary OT – OCCUPATIONAL THERAPY ASSESSMENT

(Please fill in any significant information that can be incorporated into the riding program)

Name of Patient: _____ Date: _____

General Information: _____
_____
_____

Medications (diagnosis/precautions): _____
_____
_____

VisualMotor/PerceptualMotor: _____
_____
_____

Sensory Processing (areas of concern/sensitivity): _____
_____
_____

Motor Skills (fine motor, motor planning): _____
_____
_____

Self-Care: _____
_____
_____

Adaptive Equipment (mobility, discreet trial training,
ADL, Augmentative communication, PECS, etc): _____
_____
_____

Sitting balance (include static/dynamic surfaces): _____
_____
_____

Safety Awareness: _____
_____
_____

Therapy Goals: _____
_____
_____

Successful Intervention Strategies used (sensory modalities, behavioral, rewards, etc.): _____
_____
_____

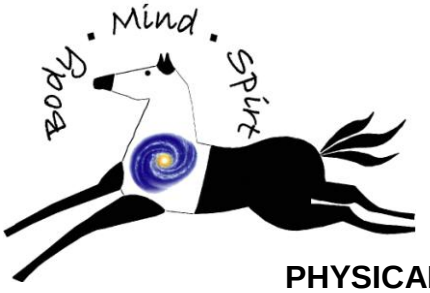
Primary Physical Therapist's Signature: _____

Print Name/Address/Telephone of Primary Physical Therapist:

_____
_____
_____
_____

Please return to Medicine Horse at the address listed below. Thank you.

38 Lizzies Lane ≈ Morrisonville, NY 12962 ≈ (518) 566-7217



Medicine Horse

Promoting Physical Wellness and Emotional Healing in Partnership with Horses

PHYSICAL/OCCUPATIONAL THERAPY ASSESSMENT

Participant's Name: _____Age:_____

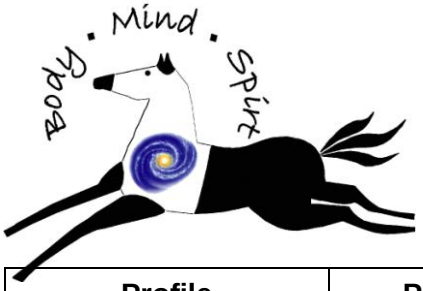
Date:_____ Diagnosis: _____

_____

History (include precautions/restrictions from medical referral and parent/guardian reports, allergies, respiratory problems, previous and current therapy.)

Profile	Problem/Limiting Factor		Recommendation
1. Head			
a) Vision			
b) Hearing			
c) Mouth			
2. Neck/Spine			
3. Upper Extremities	**Right**	**Left**	
a) ROM			
b) Strength			
c) Tone			
d) Coordination			
e) Hand Function			
4. Lower Extremities			
a) ROM			
b) Strength			
c) Tone			
d) Coordination			
5. Balance			
a) Sitting			
b) Standing			
6. Posture			
a) Sitting/Standing			
7. Skin			
8. Sensory Awareness			
9. Function			
a) Transfers			
b) Ambulation			
c) Tone			
d) Hand Dexterity			

38 Lizzies Lane ≈ Morrisonville, NY 12962 ≈ (518) 566-7217



Medicine Horse

Promoting Physical Wellness and Emotional Healing in Partnership with Horses

Profile	Problem/Limiting Factor	Recommendation
10. Cognition		
a) Orientation		
b) Attention Span		
c) Memory		
11. Language		
a) Expressive		
b) Receptive		
12. Behavior/Attitude		
13. Summary		
14. Precaution/Restrictions		
15. Suggested Exercises		
16. Equipment	Safety Belt _____ Hand Hold _____ Helmet Peacock Stirrups _____ Devonshire Stirrups _____ Ladder Reigns Bareback Pad _____ English Saddle _____ Western Saddle	

Signature(s) of Evaluator(s): _____

_____

Address: _____

_____

_____

Phone: _____

38 Lizzies Lane ≈ Morrisonville, NY 12962 ≈ (518) 566-7217

Medicine Horse

Promoting Physical Wellness and Emotional Healing
in Partnership with Horses

MENTAL HEALTH DATA FORM

Participant's Name: _____

Treatment Coordinator/Therapist _____ Phone:_____

Presenting Problems

_____
_____
_____
_____

Diagnosis (DSM-IVTR)

Axis I _____
Axis II _____
Axis III _____
Axis IV _____
Axis V _____

History

_____
_____
_____
_____

Current Medications

Drug Dose Route Time Purpose

_____
_____
_____

Psychiatric Treatment History

	Where	When	Diagnosis
Current Therapy			
Outpatient Therapy			
Inpatient Therapy			

Medicine Horse

Promoting Physical Wellness and Emotional Healing in Partnership with Horses

VOLUNTEER REGISTRATION & RELEASE FORM

Please Print

NAME _____DATE OF BIRTH _____/_____/_____ AGE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE (_____)_____WORK PHONE (_____)_____

CELL PHONE _____ E-MAIL _____

PLACE OF EMPLOYMENT OR SCHOOL _____OCCUPATION:_____

[ ] My employer gives me time off for volunteering [ ] My employer matches cash donations

PARENT/GUARDIAN NAME _____ PHONE _____
(If volunteer is under 18 years of age)

REFERENCE NAME (non relative): _____ PHONE_____

Reason for volunteering: Personal Fulfillment _____ School Requirement _____ Court required Community Service _____ Other _____

How did you hear of Medicine Horse? Friend ☐ Relative ☐ Newspaper ☐ Flyer ☐ Other ☐

PHOTO RELEASE: _____ **I consent** to and authorize _____ I **do not** consent to nor do I authorize the use and reproduction of any and all photographs and other audiovisual material taken of me/participant by Medicine Horse Therapeutic Riding, Inc. for promotional printed material, education activities, exhibitions, or for any other use for the benefit of the program. _____ Initial

POLICY OF CONFIDENTIALITY: Confidentiality is defined as "told in secret or private relations; trusted." Any information in regards to the participants (clients) at Medicine Horse must be held in strict confidentiality. It is critical that we respect each individual. Confidentiality is considered one of the most basic responsibilities to our facility. Failure to abide by this policy may diminish the quality of the service we provide and result in legal ramifications. I have read and understand Medicine Horses' Policy of Confidentiality and agree to abide by same. _____ Initial.

LIABILITY RELEASE: I acknowledge the risks and potential of horseback riding and working with horses, including grievous bodily harm. However, I feel that the possible benefits to myself are greater than the risks assumed. I herby, intending to be legally bound for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Medicine Horse, its Instructors, Therapist, Aides, Volunteers, and/or Employees for any and all injuries and/or losses I may sustain while participating as a Medicine Horse volunteer from whatever cause, including but not limited to the negligence of these related parties.

The undersigned acknowledges that he/she has read this Volunteer Application in its entirety; that he/she understands the terms of this release and has signed this release voluntarily and with full knowledge of the effects thereof. ____ Initial

Date:_____ Signature:_____

Signature of Parent/Gaurdian:_____
(If volunteer is under 18 years of age, both signatures are required)

Medicine Horse

Promoting Physical Wellness and Emotional Healing
in Partnership with Horses

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FOR VOLUNTEERS

In the event emergency medical aid/treatment is required due to illness or injury while being on the property of the agency, I authorize Medicine Horse to:

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

In case of Emergency, contact: _____Phone_____

Or: _____ Phone _____

Physician's Name: _____Town: _____Phone _____

Preferred Medical Facility: _____

Health Insurance Carrier: _____ Policy #: _____

Medical conditions and/or medications that may affect your volunteer role and that we should be aware of in the event of an emergency: _____

Allergies: _____Date of last Tetanus shot: _____

CONSENT PLAN (to be invoked in the event that your Emergency Contact cannot be reached.) I give consent for emergency medical treatment/aid (including x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician) in the event of illness or injury while on the property of the agency.

Date: _____Consent Signature _____
(Parent or Guardian if volunteer is under 18 years of age)

NON-CONSENT PLAN – I do not give consent for emergency medical treatment/aid in the event of illness or injury while on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

_____

Date: _____Non-Consent Signature _____
(Parent or Guardian if volunteer is under 18 years of age)

Please Complete

Are you First Aid Certified? _____ Are you CPR Certified? _____

Driver's License #: _____ State _____

Has your driver's license ever been suspended or revoked in any state? ____ YES _____ NO

If yes, when? _____ Where? _____ Why? _____

Have you ever been convicted of a criminal offense? ___ YES ___ NO. If yes, when? _____

Where? _____ Please explain: _____

Upon request, you can be asked to submit an application for a criminal background check.
The information that I have provided may be verified, and I give permission to Medicine Horse to make inquiry of others concerning my suitability to act as a volunteer at Medicine Horse.

Date: _____ **Signature** _____
(If volunteer is under 18 years of age, **both** signatures are needed)

Medicine Horse

Promoting Physical Wellness and Emotional Healing in Partnership with Horses

GENERAL VOLUNTEER INFORMATION FORM

Name: _____

1. Please tell us of your experience with:
   - Horses: _____
   - Leading Horses and/or Sidewalking: _____
   - People with Disabilities: _____
2. Your Volunteer Interests
   (A) **Lesson Program Volunteer**. I am interested in volunteering for the riding program in the following way(s): ____ Sidewalking Riders ____ Horse Leading (must have horse experience) ____ Coordinator (grooms & tacks horses for lessons)
   (B) **Equine Program Volunteer.** ____ Horse Care, Feeding, Cleaning Paddocks, etc.
   (C) **Facility / Farm Volunteer.** ____ General Maintenance & Repairs ____ Carpentry ____ Equipment Repair
   (D) **Office Volunteer.** ____ Data Entry ____Reception ____ General Office Support ____Mailings
   (E) **Summer Camp Volunteer.** ____ Assists with day camp activities
   (F) **Special Events & Fundraisers Volunteer.** ____ Serve on Special Events Planning Committees ____ Provide assistance day of event ____ Baking/cooking
   (G) **Special Skills Volunteer.** Do you have skills, technical/professional experience that would be beneficial to Medicine Horse? If so, please check any that apply?

   ____Photography ____ Sign Language ____Cooking/Baking ____Public Relations/Outreach
   ____Construction ____Fundraising Experience ____ Grant Writing ____Computer ____Graphic Design
3. Please indicate your Volunteer **availability**. This will serve as a **guideline** only. Your actual schedule will be arranged with the Volunteer Coordinator. Please put an ***X*** in the days and times when you are available to volunteer.

	8-9 am	9-10 am	10-11 am	11-12 pm	12-1 pm	1-2 pm	2-3 pm	3-4 pm	4-5 pm	5-6 pm	6-7 pm	7-8 pm
Mon												
Tue												
Wed												
Thu												
Fri												
Sat												
Sun												

I would like to commit to a regular day/time: _____ YES _____ NO
I cannot commit to a regular day/time right now, but would like to serve as a substitute _____ YES _____ NO
In addition to my regular hours (if applicable), I am available to substitute the following day(s)/time(s): _____
_____

Thank you for taking the time to answer this questionnaire. Your responses provide useful information to help us better assess our volunteer corps, as well as select the best assignment for you. If, at any time, you would like to change your time, day or job assignment, please let us know