

Always By Your Side: Strategies for Success in Volunteer Management

High Hopes Therapeutic Riding, Inc. • Old Lyme, CT
March 29—30, 2018



High Hopes is...

*A PATH Intl. Premier
Accredited Center*

*Internationally renowned
for training & education*

501c3 Non Profit Center

*Four Star Charity
through Charity Navigator*

We offer...

*Lectures by experienced
professionals*

Networking opportunities

*A dynamic learning
environment*

An interactive two-day workshop designed to help you develop strategies and techniques for managing volunteer resources

Topics to include:

- Recruitment, training and retention
- Fostering volunteer relationships
- Managing volunteers for maximum effectiveness
- Volunteer program evaluation and data tracking and more!

Day 1

Administrative Volunteer Management: Recruit—Train—Schedule—Retain

Day 2

Instructional Volunteer Management:

Program specific training
Program volunteer placement (leaders, sidewalkers, etc.),
Solution/team base approach to managing volunteers in therapeutic riding

Who Should Attend

Volunteer Managers/Coordinators
Non Profit Program Administrators
Therapeutic Riding Instructors
Anyone who wants to learn more about volunteer management

Workshop Faculty

Megan Ellis, High Hopes Program Manager

PATH Int'l approved CEU's = 7 CE; 7 Riding CR



For more information, contact:
Sarah Carlson, Special Programs Manager
High Hopes Therapeutic Riding, Inc.
36 Town Woods Road
Old Lyme, CT 06371
(860) 434-1974 ext. 115 or scarlson@highhopestr.org

HighHopes

Therapeutic Riding

HORSES AND HUMANS
IMPROVING LIVES

To register for a workshop, please complete the information requested below and send it together with the required fee* to:

High Hopes Therapeutic Riding, Inc.
36 Town Woods Road, Old Lyme, CT 06371
www.highhopestr.org
Fax: (860) 434-3723

Upon receipt of this completed form and payment, High Hopes will send you an official letter of welcome and any additional materials necessary. For questions contact Sarah Carlson at (860) 434-1974 ext. 115, or scarlson@highhopestr.org.

Name: _____ Phone: _____

E-mail: _____ PATH Member # _____

Address: _____

City: _____ State: _____ Zip: _____

Organization or Program Affiliation: _____

Please register me for the following: (Registration includes light lunch)

Administrative Volunteer Management: March 29, 2018

_____ \$195 *Recruit—Trail—Schedule—Retain*

Instructional Volunteer Management: March 30, 2018

_____ \$195 *Program specific training, program volunteer placement, solution/team base approach*

Administrative Volunteer Management & Instructional Volunteer Management: March 29—30, 2018

_____ \$350

Registration Deadline: February 26, 2018

Reimbursement policy: Cancellations prior to the registration deadline will receive a refund minus a \$75 service fee. No reimbursements will be granted after the registration deadline.



**HIGH HOPES THERAPEUTIC RIDING INC
REGISTRATION & RELEASE**

VISITOR & SPECIALTY VOLUNTEER FORM

PLEASE COMPLETE ENTIRE FORM

Please Check One: Visitor: ___ **Brd/Cmt Member:** ___ **Spec Event Volunteer:** ___ **One Day Vol/Group:** _____

Name: _____ Home #: _____ Cell #: _____ DOB: _____

Address: _____ Town: _____ zip _____

Email: _____

In case of Emergency, contact: (Parent if minor) _____ Phone: _____

Please indicate any medical conditions or medications we should be aware of in the event of an emergency: _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT: In the event emergency medical aid/treatment is required due to illness or injury while being on the property of the agency, I authorize High Hopes to: Secure and retain medical treatment and transportation, if needed and release records upon request to the authorized individual or agency involved in the medical emergency treatment.

Date: _____ **Consent Signature:** _____

If volunteer is under 18 years of age, both parent & volunteer/visitor signatures are required.

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:** _____

If volunteer is under 18 years of age, both parent & volunteer/visitor signatures are required.

***If you choose non-consent for emergency medical treatment/aid in the event of illness or injury while on the property of the agency, please request a Non-Consent Form, which requires notarization.**

PHOTO RELEASE:

_____ I hereby consent and authorize _____ I do not consent to, nor do I authorize. 1) High Hopes Therapeutic Riding, Inc. to use my(my child's) photograph or image in its print, online and video publications; 2) release High Hopes Therapeutic Riding, Inc., its employees and any outside third parties from all liabilities or claims that I might assert in connection with the above-described activities and 3) waive any right to inspect, approve or receive compensation for any materials or communications, including photographs, videotapes, DVDs, website images or written materials, incorporating photos/images of me(my child).

Date: _____ **Consent Signature:** _____

If volunteer is under 18 years of age, both parent & volunteer/visitor signatures are required.

CONFIDENTIALITY POLICY: At High Hopes, we place great importance on protecting the confidential information of our clients, our staff and our volunteers. "Confidential Information" includes, but is not limited to, personally identifiable information such as surnames, telephone numbers, addresses, e-mails, etc., as well as the non-public business records of High Hopes. In particular, medical information about clients, and information about their disabilities or special needs, must be protected as Confidential Information. Volunteers shall never disclose confidential information to anyone other than High Hopes staff. Volunteers must seek staff permission before taking any pictures or videos. I have read and understand High Hopes Confidentiality Policy and agree to abide by same.

Date: _____ **Signature:** _____

If volunteer is under 18 years of age, both parent & volunteer/visitor signatures are required.

LIABILITY RELEASE: I acknowledge the risks and potential for risks of horseback riding and related equine activities including grievous bodily harm. However, I feel that the possible benefits to myself are greater than the risks assumed. I hereby, intending to be legally bound for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against High Hopes Therapeutic Riding Inc., its Board of Trustees, Instructors, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses I may sustain while participating as a High Hopes 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.

Date: _____ **Signature:** _____

If volunteer is under 18 years of age, both parent & volunteer/visitor signatures are required.